Health and Community Services
COMPLAINTS COMMISSION




Twelfth Annual Report 2009/10

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HEALTH AND COMMUNITY SERVICES COMPLAINTS COMMISSION

Twelfth Annual Report 2009/10

The Honourable Kon Vatskalis, MLA
Minister for Health
Parliament House
DARWIN NT 0800

Dear Minister

As stipulated by Section 19(1) of the *Health and Community Services Complaints Act 1998*, the Twelfth Annual Report of the Health and Community Services Complaints Commission, for the year ending 30 June 2010 is submitted to you for tabling in the Legislative Assembly.

Yours sincerely

Carolyn Richards
Commissioner

10 September 2010

Inquiries about this report, or any of the information or references contained within, should be directed to:

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STATEMENT OF ACCOUNTABLE OFFICER

As an Accountable Officer I advise that, to the best of my knowledge and belief:

(a) proper records of all transactions affecting the Commission were kept and that employees under my control observed the provisions of the *Financial Management Act*, the *Financial Management Regulations* and *Treasurer's Directions*;

(b) procedures within the Commission afforded proper internal control, and a current description of these procedures can be found in the *Accounting and Property Manual* which has been prepared in accordance with the *Financial Management Act*;

(c) no indication of fraud, malpractice, major breach of legislation or delegations, major error in or omission from the accounts and records existed;

(d) in accordance with Section 15 of the *Financial Management Act* the internal audit capacity available to the Commission is adequate and the results of internal audits were reported to me;

(e) no financial statements are included in this Annual Report. The Ombudsman prepares the Commission's financial statements from proper accounts and records and are in accordance with Part 2, Section 5 of the *Treasurer's Directions* where appropriate;

(f) all actions have been in compliance with all Employment Instructions issued by the Commissioner for Public Employment; and

(g) the Commission has complied with Section 131 of the *Information Act*.

In addition, I advise that in relation to item (a) the Chief Executive Officer (CEO) of Department of Business and Employment (DBE) has advised that to the best of his knowledge and belief, proper records are kept of transactions undertaken by DBE on my behalf, and the employees under his control observe the provisions of the *Financial Management Act*, the *Financial Management Regulations* and *Treasurer's Directions*.

Carolyn Richards
Commissioner
10 September 2010

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FROM THE COMMISSIONER

Five years ago I took up the position of Commissioner for Health and Community Services Complaints. In those five years the Commission has been approached by approximately 1800 people who were disappointed or aggrieved by aspects of health and community services in the Northern Territory. The Commission has jurisdiction over both public and private health services. There is no significant difference in the number of approaches about either sector. Both the private and the public sector generate on average fifty per cent of approaches to the HCSCC.

The HCSCC has two main aims.

One is to resolve complaints between providers and patients. At this the Commission has been consistently effective and, over the last five years, increasingly effective. The credit for that must be given as much to the health service providers as to the HCSCC staff. Over five years I have noticed a greater willingness by health service providers to accept that good patient service includes good communication, respect for a patients' expectations, and acknowledgment of their anxieties and fears as well as providing treatment. In the public hospitals of the Territory, although there is as yet no general acceptance of open disclosure, big strides have been made towards patient focused care. I wish to pay tribute to the Customer Relations Manager at Royal Darwin Hospital and to Robyn Harrison, an unsung hero, who for many years has patiently and skilfully advocated for patients who have been dissatisfied, or angry sometimes, with various aspects of access to, or the quality of services at RDH. Robyn has manoeuvred outcomes for patients and clinicians and the HCSCC with equity, understanding and skill.

The work of the HCSCC in reaching resolution for patients has also been assisted by the skills, personal attributes and professionalism of two other outstanding people working for the Department of Health and Families (DHF), Karen Mulligan, the Safety & Quality Co-ordinator and her successor, Suzanne Cameron. On behalf of all those patients who have been helped by Karen and Suzanne, without those patients ever knowing how instrumental they were in achieving resolution of their complaints and instigating changes of the system, I say thank you.

My observations of health services over the last five years lead me to praise and admire all those nurses, medical practitioners, mental health workers, allied health workers, Aboriginal health workers, St John Ambulance, oral health dentists and workers, general practice managers and the regional health centres whose skills and dedication actually provide health care in the Northern Territory directly at the "coal face".

The second aim of the HCSCC is to help improve the quality and safety of health services. The Commission critically examines the systemic issues that surround an individual complaint to identify what was the ultimate cause of a patient's dissatisfaction or adverse outcome. The health service providers examine matters brought to their attention by a complaint and by HCCC inquiries and recommendations. In that regard the HCSCC and health service providers have a common aim.

Patients are often not aware that high quality health care requires many services and the quality or availability of a health service depends on a system and a team. Complaints are made to the HCSCC that name or criticise a particular health practitioner. This is understandable because the patient interacts and relates to the person in whom trust is placed. The reality is more complex. I use an example from a public hospital but the same interdependence of aspects of a system occur with private services.

WHAT THE PATIENT EXPERIENCES	TO DELIVER THE INPATIENT EXPERIENCE THE HEALTH SYSTEM NEEDS
Consultation with a doctor in outpatients	Recruitment, registration, accreditation, scheduling of appointments, referral, protocols, prioritisation of resources, adequate records, availability of patient's previous medical history, transport arrangements, availability of consulting room.
Diagnostic tests	Adequate funding for x-rays, CT scans, ultra sounds, MRI's, pathology testing laboratories, training of staff to do tests, staff able to maintain the equipment, systems for recording the patients results, communicating the results promptly to those tho need to know them and skilled clinicians and specialists able to interpret the results.

Diagnosis – prognosis	Medical practitioners highly trained for many years to understand the significance of a patient's history, diagnostic tests, personal circumstances to reach a working diagnosis, supported by nurses, administrative officers and managers to arrange for the patient and clinician to have adequate time together, in a conducive environment. This can involve travel arrangements, provision of a room, interpreters, interaction with family or carers and access to previous treatment records.
Recommended treatment Treatment plan Hospital admission Surgery Inpatient care	These all involve a team of health providers such as surgeons, medical officers, clinical nurses, operating theatres equipped with sterile and well maintained fail safe machines, lights, devices and with prostheses and substances. To provide that environment there is a plethora of people who procure what is needed, schedule people, arrange for the doctors and nurses to be recruited, rostered, and have updating training, cleaning services, security services, building maintenance, power and water services. All are part of the complex planning to support the patient experience. And let me not fail to mention the catering arrangements ensuring food and liquid is served to patients and staff.
Discharge Follow up treatment	Administrative services, clerks, social workers to find out what a patient will have available when discharged. Referrals to care services, "hospital in the home", community services, a general practitioner, meals on wheels, home and community care or one of the support services for those who have suffered cancer or leukaemia or are HIV positive, need to be made.

When considering the things that go wrong or make patients unhappy, I have been struck by the complexity, intricacy and interdependence of all aspects of providing good and safe patient care.

Of all the complaints the HCSCC has received over my last five years most have not been about incompetence or negligence. Patients are aggrieved or mistakes happen because the system is so complex. A small failure in communication, or a test result coming in late, or handovers between staff shifts are rushed, or there are not enough nurses to listen to the patients or doctors with time to reflect on all possible diagnoses. And underpinning the whole complex system are the cornerstones – Medicare and funding by Government; rules of private health insurers; government policy, the universities that train the doctors, nurses and allied health workers; the various colleges of medical specialties that develop the standards for specialists, the credentialing committees of hospitals and organisations such as the Registration Boards for Health Professionals.

When the whole complex edifice of health care results in an "adverse incident" it is usually a combination of various risk factors that by chance coalesce for a particular patient, but arises from the reality that delivering safe, quality health care is a team effort at the frontline, the safety and quality of which depends on an immense number of other factors and influence.

Mistakes will inevitably happen. The aim of well minded people is to minimise "adverse outcomes" and to improve safety and quality by learning from patients who have unsatisfactory, in some cases, tragic experiences. If that is not possible another aim is to relieve or resolve the complaint of the patient.

The importance of learning from mistakes, as well as the value of listening to patients and validating their experiences is recognised in what can be considered the foundation of the provision of health services in Australia. I am referring to the National Healthcare Agreement entered into by the –

- Commonwealth of Australia; and
- The States and Territories.

The latest such agreement was entered into in 2008. It commences with these words:

> *"This Agreement defines the objectives, outcomes, outputs and performance measures, and clarifies the roles and responsibilities that will guide the Commonwealth and States and Territories in delivery of services across the health sector."*

The agreement provides in Appendix B:

B29 States and Territories agree to maintain an independent complaints body to resolve complaints made by eligible persons about the provision of public hospital services to them.

B30 States and Territories agree to the following minimum standards:

(a) the complaints body must be independent of bodies providing public hospital services and States and Territories' health departments;
(b) the complaints body must be given powers to investigate, conciliate and/or adjudicate on complaints received by it; and
(c) the complaints body must be given the power to recommend systemic and specific improvements to the delivery of public hospital services.

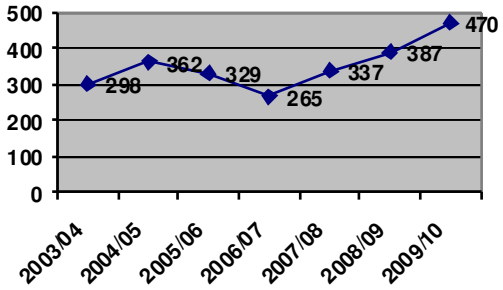
B32 To assist in making recommendations and taking action to improve the quality of public hospital services, States and Territories agree to implement a consistent national approach, agreed with the Australian Commission for Safety and Quality in Healthcare or any successor, to collecting and reporting health complaints data to improve services for patients

Over the last five years the HCSCC has worked collaboratively with all other health complaints entities from other States, the ACT and New Zealand to implement a consistent national approach. The Australian Commission for Safety and Quality in Healthcare has supported and guided all health complaints entities. They in turn have been able to interact with the Commonwealth policy makers, with the fledgling Australian Health Practitioners Registration Authority and with each other in a united and better informed way.

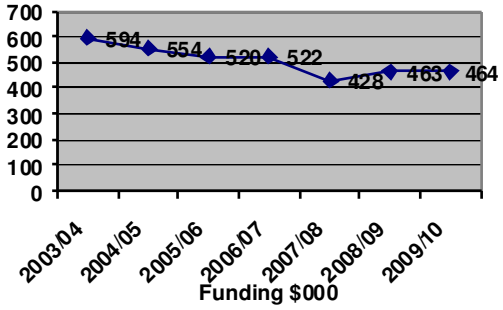
The Health and Community Services Complaints Commission of the Northern Territory enters a new phase in its development. Its workload has increased, its work on systemic issues, the formation of national standards, policies and data collection to achieve a "consistent national approach" is a new and evolving function. The NT Government has recognised that the work of the HCSCC and compliance with the Healthcare Agreement and an effective service to Territorians are best served by making the HCSCC a stand alone statutory entity, independent, and adequately resourced rather than an add on to the Office of the Ombudsman. Lisa Coffey has been appointed by the Administrator to implement the necessary changes.

To succeed in complying with the Healthcare Agreement, the Commissioner will need sufficient resources to provide a service comparable with other health complaints entities in Australia, and to respond to the requests of the Australian Commission for Safety and Quality in Healthcare to fulfil the Territory's obligations under the National Healthcare Agreement. Over previous years the workload and resources of the HCSCC have not been aligned. This has resulted in the HCSCC not complying with its legislatively prescribed time frame to assess complaints within 60 days. The correlation between the number of people approaching the HCSCC, funding of the HCSCC and the consequences on time frames is seen in the tables below.

Number of persons approaching HCSCC 2003 – 2010:



Funding of HCSCC 2003 – 2010:



Timelines of complaints resolved 2008 – 2010:

	08/09	09/10	+/-
No. of enquiries & complaint received	457	552	+20%
No. of approaches	387	470	+22%
No. enquiries/complaints closed within 180 days	98%	94%	
No. of complaints assessed within 60 days (legislated)	37%	35%	
Average time taken to assess a complaint	97days	107 days	+10%
Average time to finalise an enquiry	14 days	17 days	+30%
Average time to finalise a complaint	68 days	132 days	+90%
Average time taken to finalise all approaches	28 days	40 days	+60%

PERFORMANCE OVERVIEW

The key performance indicators for the 2009/10 period were:

- The number of approaches to the Commission was 20% more than for the previous year.
- Since 2006/07 there has been a 75% increase in the number of enquiries/complaints received.
- 93% of approaches were finalised during the year.
- The average time taken to finalise a complaint increased substantially from 70 days last year to 132 days this financial year, a 90% increase.
- The average time taken to assess a complaint increased from 97 days to 107 days with only 35% of complaints being assessed within the legislated 60 days.
- 91% of approaches to the Commission were resolved without a formal investigation or conciliation process.
- The Commission facilitated the resolution of 30% of complaints received directly between the provider and the complainant.
- Six investigations were completed.
- Visits to the Commission's website decreased by 20%

This snapshot of the Commission's activities over the 2009/10 financial year demonstrates that, because of the continuing increase in workload and reduction in resources, it has not been able to sustain the productivity gains of previous years. This is no reflection on the staff of the Commission who have continued to provide an exceptional standard of service to complainants while working under extreme and constant pressure.

At the closure of each case the HCSCC offers clients an opportunity to provide feedback in an evaluation form. It is a great tribute to the team I have had the pleasure to lead, that even though some people are unhappy about the outcome of their complaint they always rate highly the courtesy, responsiveness and attitude of the staff. One message received from a complainant typifies why I have pride in the team at HCSCC-:

> *Just a comment from me, personally. I have been dealing with government departments for over 17 years in my role as a parent-support contact for the…..*
>
> *. I have had good experiences, bad experiences and some that were just somewhere in the middle. Never in all this time have I communicated with a department as responsive and respectful as yours. From the switchboard operator who returned my call from yesterday afternoon, to Mr ..this morning right through to you as the Commissioner, this has been a very positive experience, regardless of the eventual outcome and I wanted to say thank you and well done!*

I thank all of those who have given their dedication and skills to the people of the Territory through their work at the Commission during my five year term, especially my Deputy, Vic Feldman, and I wish them well for the future.

CAROLYN RICHARDS
COMMISSIONER FOR HEALTH AND
COMMUNITY SERVICES COMPLAINTS

ABOUT THE COMMISSION

The Commission operates under the *Health and Community Services Complaints Act 1998*.

STRATEGIC FOCUS

The Commission's services are of the highest quality, open to scrutiny and accountable. Details of the Commission's strategic focus can be found at Appendix 1.

POWERS AND FUNCTIONS OF THE COMMISSIONER

The functions of the Commissioner are:

(a) to inquire into and report on any matter relating to health services or community services on receiving a complaint or on a reference from the Minister or the Legislative Assembly;

(b) to encourage and assist users and providers to resolve complaints directly with each other;

(c) to conciliate and investigate complaints;

(d) to record all complaints received by the Commissioner or shown on returns supplied by providers and to maintain a central register of those complaints;

(e) to suggest ways of improving health services and community services and promoting community and health rights and responsibilities;

(f) to review and identify the causes of complaints and to —
  (i) suggest ways to remove, resolve and minimise those causes;
  (ii) suggest ways of improving policies and procedures; and
  (iii) detect and review trends in the delivery of health services and community services;

(g) to consider, promote and recommend ways to improve the health and community services complaints system;

(h) to assist providers to develop procedures to effectively resolve complaints;

(i) to provide information, education and advice in relation to —
  (i) this Act;
  (ii) the Code; and
  (iii) the procedures for resolving complaints;

(j) to provide information, advice and reports to —
  (i) the Boards;
  (ii) the purchasers of community services or health services;
  (iii) the Minister; and
  (iv) the Legislative Assembly;

(k) to collect, and publish at regular intervals, information concerning the operation of this Act;

(l) to consult with —
  (i) providers;
  (ii) organisations that have an interest in the provision of health services and community services; and
  (iii) organisations that represent the interests of users;

(m) to consider action taken by providers where complaints are found to be justified;

(n) to ensure, as far as practicable, that persons who wish to make a complaint are able to do so; and

(o) to consult and co-operate with any public authority that has a function to protect the rights of individuals in the Territory consistent with the Commissioner's functions under this Act.

STAFFING

Table 1: By gender and position level

Position Level	Male	Female	Total
Commissioner (ECO5)	0	1	1
Deputy Commissioner (ECO2)	1	0	1
Administrative Officer 7	1[1]	2	3
Total	**1**	**5**	**6**

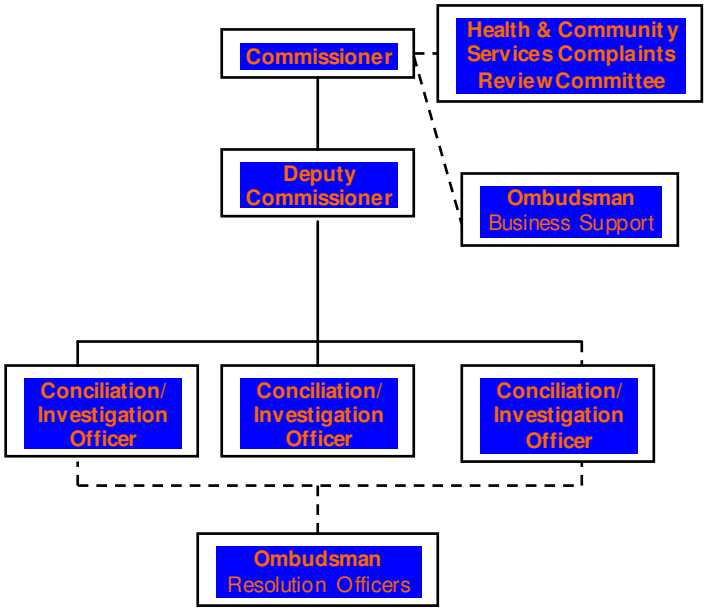
The Commissioner and Deputy Commissioner for Health and Community Services Complaints are also the Ombudsman and Deputy Ombudsman.

During the year one of the positions of Investigation/Conciliation Officer was not staffed for six months due to funding restrictions and for the remaining six months a

[1] This position was staffed for 6 months only to undertake an access and awareness project.

Project Officer was employed by the Ombudsman's Office to undertake a public awareness and community engagement project.

ORGANISATIONAL STRUCTURE



Administrative support (through the Business Support Unit) and the handling of some enquiries (through the Resolution Officers) are undertaken on behalf of the Commission by the Office of the Ombudsman.

FINANCES

Detailed financial statements for the Commission are not provided with this Annual Report as they form part of the overall financial statements of the Office of the Ombudsman and are included in its Annual Report. The Commission's identifiable expenditure for 2009/10 (when compared to the previous two years) was:

	2007/08	2008/09	2009/10
Personnel costs	$346,253	$354,215	$361,314
Op. costs	$78,641	$108,540	$103,312
	$424,893	**$462,755**	**$464,626**

The annual reduction associated with the "efficiency dividend" continues to have a detrimental impact on the funding available to the Commission.

The Commission can only provide this dividend by reducing the funding available to employ personnel and operational funding available for discretionary activities such as access and awareness, staff development, training and travel. The reduction in personnel funding only allowed for the full time employment of one of three AO7 positions for a period of 6 months and this was as a Project Officer to conduct a major community engagement program for both the Ombudsman.

As stated in previous annual reports *there is a limit beyond which activities can be reduced and an unacceptable quality of service and an unfair burden on staff morale and diminished job satisfaction and, ultimately, productivity occurs.* This limit has been reached and the productivity and service delivery of the Commission has greatly diminished.

HEALTH & COMMUNITY SERVICES COMPLAINTS REVIEW COMMITTEE

A Health and Community Services Complaints Review Committee (the Committee) is established under the Act to:

- review the conduct of a complaint to determine whether the procedures and processes were followed and to make recommendations to the Commissioner in respect of the conduct of the complaint;
- monitor the operation of the Act and make recommendations to the Commissioner in respect of any aspect of the procedures and processes; and
- advise the Minister and the Commissioner, as appropriate, on the operation of the Act and the Regulations.

It is not authorised to:

- investigate a complaint;
- review a decision made by me to investigate, not to investigate, or to discontinue investigation of, a complaint;
- review a finding, recommendation or other decision by me, or of any other person, in relation to a particular investigation or complaint.

The Review Committee consists of a Chairperson, two provider representatives and two user representatives who are appointed by the Minister for Health.

There was one (1) application for a review received in the reporting year.

COMPLAINT PROCESS

TAKING, RECORDING, RESOLVING AND ASSESSING COMPLAINTS

The Commission works independently and impartially, and has a supportive and primarily non-adversarial focus. Support is provided to both consumers and providers. Our aim is to resolve the complaint as informally as possible.

A complaint may be made electronically, orally or in writing, but must be reduced to a written form that contains sufficient details to enable it to be responded to and assessed. Once received by the Commission the complaint may move through any one of a number of stages.

On receipt, the Commission will make one of the following decisions:

1. That the person wants information only. Once the information has been provided the enquiry will then be closed.

Wanted information about permits

Caller was simply enquiring as to which section of the Department of Health and Families he would need to speak with in relation to obtaining his permit for the Alice Springs markets. The Commission provided the appropriate information.

2. That the complaint is out of jurisdiction and therefore take no further action

Lack of information leads to decline

The Commission received an enquiry from a Community Legal Service regarding an anonymous complaint they received. The complainant had been working for a non-government organisation that provided care, support and respite services for people with disabilities and was caring for a young lady who had autism. She stated that in the last few weeks a number of issues had come to her attention which did not sit well with her professional training. The Commission advised the Community Legal Service that the complaint did not contain sufficient details of the matter to enable the complaint to be assessed, including sufficient details of both the consumer of the service and the complainant. The Commission advised the Community Legal Service that it could accept a complaint from an individual who provides their details but wishes to remain anonymous but would need information in relation to the consumer.

3. That the complaint should be referred to another body/organisation/agency and therefore assist the complainant with the referral. Once referred the complaint will then be closed, as the Commission has no further authority to consider the matter.

Poor administration issue referred to Ombudsman

The complainant was a registered practitioner trying to gain registration interstate. Unfortunately the interstate registration board would not register the provider because he had an outstanding complaint with the registration board in the Northern Territory. The complainant's concerns related to the amount of time it had been taking to resolve the complaint with the NT Board. The complainant was advised that it was not within the Commission's jurisdiction and that it would be referred to the Ombudsman.

Mental illness issues referred to Community Visitor Program

The complainant advised that his wife's mother passed away following a motor vehicle accident and since then his wife had become extremely depressed and suicidal. The complainant advised that he had made several reports to the police and on some occasions his wife had been escorted to a mental health facility because of the state she was in. The complainant's wife had not been diagnosed as mentally ill under the *Mental Health Act* and according to the complainant the doctors at a Mental Health Service refused to do so. The Commission explained to the complainant that given the circumstances surrounding his complaint his concerns would be much better dealt with by the Community Visitor Program (CVP). The Commission explained the role of the CVP and that it could provide information about ways to resolve his concerns including speaking directly to staff involved in his wife's treatment. The complainant gave his permission for the Commission to refer the matter to the CVP on his behalf to try and resolve his concerns. The Commission advised the complainant it would close his complaint, however, if he was unable to resolve his concerns through the CVP to contact the Commission for further assistance.

4. That the complaint is within jurisdiction and the complainant chooses to approach the provider direct without the need for any assistance from the Commission.

Orthotics not provided on time

The complainant attended a podiatrist who advised that she needed orthotics and after tests she was told that they would be ready in a week. After following up each week for three weeks the complainant still had not received her orthotics. On the fourth week she was advised that they had not been ordered as yet. This left the complainant upset and she approached the Commission. As the complainant had not raised her concerns directly with the clinic, the Commission encouraged her to do so in writing as advised by the receptionists. The complainant was advised, when writing to the provider, to list her issues of concern and the outcomes she was seeking. The complainant was happy to do this. The Commission advised the complainant that her details would be placed on our system but the file would be closed. In addition, the complainant was advised that if she did not receive a response from the clinic within the specified time frame or the response was inadequate she could return to the Commission to have the matter considered further.

Doctor charges fee for non attendance

The complainant advised that his wife, who was the consumer, forgot to attend her doctor's appointment and was sent an invoice for the full fee. The complainant wanted to know whether the medical centres could do this and whether there was a limit. The Commission advised the complainant that the medical centres were within their rights to charge fees for non-attendance, however, there was no limit on what they could charge. The Commission did advise that there would be a requirement for the medical centre to inform their patients about the fee prior to charging it and this would normally be done with a sign in the waiting room. The complainant advised that his wife had a history of mental illness and was very forgetful, particularly recently. The Commission suggested that he write to the clinic manager, explain his situation and request a waiver of the fee. The complainant was happy to do this and thanked the Commission for their assistance.

5. That the complaint is within jurisdiction and the complainant, with their agreement, requires assistance from the Commission to approach the provider direct. The complaint will be registered and the Commission will assist the complainant to resolve the matter directly with the provider (at point of service).

Difficulty in getting surgery deposit refunded

The complainant decided to get some surgery through a visiting cosmetic surgeon and was required to pay a 50% deposit. However the cosmetic surgeon had to cancel her visit to Darwin and asked the complainant if she could travel to Sydney or the Gold Coast for the treatment. The complainant advised that she would not do this and requested a refund of the deposit she paid. The provider agreed to the refund, however it was not forthcoming. After several phone calls the complainant was advised another surgeon would be coming to Darwin in a few months to perform the procedure. The complainant advised the provider that this was not suitable and she required the refund. The Commission contacted the provider who disputed the details as given by the complainant and advised that the deposit was going to be refunded to her. The Commission enquired as to when this would occur and was advised it would happen by next week. The complainant was advised of the provider's response and told to contact the Commission if the deposit was not refunded. The money was refunded and the complaint resolved.

Surgery delayed many times

The complainant's toes required surgery. Following the surgery the complainant developed complications which required further treatment through the foot clinic at a public hospital. However, each time he made an appointment it was cancelled because patients with diabetes were given priority. This happened a number of times. The Commission obtained the complainant's agreement to forward the complaint to the hospital's Patient Advocate and for her to contact him in order to resolve his concerns without the need for the Commission's further involvement.

6. That the complaint is within jurisdiction and cannot be resolved at 'point of service' but may be resolved with the help of the Commission. In these cases the complaint will be registered and the Commission will attempt to facilitate the resolution of the complaint by:
   - providing information;
   - organising meetings;
   - facilitating/mediating meetings; and
   - providing advice and options.

Actual cost of procedure more than quote

The complainant required something excised from her big toe and consulted a practitioner who agreed to perform the procedure that same day under local anaesthetic. The complainant was concerned about the cost of the procedure and when she asked the provider, she was given a quote which she accepted. However after undergoing the procedure shortly after being given the quote, she was advised by the receptionist that the provider had given the incorrect item number for the procedure and that the actual cost would be somewhat more. The complainant attempted to resolve this with the provider, however she was told that as it was only a quote they could change it at any time. The Commission contacted the provider and provided details of the complaint. The provider advised that he had not been aware of any dispute with his staff in relation to the account but acknowledged that as it was his error he was willing to accept the initial quote as full payment. The complainant was advised of the provider's response and the complaint was resolved.

Home care assistance stopped without explanation

The complainant was an elderly lady who suffered a stroke some time ago and had an ongoing disability. She had been receiving home care assistance from the service provider for approximately five years. The complainant had previously approached the Commission regarding her dissatisfaction with the level of services provided by the Service. According to the complainant, the service often did not turn up and did not advise her that they were unable to attend even though she had asked them to notify her of such situations. The complainant stated that her efforts to resolve her complaint directly with the Service have been unsuccessful and she was seeking the assistance of the Commission. The Commission contacted the service and advised them of the complainant's issue. They agreed to look into the matter and then contact the complainant directly to discuss their findings and future arrangements. They also advised they would let the Commission know of the outcome. The Service advised the Commission that they had managed to work out the issues and a resolution and that they would be discussing this with the complainant. The complainant advised that she felt her issues had been addressed by the Service and her matter had been resolved.

7. That the complaint is within jurisdiction and after taking into account its issues, **will not be** resolved expeditiously by directly approaching the provider or through facilitation. These complaints will be registered, preliminary inquiries will be undertaken and they will be formally assessed. Tasks undertaken during preliminary inquiries can include:
   - notifying various parties of the complaint;
   - exploring and arranging resolution options;
   - gaining responses to complaint issues;

- obtaining relevant documents and information, eg medical records, x-rays, etc;
- interviewing the parties;
- initiating and/or facilitating meetings; and
- obtaining independent clinical advice.

The objective of the assessment process is to find out whether the complaint warrants further enquiry or investigation and the Commission has 60 days in which to make this decision.

On completion of preliminary inquiries the case officer makes a recommendation to the Commissioner as to what further action should be taken and this can be to:

- take no further action;
- conciliate;
- investigate; or
- refer to a Professional Registration Board or other body.

Once the assessment determination is made by the Commissioner, all parties to the complaint are advised.

Of all the complaints received by the Commission, 75% were resolved or finalised either before or during the assessment process. Nine (9) complaints were finalised after being either conciliated (3) or investigated (6), and sixteen (16) were referred to the appropriate Board.

Difference in Professional Opinion Leads to Complaint

The complainant had concerns regarding the treatment provided to her by an osteopath. She alleged that she presented with acute muscle spasms in the left side of her middle and lower back and the clinical examination undertaken was inadequate, the consultation and standard of service was not professional and the manner and attitude of the provider was not professional. The complainant was also an osteopath and the fact that they were known to each other may have clouded and complicated the matter further.

The Commission's enquiries, in particular the expert opinion that was obtained, revealed the examination undertaken by the provider was reasonable. However, the delivery of the treatment (the manner in which it was applied) may not have been to an appropriate standard. It was the Commission's opinion that the matter involved a difference of professional opinion which could not automatically be seen as a sign of sub-standard clinical practice. The provider also acknowledged that he did not discuss treatment options with the complainant and as a result it was the opinion of the Commission that the provider did not obtain informed consent from the complainant prior to administering treatment.

The Commissioner determined the matter be referred to the Chiropractors and Osteopaths Board for their attention and action.

Restraint of Patient Justified

The complainant rang to advise that she had been taken to and admitted to A&E of a public hospital after having a convulsion. The complainant was also an out patient of a mental health service. The complainant believed that she had been treated badly at A&E as staff had strapped her onto a gurney bed, administered medication and not given any help.

The Commission undertook preliminary enquiries which included seeking a response from the provider and reviewing medical records. It was apparent from the information provided by the provider that the complainant had had many presentations at the hospital and that due to the violent behaviour she frequently displayed it had been necessary for a specific protocol to be put in place to deal with this behaviour.

The reply from the provider explained the reasons why the hospital was forced to restrain the complainant and the Commission was satisfied that under the circumstances their actions were reasonable and in accordance with the approved protocol. The Commissioner determined to take no further action in relation to the matter.

TAKING NO FURTHER ACTION ON COMPLAINTS

The Commission will take no further action on a complaint if it is satisfied that:

- the complainant is not eligible to make the complaint;
- the complaint does not relate to a matter covered by the Act;
- the user became aware of the circumstances giving rise to the complaint more than 2 years before the complaint was made and does not have an exceptional reason for the Commissioner to exercise a discretion to consider it;
- the complainant has not taken reasonable steps to try and resolve the complaint with the provider;
- depending on the circumstances and the enquiries made, there is no justification, or it is unnecessary, to investigate the matters raised by the complaint further;
- the complaint lacks substance;
- the complaint is vexatious, frivolous or was not made in good faith;
- the complaint is resolved;
- the user has commenced civil proceedings seeking redress for the subject matter of the complaint and the court has begun to hear the substantive matter; or
- the complainant fails to provide additional information or documentation when requested to do so by the Commissioner.

CONCILIATING COMPLAINTS

Cases involving serious or complex issues or substantial disputes that warrant compensation or a detailed explanation will normally be recommended for referral to a conciliator. The functions of a conciliator are clearly defined in the Act.

The conciliation process has statutory privilege. This means that anything discussed during conciliation, or any document prepared specifically for conciliation, remains confidential and cannot be used in another forum. In addition, the process is non-adversarial, free of charge and stands as an alternative to civil litigation where claims for compensation form part of the substantive complaint.

Enforceable agreements, documenting the outcome of conciliation, can be made as part of the conciliation process.

During the course of the financial year the Commission finalised three (3) conciliations. It would be a breach of faith and of confidence to describe the facts of the cases concerned. It is important that parties have confidence that disclosures made during conciliation will not subsequently be disclosed either in an Annual Report or even in an application under the *Information Act*.

INVESTIGATING COMPLAINTS

An investigation using statutory powers is likely to be instigated in complaints:

- which are not suitable for informal resolution or conciliation, eg. patients may be at imminent risk, or serious misconduct is alleged;
- where conciliation has been declined or failed and further investigation is warranted;
- that appear to raise a significant question as to the practice of the provider; or
- that appear to raise a significant issue of public health or safety or public interest.

The Commission has wide powers during the investigation process and may propose remedies, or make recommendations which are usually furnished in a report and a notice is provided to the complainant and the appropriate provider or body able to implement the actions.

Any information, documents, reports, etc produced as a result of an investigation cannot be used for any other purposes, eg. as evidence in a court of law.

During the course of the financial year five (6) investigations were completed. Refer to Performance Activity 3, Improving Services for further details.

REFERRING COMPLAINTS TO RELEVANT REGISTRATION BOARD

Complaints involving the practice or procedures of registered providers will, in most cases, after consultation with the relevant Registration Board, be referred to them to exercise their powers as appropriate. Once referred to a Board the Commission can no longer take action in relation to the complaint unless formally referred back by the Board and the file is therefore closed.

This financial year six (6) complaints were finalised following referral to an appropriate Board.

Dentist gets Physical

The complainant attended a dental appointment for a check-up and clean. Prior to commencing the procedures the dentist administered local anaesthetic to the complainant. The complainant questioned this as she had not been administered this previously. The dentist then continued to use a hook to remove plaque from her lower teeth which were quite sensitive even with the local anaesthetic. The complainant then rinsed and the dentist commenced scrapping across the front of the complainant's upper teeth to remove a stain. The complainant asked why this instrument was being used to undertake such a procedure. The dentist stopped the procedure and asked the complainant to leave. The dentist allegedly became angry as he had already explained that he was attempting to remove the complainant's plaque. The complainant went to grab a cup to rinse, prior to leaving, at which time the dentist put his hand on the complainant's, grabbed the cup and threw it in the bin. The dentist would not allow the complainant to do a final rinse and insisted she leave the clinic. Allegedly, when the complainant advised that she wanted to complain the dentist threw her out.

When the complainant lodged her concerns with our office she also raised concerns about the level of hygiene of the clinic. A response was sought from the dentist in which he advised that the complainant was the one who entered the clinic in an agitated state and seemed nervous about the procedures to be undertaken. The dentist further advised that the complainant appeared to be condescending and had no confidence in the dentist which resulted in comments by the complainant. He further claimed that he eventually asked the complainant to leave the clinic. The complainant did not leave and this allegedly resulted in the complainant swearing and abusing the dentist. This claim was supported by the dental nurse assisting in the procedure. However, with respect to the grabbing of the complainant's hand whilst attempting to get possession of the cup she was holding, the dental nurse verified that the complainant was holding the cup first which was then grabbed from her by the dentist. This was contrary to the dentist's recollection. Most of the issues raised were discontinued due to insufficient evidence, however the matter of hygiene and the alleged grabbing of the complainant's arm were referred to the Dental Board for their consideration.

Breast Implants not up to Standard

As a result of surgery the complainant maintained that she developed symmastia (medial shifting of the implants towards the midline). She maintained that the risk was never explained to her by the provider. The complainant maintained that the development of symmastia was as a result of the provider failing to take measurements of her chest; failing to explain that dissecting the muscle medially can weaken and allow the implants to move in; and not being aware that if you push the dimensions and size of the implants too much it will apply too much pressure both medially and laterally, resulting in symmastia. The complainant was also dissatisfied with the post-operative care provided by the provider and with his proposed method of correcting the symmastia. The complainant therefore sought corrective treatment from an interstate surgeon, resulting in considerable out of pocket expenses. The matter was finally settled between the parties and, accordingly, the Commission could not take any further action as the matter had been resolved. However, the clinical advice obtained did raise the possibility of standards/competence issues and the matter was forwarded to the appropriate Board to take action in accordance with their own legislation.

CONCLUSION

The Commission's objective is to finalise complaints as quickly and informally as possible. Of all the enquiries and complaints received less than 5% are assessed as requiring one of the more formal processes under the Act, that is, either investigation or conciliation.

The success of this expeditious resolution process can be attributed to the excellent work undertaken on receipt of a complaint by the Senior Investigation/Conciliation Officers through their skills in communication, negotiation and mediation, combined with flexibility and common sense.

CASE STUDIES

Prisoner Complains About Pain Relief

The Commission received a complaint from a prisoner regarding services provided by the Corrections Medical Service (CMS). The complainant had sustained a back injury in an accident involving a cement truck and the prison van that was transporting him. Since then he had been in and out of prison and each time he returned he sought physiotherapy for his back problems but these services had been consistently denied to him. The complainant was also prescribed pain medication following the accident, and in subsequent incarcerations This time, however, medical staff were refusing to provide it. The complainant also raised concerns regarding CMS's refusal to provide a medical report to an insurance company. According to the complainant, the insurance company had offered to meet the costs of a physiotherapist but required a medical report from the provider which they refused to do.

The Commission forwarded a copy of the complaint to CMS, asking them to contact the complainant in an attempt to resolve his concerns without the need for the Commission's further involvement. The Commission subsequently received a response from CMS advising that

- The injuries the complainant sustained in the motor vehicle accident were fully investigated at the time and he was treated appropriately with analgesia and physiotherapy.
- The complainant presented to CMS requesting additional meals and an appointment to see the dentist and the physiotherapist, including a neck brace because he alleged he was suffering from neck pain as a result of injuries sustained in the motor vehicle accident. The complainant was found to have a full range of movement and was provided with stretching exercises and prescribed Panadol and Brufen to relieve any pain.
- The complainant had been prescribed Panadol and Brufen in the past on request and there was no evidence in the medical records to indicate that these medications were inadequate in controlling his pain.
- There was no record of the complainant having requested a medical report for insurance purposes. However CMS were willing to provide this information if formally requested by the complainant's solicitor or insurance company.

The Commission contacted the complainant and advised him of the response received from CMS in respect to his complaint. The complainant indicated he was satisfied with the response and, as the complaint had been resolved, the file was closed.

Schedule 8 Medication Cancelled

The complainant had been a patient at a medical centre for approximately five years. His medical conditions included chronic pain, narcotic dependence, depression, hypertension and a past history of Hepatitis C. The complainant had been on Kapanol (slow reducing dose) during this time following an assessment by the Pain Clinic. His dosages had been slowly reduced from 400mg to 150mg Kapanol daily. In addition to Kapanol, the complainant had also been prescribed Diazepan. The complainant received a letter from his doctor advising him that a urine drug screen indicated he failed to comply with the conditions imposed on him by the practice for the continued prescription of Schedule 8 medications and therefore Kapanol or other S8 medications would not be prescribed to him. He then complained to the Commission.

The Commission attempted to resolve the complaint at point of service and to this end obtained the permission of the complainant to refer the matter back to the provider to be resolved without the need for the Commission's further involvement. A short time later the provider advised the Commission that the complainant had breached his contract for the prescription of Schedule 8 medications on several occasions, including one incident where he was brought to the hospital's Emergency Department in a state of unconsciousness. As a result of these previous breaches the provider had been monitoring the complainant closely and during routine urine tests other illicit substances were detected. At that time the provider gave the complainant six weeks in which to comply but he failed to do so and the provider advised that she was no longer willing to prescribe the Schedule 8 medications and wrote to the complainant advising of her decision and reasons why.

The Commission discussed the provider's response with the complainant who acknowledged that he had breached the conditions. The Commission advised the complainant that it could not direct the provider to reinstate his contract and resume prescribing Schedule 8 medications and that it would be taking no further action in relation to the complaint.

Carer Services not up to Standard

The complainant contacted the Commission with concerns about the service being provided to her son who resided in supported accommodation. The complainant's son had an intellectual disability that required constant care. The complainant advised that her son shared a home with another young man with intellectual disabilities and that her son had contracted various cross infections due to the other person's behaviours. Since this had occurred the complainant's son had lost weight and become very ill. The complainant claimed the carers were not qualified to be looking after her son (backpackers, people with poor English, individuals with mental health issues themselves). It was alleged that the carers were too busy caring for the other patient to provide the required level of support to the complainant's son.

The complainant attempted to resolve her concerns with the agency, however she was not satisfied with the result. She considered the quality of care to be totally inadequate. The complainant also advised the Commission that she had scheduled a meeting with the manager because she had been bringing her concerns to his attention for some time and he had failed to address them.

The Commission, in attempting to resolve the matter at point of service, provided details of the complainant's issues to the service providers. As a result, a detailed response was provided to the Commission from the provider with explanations and proposals for change to address the complainant's concerns. This response was provided to the complainant who was satisfied with the information and so the Commission took no further action on this matter.

Adequate Explanation Resolves Complaint

The complainant's representative approached the Commission with concerns relating to health services provided to the complainant's daughter since her birth. The complainant took her daughter, who was 11 at the time, with a history of centralised low abdominal pain and vomiting during the night, to a remote health clinic. She was reviewed by clinic staff and given treatment for suspected acute appendicitis. The complainant and her daughter were then transferred by air to a regional hospital and then to the Royal Darwin Hospital for re-evaluation by the on call surgical team. An abdominal ultrasound was performed which revealed that the complainant's daughter was suffering from the condition uterum didelphys (where the person has two separate uterine bodies) and was missing her right kidney. The complainant advised, through her representative, that her daughter had been consistently unwell since birth. She stated that on several occasions she had requested health professionals undertake a full medical examination of her daughter, but this was never taken seriously. This previous disregard for her concerns had made the complainant reluctant to raise the matter again with relevant service providers.

The complainant was seeking the assistance of the Commission in identifying whether the treatment provided to her daughter since birth was reasonable and adequate given her medical condition. The complainant expressed serious concerns that her daughter's condition was not identified at an earlier time given her history of medical interventions. The complainant sought an explanation from the relevant health providers in relation to her queries and concerns. The Commission noted that the daughter's condition was extremely rare.

As the complaint involved a number of the provider's facilities, it was forwarded to the provider's Complaints and Sentinel Events Coordinator rather than the individual facilities themselves. The provider indicated a willingness to meet with the complainant to provide a more detailed and understandable response and this was agreed to by the complainant and her representative. An appropriate place and time for the meeting was arranged to suit the complainant. The Commission subsequently received written notification from the provider that they had arranged and confirmed a meeting with the complainant. After writing to the complainant and her representative with the details of the meeting, the Commission advised the parties that it would be taking no further action in relation to the complaint. The Commission instructed the complainant to contact the Commission in the event that she was not satisfied with the outcomes of the meeting.

New Mattress Alleviates Pain

As a result of a prior complaint lodged by a prisoner, he was referred to a rheumatologist who was required to examine him and make a recommendation with respect to a suitable mattress for his condition. The mattress he currently had was very thin and exacerbated his back pain. On examination, the rheumatologist advised the complainant that he was not in a position to make any recommendation about a suitable mattress as his role was primarily to assist with pharmacology.

In the prior complaint the understanding and agreement reached by the parties (Corrections Medical Service and complainant with assistance from our office) was that the complainant's mattress would be assessed by the specialist to determine suitability. The Commission contacted the specialist direct to discuss the matter and it was established that the photo of the complainant's existing mattress had not been provided to the specialist. The Commission arranged for the photo to be forwarded and on receipt of this the specialist did confirm that the type of mattress may be contributing to the complainant's pain levels. A thicker mattress was arranged for the complainant which alleviated some of his pain. As the complaint had been resolved the Commission took no further action on the matter.

Poor Hospice Care Leads to Positive Response

The complainant was referred to the Commission by the Office of Aged Care Quality and Compliance who were conducting an investigation into the care and treatment provided by an aged care facility. The complainant's husband, who is now deceased, was transferred from an aged care facility to the public hospital for emergency treatment in relation to bladder control and blood in his urine. When the complainant arrived at the emergency department she asked the nurse at the reception where her husband was and was directed to the waiting room. When the complainant went over to her husband he was still sitting in his wheelchair in a puddle of urine because he did not have a nappy on to prevent leaking. He was in pain and appeared to have been in the waiting room for some time. The complainant went over to the receptionist to ask for a napkin for her husband and a private room so she could put it on him which staff immediately arranged. The complainant stated she had informed staff at the aged care facility to ensure that her husband had a napkin on before he was transferred but it appeared they had failed to do so. The complainant was concerned that the hospital had not ensured her husband had a napkin on and left him in the waiting room for a long time without being seen.

The hospital performed a number of diagnostic tests on the complainant's husband, including x-rays, MRI scans, CT scans and blood tests. The complainant stated that the test results had not been provided to her despite requesting them and having received reports in the past. It appeared that the test results were sent to the family GP but he was unable to provide them to the complainant on the grounds of patient confidentiality. The complainant wanted a copy of the reports or an explanation of the findings including the discharge form.

The complainant's husband was eventually transferred to the hospice and the complainant raised a number of concerns regarding the care and treatment he received there as a patient, namely:

- Her husband was unable to properly feed himself due to his debilitating health and required assistance which had not been forthcoming. This usually resulted in the food ending up all over the place and her husband not receiving an adequate diet.
- The complainant's daughter discovered her father eating a plate of food which he had vomited on, but was continuing to eat due to a lack of monitoring.
- Her husband was provided with steaming hot porridge and force fed causing him great discomfort.
- When the complainant raised her concerns she was advised to come in and feed him herself.
- The excessive administration of enemas by the nursing staff to her husband.

The complainant was also concerned about the lack of care provided to her husband in respect to his hygiene. For example:

- Her husband's false teeth were not being cleaned by staff after his meals and on one occasion when she examined his teeth she found them to be in an extremely unhygienic state.

- Staff were not doing his laundry on a regular basis and the complainant had to eventually take her husband's laundry home to wash.

The complaint was referred by the Commission to point of service for resolution. The hospital agreed to meet with the complainant to discuss her concerns and to provide an explanation regarding the care and treatment her husband received in an attempt to resolve the complaint without the Commission's further involvement.

The complainant met with the Palliative Care Registrar, the Clinical Nurse Manager at the Hospice and the Acting Clinical Nurse Manager in the Emergency Department. An open and positive discussion was held between the parties and the hospital provided an explanation as to the cause and nature of the complainant's husband's death. In addition the provider agreed to:

- Arrange for a speech therapist to provide instruction to Hospice staff on appropriate and safe feeding.
- Develop a food preparation policy, with training, for the Hospice.
- Implement flexible meal arrangements with cold storage portions available outside fixed meal times.

The Commission contacted the complainant following the meeting to discuss the hospital's response and was advised that she was very satisfied with the outcomes of the meeting, particularly the action the hospital intended to take to improve services in the hospice. The Commission advised the complainant that based on the resolution of the complaint, it would take no further action and close the file. The complainant thanked the Commission for its assistance.

Medical Records Inappropriately Accessed

The complainant was employed by an Aboriginal health service and he alleged his medical records at the health centre were improperly accessed by a senior Aboriginal health worker. According to the complainant his medical records contained sensitive information about a condition he had which the Aboriginal health worker used to discredit him and have his employment terminated. According to the complainant, it was widely known that client medical records were not properly secured and were often accessed without reason.

The complainant wanted an apology for the breach of his confidentiality and disciplinary action taken against the Aboriginal health worker for improperly accessing his medical records. By making his complaint to the Commission, the complainant was also hoping to contribute to the review and improvement of services provided by the health service, in particular, the security and management of client medical records and to have staff at the health centre appropriately trained in relation to confidentiality issues.

The Commission's preliminary enquiries found no evidence to substantiate the complainant's allegations that the provider had improperly accessed his medical records at the health centre and used this information to discredit him and have his employment at the health centre board terminated.

Following the complaint the health centre implemented an electronic Primary Care Information System which enabled the identification of anyone accessing a patient medical record. This had ensured that the medical records at the health centre were kept in such a manner as to preserve the confidentiality of the information that was contained in them and to prevent them from being improperly accessed.

Having regard to the circumstances of the case and the inquiries undertaken by the Commission, particularly the lack of any evidence or witnesses to substantiate the complainant's allegations, the Commissioner determined to take no further action in respect to the matter.

Changes in Codeine Scheduling Requirements Causes Pain

The complainant attended a pharmacy intent on purchasing a couple of packets of 24 over-the-counter pain relief 500mg paracetamol and approx 9mg codeine or Nurofen Plus as she was travelling for three weeks to remote communities, including a lot of time driving. The complainant advised she had a back injury which she had been receiving treatment for. The purchase of pain relief for her injury prior to going on these lengthy trips was a practice the complainant had done before. The pharmacy salesperson started asking the complainant some questions, when the pharmacist came out and started asking the same questions and was allegedly very rude. The complainant explained her circumstances but the pharmacist demanded to see the complainant's ID and said that she would record it. The complainant alleged there were no signs up, or information brochures around, or offered, advising of this new procedure. Because of all the questioning the complainant only asked for 1 packet in the hope that she could get another packet somewhere else.

The complainant went to another pharmacy after work the next day and asked for a packet of the pain relief tablets. The same pharmacist was present and allegedly refused to sell the complainant any of the tablets. It was alleged that the pharmacist didn't believe the complainant's history of injury nor her upcoming work schedule. The pharmacist informed the complainant that she would have to get a letter from her doctor in order to be able to purchase more. The complainant responded by stating "It's 4.30pm on Friday, I leave Monday morning first thing so how am I supposed to get an appointment?" The pharmacist again refused to sell the complainant any pain relief and stated that the complainant would have to see the pharmacist on Monday when she might sell her more as long as she had a letter from her doctor. The complainant made a doctor's appointment for the next Monday that she would be back in town.

The complainant allegedly experienced a lot of back soreness while she was away for the three weeks because she had no pain relief for most of the time. On her return, the complainant saw her doctor and obtained a letter stating her injury, travel and pain management requirements, including prescriptions for the tablets. The complainant went to the two pharmacies she had dealt with previously and left them copies of the letter. At a later time the complainant was allegedly leaving for travel again and attended one of the pharmacies. The complainant explained that she was about to undertake remote travel and needed to obtain pain relief. The staff member said she would have to talk to the pharmacist. After some 12 minutes the pharmacist advised her she could not obtain the pain relief from them as she had to attend the other pharmacy where a copy of the letter was held.

The Commission undertook preliminary enquiries and it was established that the Pharmacist's Guild of Australia had introduced new codeine scheduling requirements which required stronger controls for the dispensing of codeine based pain relief.

Medication that was previously available over the counter was now only available through pharmacies with purchases over a certain amount requiring a doctor's prescription and stricter controls. It was considered reasonable that the pharmacist attempt, through her duty of care, to control the overuse of codeine based pain relief in a situation she perceived to be a risk to the customer. Although the complainant had legitimate reasons for her request and attendance at different pharmacies a day apart, the pharmacist had no way of verifying this other than through a doctor's letter. The pharmacist advised she was only aware of the doctor's letter being held at one pharmacy and claimed that at no time did she decline the complainant's codeine based pain relief after the doctor's letter was obtained. It appeared there was a case of miscommunication between the two pharmacies involved, which only became an issue because the pharmacist worked in them both. With the Commission acting as an intermediary the parties were able to agree on a resolution which involved arrangements to provide the pain relief that was acceptable to both parties.

Prisoner Treated Appropriately

The complainant, a prisoner, fell over and injured his right elbow. The complainant consulted the doctor at Corrections Health Service (CMS) and was referred to the public hospital for an x-ray. He was subsequently seen by CMS who advised him that there was nothing wrong with his elbow and they put it in a sling and discharged him without any pain relief. Approximately one month later, the complainant's elbow was still sore and CMS referred him back to the hospital where he was seen by another doctor who examined the x-rays taken previously and advised the complainant that there were in fact two fractures in his elbow. The complainant also advised that he had been experiencing pain in his wrist and bicep, however the doctor did not undertake any further investigations and discharged him without dressing the wound or providing any pain relief.

The main issues raised by the complainant were that both the CMS and hospital failed to adequately investigate and diagnose the fractures to his elbow which were evident on the x-rays and that the hospital failed to adequately investigate the complainant's concerns of pain in his wrist and bicep and discharged him without adequate care and treatment.

The Commission undertook preliminary enquiries which included writing to the providers seeking a response to the complaint and obtaining copies of the complainant's medical records. The Commission's preliminary enquiries revealed that when the complainant first presented to the hospital, x-rays of his elbow did not demonstrate a definite fracture and there was no indication of abnormal soft tissue swelling. However, there was some indication of a subtle abnormality that suggested an un-displaced fracture and his arm was placed in a collar and cuff, which is the standard treatment for an un-displaced radial head fracture.

The complainant was discharged with a letter to the doctor at CMS advising the results of the x-ray and suggesting he be administered analgesia for pain relief. The letter also advised the doctor to contact the hospital for a formal x-ray report should the complainant's pain persist.

In relation to the treatment and care the complainant received for his wrist and bicep, there was no record of him complaining about any pain when he attended the hospital and the CMS some time after. The CMS examination found that the complainant had a very good range of motion and was only feeling slight tenderness, suggesting that that there was no significant instability to the forearm joint. The complainant was also referred to a physiotherapist by CMS after complaining of stiffness and limited range of motion in his right arm.

The Commission's preliminary enquiries suggested that the standard of care and treatment provided to the complainant by the providers was reasonable and determined to take no further action with respect to this issue of the complaint.

Open Disclosure Leads to Resolution

The complainant was admitted to a public hospital to undergo a same day elective colonoscopy procedure. During the procedure the complainant's sigmoid colon was perforated and she required an emergency laparotomy to repair and wash out the peritoneum. Following the emergency procedure the complainant was admitted to the Intensive Care Unit (ICU) for three days and was then transferred to the High Dependency Unit and then to another ward.

While on the ward the complainant's health did not improve and she began experiencing abdominal cramps. She was unable to eat and her feet swelled. An ultrasound was performed which revealed the complainant had developed a clot in her lower left leg and she was administered Warfarin. However the pain became worse and her leg became swollen. The complainant's family insisted that doctors undertake further investigations on her left leg. It was later discovered that the complainant's blood count had dropped and doctors discovered a haematoma behind her kidneys which was caused by the large amounts of Warfarin being administered. The doctors attempted to reverse the effects of this causing her further difficulties with bowel movement and her leg to go numb.

On discharge, the complainant was placed on the Transition Care Program in order to receive coordination and assistance for up to twelve weeks to promote independence and facilitate services to meet the complainant's needs. As part of the program the complainant received physiotherapy and hydrotherapy treatment during the term of her Transition Care Program Plan. The complainant's health was slowly improving when the program finished, but the complainant felt that she needed to get further assistance under the Program in order to fully recover. Her leg was still not functioning properly and she required further assistance including physiotherapy.

The Commission wrote to the provider seeking a response to the issues raised and the outcomes sought by the complainant and subsequently received a response. The response was forwarded to the complainant to examine and she then discussed it with the Commission. In the meantime the Commission had obtained copies of the complainant's medical records from the hospital.

Apart from some minor issues that had been resolved between the provider and the complainant, the Commission's preliminary enquiries suggested that the standard of care and treatment provided by the hospital was reasonable and that the outcomes sought by the complainant had been resolved by the provider. The actions taken by the provider included a review of and improvement to health care services, disciplinary action and counselling, and further education and training for staff involved in the complainant's care and treatment.

The provider wrote to the complainant directly thanking her for raising her concerns about the care and treatment she received and expressed its concern that her experience was not of the expected standard. The provider advised that in cases where system improvements can be made they will be or have been implemented to ensure the care they provide is safe and of a high quality. Based on the Commission's preliminary enquiries and the actions taken by the provider the Commission determined to take no further action in respect to the issues of complaint.

Violence Leads to Withdrawal from Alcohol and Other Drugs Service

The complainant was a client of an alcohol and other drug service (the service) and was trying hard to detoxify from morphine. He had been a client of the service in 2007 and had recently been referred back to the service. Under the service he was being prescribed Subox and he claimed he had been steadily reducing the dosage. However six weeks into the program the complainant injected a substance into his hand which lead to the amputation of all five fingers and during this time he did not continue dosing with Subox at the service. The complainant was discharged from hospital with a week's supply of methadone tablets. However, after three days he was still experiencing pain and went to the Emergency Department at the hospital where he was advised that, as he was being treated for addiction by the service, the hospital could not increase his prescription.

The complainant subsequently went back to dosing at the service and was initially prescribed 40ml of liquid biodone but it wasn't enough and was increased by 10ml once a week until the dosage reached 130ml. The complainant was adamant that his urine samples were clear during this time, however he had a dispute with one of the case workers regarding an issue with his partner, who was also a client of the service, and this had lead to him being banned for six months.

The Commission undertook preliminary enquiries into the complaint and these revealed that the provider's clinical management team had discussed the complainant's case and his recent threatening and violent behaviour and had made a decision that he would not be able to access the provider's services for a period of six months. According to the provider the complainant had displayed behaviour that was in direct violation of their Zero Tolerance Policy.

The Commission's enquiries found that when the complainant was accepted as a client on the provider's Opiate Pharmacotherapy Program (OPP) he was given a client information booklet which outlined the policies under which he agreed to be on the program. Under the section headed "Discharge from the Program", it clearly stated that "*The ..... staff and facilities are Zero Tolerance Zones for aggression. We will not tolerate any form of abuse, aggression, violence or threats of violence. An immediate stand down will result if this behaviour occurs*". The complainant also signed an acknowledgement that he had a copy of the OPP Guidelines, and that he understood and agreed to abide by them.

According to the provider, and supported by the complainant's medical records and Urine Drug Tests, the complainant had a history of unacceptable behaviour with the provider which had resulted in him being stood down previously from the provider's service for twelve months. On returning to the service the complainant continued to demonstrate threatening and aggressive behaviour towards staff and at one point was counselled by the manager of the service about his behaviour. During the recent event that lead to the six month stand down, the complainant had become violent and aggressive during the dosing and threatened to kill a staff member, which the provider reported to the police. During this time the complainant consistently violated the agreement that he would not use illicit substances and every random urine drug screen revealed contamination with an illicit drug including cannabis, opiates and/or benzodiazepines.

Based on the preliminary enquiries undertaken during this time, it was determined that the actions of the provider were reasonable and no further action would be taken on the complaint.

New Dentures Likely to Take Two Years

The complainant called on behalf of his mother. The complainant claimed that his mother was an elderly woman of 83 years, was blind, in a wheelchair and had trouble eating due to a lack of dentures for her bottom teeth. The complainant's mother had been assessed by the public dentist and was advised that she would have to wait two years for her dentures. The complainant was concerned about their prioritisation of patients and was keen for his mother to obtain her dentures earlier. The complainant also advised that his mother had been referred to the dental service by an out patient mental health service. The complainant stated that he had spoken to the clinic reception staff about his concerns and they advised they would get someone to call him, however no one ever returned his calls.

The complainant was advised that our office could not make the clinic change their prioritisation of the consumer, however we could make some enquiries in relation to how the complainant could raise his mother's concerns within the clinic.

The Commission contacted the clinic and provided details of the complainant's concerns about his mother and this resulted in the mother being scheduled for an appointment to have her dentures made. Further to this, the complainant raised his concern that his mother's appointments kept being cancelled or rescheduled. The complainant was advised that the Commission could not force the clinic to reprioritise their clients as this was done on clinical need. The complainant requested that the file be left open until after his mother's appointment and it was agreed that if he did not contact the office after that date the file would be closed. The complainant did not contact the office again.

Pap Smear Examination Questioned

The complainant attended a medical centre and saw the provider for a pap smear. The complainant sounded shaky and advised she felt very uncomfortable as the doctor first placed his finger inside her to identify the cervix and when he tried to position the equipment she felt an in and out feeling with no actual scrapping. The doctor then placed his finger in the complainant's cervix again and asked her if she could feel anything. He did this a few times also changing the equipment. The complainant advised that there was no-one else in the room, the ceiling light was on but no further lighting was used and that the procedure took around 15 minutes. The complainant questioned "what was taking so long" but did not get a satisfactory response. The complainant felt that something was not right as she had had several pap smears in the past, none of which have been similar to this. The complainant felt there was too much probing and commented that either the doctor did not have the skills to perform a pap smear or something else was going on.

The complainant advised that the procedure made her feel 'dirty' and she did not feel comfortable going back to the clinic, not even for her results. The complainant was advised that if she felt she had been violated then she had every right to bring her

matter to the police. The Commission forwarded the complainant a letter and brochures explaining the role of the Commission, including a complaint form for completion. The complainant was requested to start writing down all the details of her complaint whilst it was still fresh in her mind. The complainant did attempt to make a complaint with the clinic manager, however was not satisfied with the response and the perceived procedure.

Once the written complaint was received by the Commission, a copy was forwarded to the clinic and provider for their response. The initial response obtained from the clinic with respect to their complaint's procedure was to the complainant's satisfaction, however the response from the provider still left some unanswered questions. A further response was sought from the provider and, once received, a copy was forwarded to the complainant. The complainant contacted the Commission to advise that sufficient detail and reasons had been provided by the provider and she felt her concerns were resolved.

Removal of Limb Leads to Reduction in Pain Relief

The complainant underwent a right leg amputation at a public hospital. The complainant asserted that he had suffered from a number of orthopaedic matters down his right and left lower limbs for many years, and had been taking MS Contin for pain relief in relation to these conditions, amongst others.

The complainant asserted that post-surgery, a nurse wrote a fraudulent letter to his GP stating that as the complainant's right lower limb had been amputated, he was no longer in pain, and therefore pain medication (MS Contin) was to be decreased by a third. The complainant asserted the letter was prepared without the consent or knowledge of the hospital doctor, whose name appeared on the letter. As a result of receiving the letter the complainant's GP reduced his MS Contin dosage and would not re-instate the prior MS Contin dosage to the complainant without the approval of the Pain Clinic.

The complainant wanted to be appropriately reviewed by a doctor regarding his MS Contin needs – taking a holistic approach and acknowledging MS Contin has been prescribed also for his left lower limb requirements and other health conditions – and to have his correct MS Contin dosage levels re-instated.

The Commission undertook preliminary enquiries into the issues of complaint and was of the opinion that:

- The complainant's MS Contin was reduced, and continued to be under review with a plan to possibly further reduce the dosage, under the authorization and direction of an appropriately registered medical practitioner.
- With respect to the discharge letter containing the doctor's name, but signed by the nurse, the Commission was satisfied the production of such a letter resulted from the automatic nature in which such letters were generated by the hospital's electronic system. The Commission noted that the hospital undertook to implement changes to the format of the discharge letter in order to prevent future misunderstanding of the roles of the primary specialist and to make it clear that the letter was composed after discussion of the plan with a medical specialist in Acute Pain.
- The dosage of medication, or medication per se, fell outside the scope and powers of the Commission and constituted a medical question for the medical practitioner to assess and determine. Therefore the complainant's GP was exercising his medical opinion with regards to the complainant's MS Contin dosage. Whether elected to be guided by the contents of the Acute Pain Service discharge letter or such other recommendations made by the Acute Pain Service at the hospital post-discharge, it was a medical matter for the complainant's GP to consider in his professional capacity.

The Commission determined that the actions taken by the provider were reasonable and took no further action on the complaint.

Interstate Patient Has Difficulties with Local Practitioners

The complainant attended the Commission and raised concerns relating to three practitioners. These were dealt with as follows:

Provider A

a) The complainant asked the provider if he could be her GP as she had run out of Blood Pressure (BP) and heartburn tablets. The complainant was requested to sign a form so that her medical records could be transferred from interstate. The medical records when received by the clinic were addressed to another doctor within the clinic. The complainant was upset by this and questioned why her records had been addressed to another doctor when she was not her patient. It was explained to the complainant that the records went to the correct clinic irrespective of who it was addressed to and the doctors must operate within the boundaries of confidentiality. The complainant was advised that the clinic's procedure was for all transferred files to be directed to the clinic manager (the other doctor) and it was her responsibility to arrange for them to be filed and administered on the clinic's system. The Commission determined to take no further action in relation to this issue.

b) After attending the provider the complainant received a receipt in another doctor's name. When the complainant took the receipt to Medicare they allegedly called the provider, in her presence, to enquire as to the name on the receipt. When the complainant approached the provider he denied speaking with Medicare and did not provide her with a response. Enquiries into the Medical Register showed the provider's full name as being different to the name he used in the surgery. No further action was taken by the Commission.

c) Prior to arriving in Darwin the complainant was advised by two doctors she had acquired an infection in her eye. However, when the complainant attended the provider he allegedly advised her that she had glaucoma and referred her to the hospital for surgery. The complainant was not happy with the provider's diagnosis. The complainant was advised that as the concern was purely of a clinical nature and it was one opinion versus another the Commission had no jurisdiction in the matter.

Provider B

The provider checked the complainant's eyes and advised her that she had dry eyes with one eye larger than the other. The complainant claimed that the provider was never available to see her despite making appointments as she was either out or on leave. The complainant eventually saw the provider and was referred to an eye specialist who advised that she had a cataract. The specialist further advised the complainant that she could leave it or have it removed surgically. The complainant did not want a different surgeon operating on her eye but she was advised by the specialist that as she was a public patient he could not do it and she therefore had no other choice. The alternative was for the complainant to go private and, without health

insurance, this would cost around $4,000. The complainant was advised that no action would be taken by the Commission in relation to the provider as she had obtained an appointment and had been referred to the eye specialist, hence there was nothing further that could be achieved by our office pursuing this matter. The Commission also confirmed to the complainant that the specialist's advice regarding the public health system was correct.

Provider C

a) When the complainant attended the provider's clinic she was on BP medication. The complainant was not sure whether it was the medication or her BP that was affecting her. The provider advised the complainant to stop taking her BP medication, which she did for around 3 to 4 months. However the complainant alleged that prior to ceasing the medication her blood pressure was 140/85 and after stopping her medication it rose. The complainant queried this with the provider and questioned whether she should be recommencing her BP medication. The complainant alleged that the provider stated it was better for her not to have the medication. The provider advised the complainant to stay off the BP medication and come back after a further few months. As the decision was one of a medical nature and open to the provider to make (as per the Heart Foundation recommendations) no further action was taken by the Commission.

b) The complainant again attended the provider's clinic and claimed to have had her ear syringed twice, once with warm water and once with cold water. The complainant advised that she had a small hole in her inner ear and the syringing resulted in a small infection which was smelly and itchy. The provider prescribed medication for the infection, however the complainant alleged it was the doctor's actions that had caused it in the first place. When the complainant went to the pharmacist to fill her script she alleged the pharmacist advised her against the medication due to the hole in her inner ear. The complainant went back to the provider who insisted on syringing her ears. The complainant then attended another doctor and he found the complainant's BP to be 155/90. The doctor prescribed BP tablets and referred her to the ENT specialist for her infected ear. The specialist found the hole in her ear and told her she should never have had her ears syringed. This issue was referred to the Medical Board.

c) The complainant was provided with a blank form at the provider's clinic which she was requested to sign. However, at the time, the complainant claims she was not sure what it was. The complainant then returned to the clinic and asked for a copy of the signed form which revealed it was a letter for cataract surgery but with no doctor's name on it. The provider agreed that she should not have asked the complainant to sign the blank form and she would ensure in future that patients were not put in that position, ie, they would only be asked to sign a form that was complete and they understood. The complainant accepted the provider's explanation and the issue was resolved.

No Capacity for X-rays over Weekend Causes Concern

The complainant was hit by a car when riding his bike and was transported to a public hospital by ambulance. He was treated in the Emergency Department and a closed reduction was performed to correct a wrist fracture, and a caste applied. X-rays showed that the procedure had placed the bones in a satisfactory position. The complainant stayed overnight and was discharged the next day with no direction on how to manage the injury and no sling provided.

The complainant later attended the outpatients department where x-rays were taken and he was advised that a CT scan was required to determine whether the fracture was displaced or not. Radiology advised that the scan could not be done quickly and he was encouraged to arrange his own scan, which he did, through the private hospital.

During his next outpatient's visit, the complainant's caste was tightened, he was given a sling and provided with information on how to care for the fracture which he should have been provided with when initially discharged. The complainant next presented at the outpatients department with his scans only to be told that they were now too old (6 days) and new ones were required. Unfortunately, radiology had closed and it was not possible to have them done that day. The complainant was advised to leave the old scans as they would be discussed with the consultant doctor, when he became available the next day, and he would be advised of the results.

Despite leaving a number of messages with the hospital no one returned his calls so he picked up his old scans and arranged to see another private specialist who requested additional scans be done for the following morning and another consultation was arranged to investigate the status of the injury.

The complainant had the new scans taken and was again seen by the private specialist who reported the fracture had collapsed and was now a 'borderline' call for surgery or caste management. As it was 17 days into treatment, surgery was advised and the complainant was scheduled to attend in Adelaide.

It was the complainant's opinion that had care been provided according to accepted standards changes in the condition of the injury could have been discovered enabling early intervention and management without surgery.

Preliminary enquiries were undertaken into the issues of complaint (including the receipt of an expert opinion) and the results of these enquiries were as follows:

1. **Lack of meaningful medical direction by the public hospital on how to treat and manage the complainant's injury in a timely manner**

The delay of 5 days to have a new CT scan done and to then make a decision on whether to operate or not may have impacted on the hospital's future management of the complainant's broken wrist and this issue was referred to the Medical Board for consideration. Had the complainant remained a hospital patient a new CT scan and management plan for his fracture would not have been available till almost 3 weeks after he broke his arm. There was no capacity for the public hospital to have x-rays taken (other than for very urgent matters) over weekends and public holidays such as Easter and this non-availability of radiology services may have impacted on the hospital's management of the complainant's broken wrist and the on-going treatment and care of patients. The non-availability of radiology services and access to the consultant's advice for 5 days, while not being reasonable, did not lead to an adverse event. This was mainly because the complainant took matters into his own hands by arranging a new CT scan and review by another private surgeon.

2. **Lack of communication and/or consultation by the hospital with the complainant directly on the treatment and management of his injury**

There was a lack of communication and consultation with the complainant as identified in the provider responses and medical records: For example:

- No information or direction on how to manage the injury was provided to the complainant on his discharge from hospital
- The complainant was provided with no assistance to obtain his CT scan urgently.
- The complainant had to wait for over two hours when he presented at outpatients, resulting in there being no opportunity to have a new CT scan done (Radiology had closed for the long weekend).
- The complainant's calls to the hospital consultant were not returned.
- The non availability of the hospital consultant for a period of five days over the Easter long weekend.

3. **Lack of consideration given to the complainant's profession as a training triathlete and member of the Australian Olympic Team**

The Commission was satisfied from the medical records that the hospital was aware that the complainant was an elite athlete. It therefore followed that he would want to be kept informed more than the average patient as to what was happening to him and the likely results as it could have a major impact on his future as an elite athlete representing Australia. He was not adequately informed.

Although the Commission did not determine to investigate the complaint it did bring its concern in relation to there being no x-ray capacity (other than for very urgent matters) available to the hospital over weekends and long weekends such as Easter to the attention of the department. The Commission was concerned that such delays could impact on the on-going standard of treatment and care provided to patients.

Relationship Interferes with Transportation Services

The complainant was a renal patient requiring dialysis 2-3 times per week at a public renal unit and was provided with medical transportation services by the provider so that she could attend her dialysis treatment. The complainant had personal issues with a driver employed by the provider which ended in the complainant approaching him, in front of other staff members, to discuss her personal concerns and pushing the driver away.

Following this altercation the provider wrote to the complainant advising that her alleged relationship and behaviour towards the driver was inappropriate. The provider advised the complainant that they had investigated the matter, and indicated that a relationship between a customer and staff member was not acceptable. The provider advised the complainant that in the interest of protecting the driver, the provider was suspending her transportation services indefinitely. The complainant felt the decision was harsh and unjust as she was not interviewed as part of the provider's investigation process. The complainant was also unable to indefinitely walk to the renal dialysis unit given her other conditions and could not afford to pay for taxi services. The complainant's desired outcome was to have the transportation services re-invoked, perhaps with an alternative driver.

Preliminary enquiries began and after some discussions between the Commission and the provider it was agreed that the provider would attempt to resolve the complaint by having the complainant sign a Conduct Agreement. The Conduct Agreement was signed by the parties and transportation services were commenced for the complainant. As the matter was resolved between the parties at point of service no further action was required by the Commission and the case was closed.

Dental Treatment Leads to Nerve Damage

The complainant sustained severe facial injuries in a motor vehicle accident in 2004 and was referred to the dentist (the provider) through his GP. The complainant became concerned about the standard of treatment he was receiving from the provider and decided to get a second opinion. The complainant subsequently made an appointment with another dentist and, according to the complainant, when the second dentist examined the work performed by the provider he indicated that the standard of treatment provided to him had not been satisfactory. The second dentist advised the complainant that the provider had drilled too far down into a nerve on the right side of his jaw and it had caused permanent damage.

The complainant also raised concerns that the provider prescribed 500mg Amoxhexal Capsules which is an antibiotic used to treat infections caused by bacteria with instructions to take one capsule three times daily. After consuming the medication for approximately five days the complainant began to feel ill. The complainant contacted his GP who asked if he had begun any new medication as he thought he may have suffered an allergic reaction. When the complainant advised his GP that the provider had prescribed Amohexal to him the GP instructed him to cease the medication immediately, drink water and contact him in a couple of days if he was not feeling better. After ceasing the medication the complainant's health began to improve and he did not require any further treatment.

A friend of the complainant later alerted him to the fact that the medication the provider had prescribed to him was contraindicated if the patient being prescribed the medication had an allergy to Cephalosporin which is a medication used to treat infections in different parts of the body. According to the complainant the allergy had previously been diagnosed by a doctor at a public hospital and was clearly listed on his MedicAlert card and bracelet, and in his dental records at the provider's dental surgery.

The Commission's preliminary enquiries in respect to the first issue, which included obtaining a written response from the provider and obtaining medical records and an expert opinion, suggested that the provider acted unreasonably and failed to exercise due skill and care. The Commission's preliminary enquiries in respect to the incorrect prescribing of medication, suggested that the provider failed to meet a standard of practice and incorrectly prescribed medication to the complainant that he was allergic to.

The Commissioner determined to refer both matters of complaint to the Dental Board.

PERFORMANCE

OVERALL PERFORMANCE OF THE COMMISSION

Performance	Unit of Measure	07/08	08/09	09/10
Quantity	1. Number of access and awareness sessions	10	13	39
	2. Number of enquiries/ complaints received	385	457	552
Quality	1. % of reviews of decisions requested	>1%	>Nil	>1%
Timeliness	1. % of inquiries & complaints closed within 180 days of receipt.	98%	98%	94%
	2. Average. time to finalise complaint	98 days	69 days	132 days
Cost *	1. Total output costs	$424,893	$462,755	$464,626

* Plus Ombudsman support free of charge

The key performance indicators for the 2009/10 period were:

- The number of approaches to the Commission was 20% more than for the previous year. Since 2006/07 there has been a 75% increase in the number of enquiries/complaints received.
- 93% of approaches were finalised during the year.
- The average time taken to finalise a complaint increased substantially from 70 days last year to 132 days this financial year, a 90% blow out.
- 91% of approaches to the Commission were resolved without a formal investigation or conciliation process.
- The Commission facilitated the resolution of 30% of complaints received directly between the provider and the complainant.
- Visits to the Commission's website decreased by 20%.

ACTIVITY 1: COMMUNITY ENGAGEMENT

OUTPUTS

1. Distribute Commission brochures to users and providers.
2. Provide a brochure in 10 different ethnic languages.
3. Give presentations to user and provider groups on the Commission's role and functions.
4. Utilise the media (radio, television and newspaper) to educate the public and increase awareness about the Commission.

PERFORMANCE

Performance	Unit of Measure	08/09	09/10
Quality	1. Different brochures for		
	• user groups	Yes	Yes
	• provider groups	Yes	Yes
	• ethnic groups.	Yes	Yes
	2. "Ethnic Brochure" represent majority of ethnic community[2].	Yes	Yes
Quantity	1. 1000 brochures sent.	1000	<1000
	2. Brochures to at least 10 different groups.	7	29
	3. 20 presentations & visits made.	13	39
	4. Utilise the media:		
	• newspaper	6	0
	• radio	0	0
	• television.	0	0

HIGHLIGHTS

MAINTAIN ACCESS AND AWARENESS AT THE NATIONAL LEVEL

The National Council of Health Complaints Commissioners consists of Commissioners and some Deputy Commissioners from each State and Territory, the New Zealand Commissioner and the Private Health Insurance Ombudsman. They meet on average every six months. These meetings enable the Commissioners to develop national strategies, set common goals and objectives, and discuss issues of common and national importance.

During 2009/10, two meetings of the National Council were held. The first in Hobart, Tasmania between 26 - 27 October 2009 and the second in Perth Western Australia, between 22 – 23 April 2010. Specific agendas are drawn up and actioned for each meeting. This financial year some of the matters discussed included:

- Trends in aged care in Australia;
- Measuring and managing risks by "mining" complaint data;
- Health care reform initiatives;
- Best practice investigations;
- Dealing with unregistered, deregistered and bogus health providers;
- Legal aspects of open disclosure;
- Complaint services to Indigenous populations; and
- National Registration and Accreditation.

During the year the commencement of the new National Registration Scheme on 1 July 2010 became a major focus for the Commissioners and a specific meeting dealing with issues associated with the commencement of the scheme was organised in conjunction with representatives from the Australian Health Practitioner Regulation Agency. This meeting was held in Melbourne on 14 May 2010. The agenda included:

- Interim Memorandum of Understanding/ Protocol
- Mechanisms for consultation under National Law
- Transition arrangements for matters started before 30 June 2010
- Arrangements for any jurisdictions not commencing on 1 July 2010
- Review process to finalise an MOU
- Ongoing review process
- Public interface, point of entry

ACCESS AND AWARENESS THROUGHOUT THE TERRITORY

As stated in last year's report, I utilised savings generated from the closing of the Alice Springs office to engage a project officer to undertake a six months public awareness and community engagement project for the office. While the main focus of this project was on the Ombudsman's Office and the commencement of its new Act, there were a number of spin offs for the Commission.

As part of he project the following outcomes were achieved:

- A new logo was designed for the Commission
- The Commission's website was upgraded

[2] Not including Aboriginal people who make up approximately 30% of the NT population.

- New posters and brochures were developed; and
- There were increased visits to remote communities.

Access and Awareness Sessions

During the year, staff from the Commission undertook minimal education sessions throughout the Territory, however, as part of the Public Awareness Project, 29 visits were made to communities spread throughout the Territory.

A total of 10 presentations (13 in 2008/09) on the role and operation of the Commission were held. The participants came from agencies such as community support services, ethnic groups and Aboriginal health services.

Written Material

The Commission has continued to distribute its pamphlets throughout the Territory, to consumers, targeted organisations and consumer groups. Pamphlets and posters were distributed throughout the Territory as part of the public awareness and community engagement project.

During the year a new poster and "In Your Pocket" cards were developed for the Commission. It is my intention to have these printed and distributed next financial year as funds become available.

There is still a need for the Commission to update its pamphlets, brochures and other written material and, in particular, to develop material that is more appropriate for our ethnic and indigenous populations. This activity will not commence until decisions are made in relation to the separation of the Commission and the finalisation of the review of the Act as these decisions will impact on the content of the pamphlets etc.

Advertising

The Commission did not place any advertising during the year.

Website

A major overhaul of the website took place during the year and the updated site came on line at the start of July 2010.

People throughout the Northern Territory and, indeed, worldwide can access the Commission through our website at www.hcscc.nt.gov.au. By logging onto the site people can access the Commission's Complaint Form to make a complaint, access information (including the latest Annual Report and Brochures), review our legislation or ask questions without the need to formally contact the Office.

The table below is testament to the number of people accessing the website during 2007/08:

	2007/08	2008/09	2009/10
Total visits:	11,869	15,381	12,361

Visits to our website decreased by 20% this financial year. It is hoped that the new website will generate increased visits.

10% of complaints were received via the website in 2009/10 (6% in 2008/09)

ACTIVITY 2: RESOLUTION OF COMPLAINTS

OUTPUTS

1. Accept enquiries and complaints.
2. Refer complainants to point of service for resolution.
3. Assess complaints in a timely, fair and independent manner.
4. Conciliate complaints.
5. Investigate unresolved complaints in a timely, thorough and independent manner.
6. Report to the complainant and provider and to other interested parties the results of an investigation in a clear and concise manner.

PERFORMANCE

Performance	Unit of Measure	08/09	09/10
Quality	1. Approaches finalised	94%	93%
	2. Enquiries/complaints informally resolved	96%	91%
	3. Recommendations supported	100%	100%
Quantity	1. Enquiries and complaints received	457	552
	2. Approaches finalised	365	428
	3. Approaches	387	470
	4. Investigations finalised	5	6
	5. Conciliations finalised	5	3
Timeliness	1. Average time to close a complaint	70 days	132 days

HIGHLIGHTS

APPROACHES

Enquiries and complaints are received in person, by telephone, in writing or electronically. Many of these can be handled quickly and are recorded on a separate database as enquiries. A total of 441 enquiries were received during 2009/10 of which 82 (19%) became registered complaints. An additional 29 registered complaints were received which were not the subject of an initial enquiry to the Commission, but may have resulted from a visit to the Commission's office or receipt of a written or electronic complaint.

Of the 470 approaches (refer to explanation below) to the Commission, 24% resulted in a formal complaint being registered (22% in 2008/09).

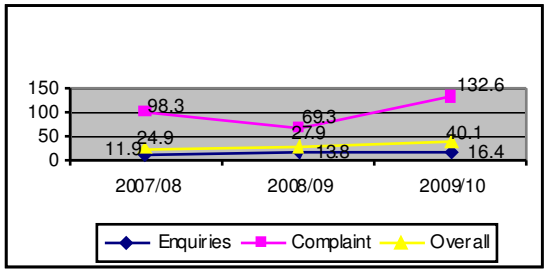
There has been an increase in the number of approaches this financial year, from 387 to 470. That is a 25% increase.

Explanation regarding approaches

Approaches registered as an enquiry	441
LESS enquiries moved to a complaint	82
Net enquiries received	359
Approaches registered as a complaint	29
PLUS enquiries moved to a complaint	82
Total complaints received	111
Total approaches for 2009/10	470

Although the number of approaches increased substantially again this financial year, unlike previous years, productivity and efficiency gains drastically reduced. For example:

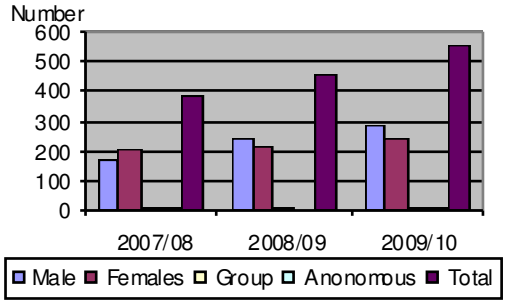
Chart 1: Average time taken to close (days)



The statistics which follow have been extracted from the Enquiry database and the Complaint database and the numbers quoted relate to the gross figures in each instance, ie the 441 enquiries and 111 complaints.

WHO COMPLAINS?

Chart 2: Gender breakdown

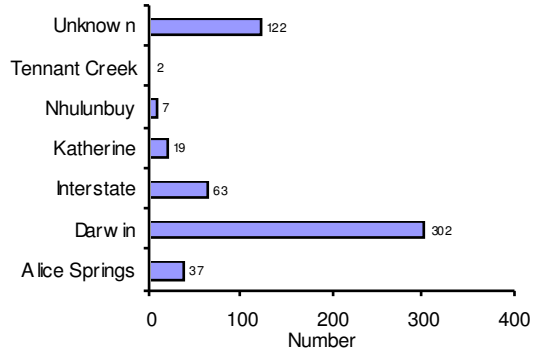


The male:female ratio over the past seven years has hovered around the 45:55 mark. As depicted in Chart 2, this year the ratio is 54:46.

This is the second year running, since the Commission commenced in 1998, that complaints from males have outnumbered females. This is attributed to the large number of enquiries/complaints received from prisoners (22%), of which the vast majority are male.

GEOGRAPHIC SOURCE OF COMPLAINT

Chart 3: Geographic source of complaint

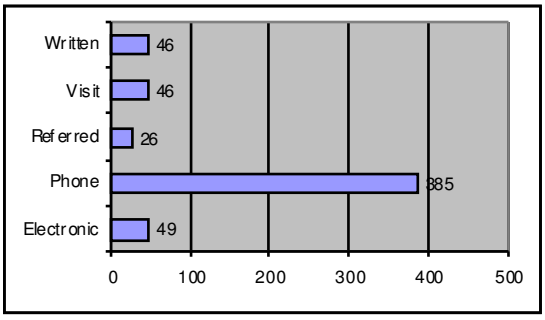


The majority of enquiries/complaints came from Darwin (55%), then interstate (7%) and Alice Springs (11%). The total number of enquiries/complaints received from Katherine, Tennant Creek and Nhulunbuy are still very low (5%)

MANNER OF APPROACH

People approach the Commission in a number of ways. As depicted in Chart 4, 77% do so by phone.

Chart 4: Manner of Approach

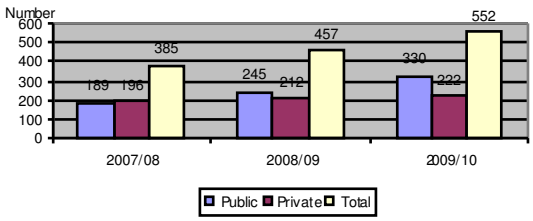


The majority of people (70%) approach the Commission via the phone, while written approaches continues to be small (8%) The number of electronic complaints increased from 6% to 9%. Only 8% of complainants made their complaint in person.

SERVICES PEOPLE COMPLAIN ABOUT?

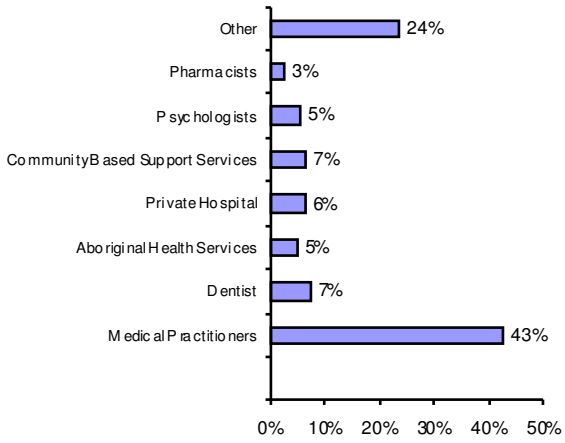
Public providers received 60% of enquiries/complaints this financial year compared to 53% last year.

Chart 5: Public/Private Enquiries/Complaints



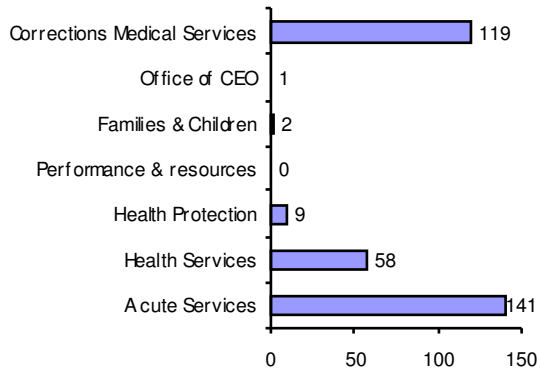
A breakdown of the type of public or private providers complained about follows:

Chart 6: Private provider respondents



Medical practitioners received the greatest number of private sector enquiries/complaints at 43% (31% in 2008/09), followed by dentists and community based support services at 7%. The category "Other" includes complaints received about nurses, chiropractors, nursing homes, optometrists, naturopaths, alcohol & other drug services, radiographers and osteopaths.

Chart 7: Public provider respondents



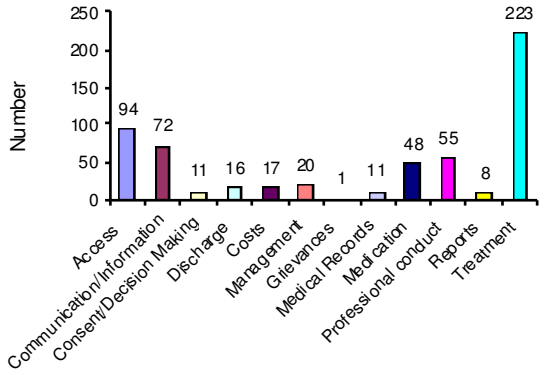
The greatest number of enquiries/complaints about the public sector related to services provided by public hospitals (43% of all public health complaints). This is a decrease from last financial year when it was 50%.

The number of complaints received about the Correctional Medical Service (CMS) also rose to 36% of all public sector enquiries/complaints.

ISSUES PEOPLE COMPLAIN ABOUT?

Information is recorded about the issues described in every enquiry and complaint and there can be more than one issue per complaint. Chart 8 provides a summary of the issues complained about during 2009/10.

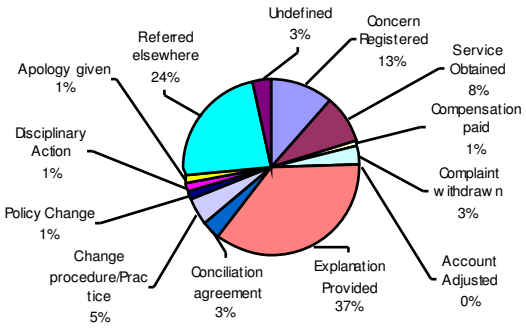
Chart 8: Issues Raised in Enquiries/ Complaints



It can be seen that issues associated with treatment were the major concern (37%). While this has always been the major issue of complaint, there has been a 33% increase compared to last financial year. Access (16%) and communication (12%) were the next most identified issues. The order of concern is similar to the complaints received over the past 3-4 years.

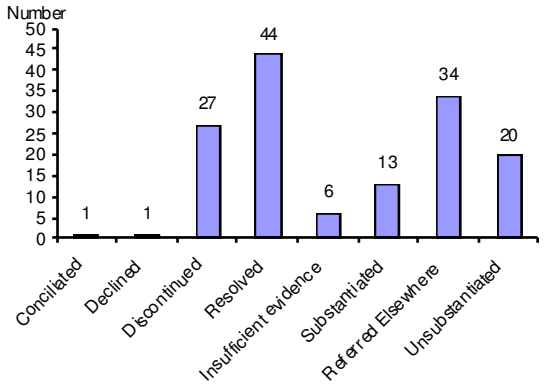
OUTCOMES OF FINALISED COMPLAINTS

Chart 9: Outcome Achieved



Being provided with an explanation was the outcome most achieved (37%), followed by referred elsewhere (24%) and obtaining a service (8%). Changes to policies and procedures accounted for 5% of the outcomes. It should be noted that there were 100 complaints closed during the year and 146 outcomes. The reason for this is that a complaint can have more than one outcome.

Chart 10: Extent to which outcome favoured the complainant



It is pleasing to see that 30% of complaints were resolved directly between the provider and complainant thanks to the assistance of the Commission (32% in 2009/10). 18% of complaints were discontinued either because the Commission lost contact with the complainant or because the complainant at some stage decided they no longer required the services of the Commission.

PRESCRIBED PROVIDER RETURNS

A number of service providers are required under the *Health and Community Services Complaints Act 1998* to implement effective internal complaints procedures and to lodge Annual Returns to the Commissioner. The providers prescribed under the legislation are:

- Anyinginyi Congress, Tennant Creek
- Central Australian Aboriginal Congress, Alice Springs
- Danila Dilba Biluru Butji Binnilutlum Medical Service, Darwin
- Darwin Private Hospital (DPH)
- Miwatj Health Service, Nhulunbuy
- Department of Health and Community Services (DHCS)
- Wurli Wurlinjang Aboriginal Health Service, Katherine

ISSUES OF COMPLAINT

Table 2 provides an overall summary of the primary issues of all complaints received by prescribed providers and the Commission.

Issues associated with quality of treatment (31%) and accessing services (25%) continue to be the major concerns of users of health services throughout the Territory. Complaints about poor communication make up 14% of issues complained about.

COMPLAINT OUTCOMES

Table 3 provides an overall summary of the outcomes of all complaints received by prescribed providers and the Commission. It highlights the fact that complainants are more likely to obtain a practical resolution to their complaint if they take up their concerns and issues directly with the provider in the first instance. For example only 6% obtained the service after making a complaint to the Commission whereas 38% obtained the service when they complained direct to the provider.

The most effective means of resolving complaints was to provide an acceptable and reasonable explanation (31%).

Table 2: Comparison between Commission and Prescribed Providers – Issues

CATEGORY	HCSCC	DHCS	DPH	A/S Con	Wurli	Miwati	Danila	Anyi	Total
Access	94	151	2	2	0	0	2	2	253
Communication & Information	72	73	0	1	1	0	0	0	147
Consent	11	1	0	0	0	0	0	0	12
Discharge & Transfer	16	0	0	0	0	0	0	0	16
Environment & Management	20	32	2	0	0	0	0	1	55
Fees, Costs & Rebates	17	6	0	0	0	0	0	0	23
Grievances	1	8	0	0	0	0	0	0	9
Medical Records	11	0	0	0	0	0	0	0	11
Medication	48	0	0	0	0	1	0	0	49
Professional Conduct	55	41	0	0	0	0	0	0	96
Reports & Certificates	8	0	0	0	0	0	0	0	8
Treatment	223	87	6	2	1	0	0	0	319
Out of Jurisdiction	21	0	0	0	0	0	0	0	21
Total[3]	**597**	**399**	**10**	**5**	**2**	**1**	**2**	**3**	**1019**

Table 3: Comparison between Commission and Prescribed Providers – Outcomes

OUTCOME	HCSCC	DHCS	DPH	A/S Con	Wurli	Miwati	Danila	Anyi	Total
Service obtained	32	150	0	0	0	0	0	1	183
Explanation provided	80	225	6	1	1	0	1	1	315
Apology given	2	40	1	1	1	0	0	1	46
Counselling/mediation	0	10	0	0	0	0	0	0	10
Concern registered	290	28	1	2	0	0	0	0	321
Change in procedures/ practice	20	1	2	0	0	1	0	0	24
Policy change effected	2	1	0	0	0	0	0	0	3
Account adjusted	2	2	0	0	0	0	0	0	4
Disciplinary action	2	0	0	0	0	0	0	0	2
Conciliated	5	0	0	0	0	0	0	0	5
Compensation paid	3	0	0	0	0	0	0	0	3
Complaint withdrawn	8	0	0	0	0	0	0	0	8
Resolved	6	0	0	0	0	0	0	0	6
Referred elsewhere	99	21	0	1	0	0	0	0	121
Other - pending	0	0	0	0	0	0	1	0	1
- unresolved	0	0	0	0	0	0	0	0	0
- unknown	17	1	0	0	0	0	0	0	18
Total[4]	**568**	**479**	**10**	**5**	**2**	**1**	**2**	**3**	**1070**

[3] Some complaints have more than one issue
[4] Some complaints have more than one outcome

ACTIVITY 3: IMPROVE HEALTH SERVICES AND COMMUNITY SERVICES

OUTPUTS

1. Make recommendations to providers and other appropriate bodies.
2. Refer professional conduct matters to appropriate registration boards.
3. Follow-up on implementation of recommendations.

PERFORMANCE

Performance	Unit of Measure	08/09	09/10
Quality	1. Number of providers who improved their practice following implementation of investigation recommendations.	2	1
	2. Percentage of providers responding to recommendations.	100%	100%
	3. Number of referrals to registration boards.	5	16
Quantity	1. Number of recommendations made.	32	20

HIGHLIGHTS

A major objective of the Commission is to utilise our complaint resolution processes to facilitate improvements in the provision of health services and community services. This objective is often supported by complainants who seek, as one of the outcomes to their complaint, an assurance that what happened to them will not happen to others.

The Commission has been very successful in identifying and recommending changes that, when implemented, will lead to improvements in the provision of services. During the course of the year 20 recommendations were made to providers.

I have included the following examples of investigations the Commission has undertaken to reflect the Commission's achievements in this regard during 2009/10.

CASE STUDIES - INVESTIGATIONS

POOR SURGERY HASTENS PATIENT'S DEMISE

BACKGROUND

The patient presented to the Alice Springs Hospital in March 2007 because of fainting and was discharged two days later around lunchtime. He was readmitted later that afternoon suffering a stroke. He had a history of lung cancer, cardiac dysfunction, severe systolic dysfunction and previously had undergone a lobectomy[5] as a result of tuberculosis. The patient was on various medications for his numerous conditions.

The patient was moved into the Intensive Care Unit (ICU) and his family was advised by a hospital doctor that he would not survive the night. After calling the family into ICU the initial doctor returned a few hours later to advise the family that he gave the worst case prognosis and now that a couple of hours had passed the patient might survive.

The patient was transferred to the medical ward and commenced receiving physiotherapy and speech pathology services, allegedly making progress. Due to feeding difficulties, as a result of the stroke, the family was advised that a PEG[6] feeding tube would be beneficial, however during the interim the patient was being fed by a nasogastric tube.

The patient subsequently had a PEG inserted however the family were informed there may be air inside the tube. For the next eight days, the patient was in excruciating pain, rating it as 9/10. The patient initially received morphine injections but was then placed on Patient Controlled Analgesia (PCA) and feed by Total Parenteral Nutrition (TPN) intravenously.

[5] An operation done to remove a lobe of an organ such as the lobe of a lung.
[6] PEG - Percutaneous Endoscopic Gastrostomy - The procedure is performed in order to place a gastric feeding tube as a long-term means of providing nutrition to patients who cannot productively take food orally.

Some time later the family were contacted and requested to attend the hospital as the patient required an emergency procedure. The family understood that the PEG had been put in the wrong place, the patient had a major infection in his stomach which required cleaning out, another PEG needed to be inserted and the patient may not survive the procedure due to his weak heart.

From this time until the involvement of Palliative Care the patient continued to experience high levels of pain. The pain affected his ability to cough and remove fluid from his lungs (as required because of his lung cancer). After Palliative Care involvement he appeared to be heavily sedated.

After the second operation which was undertaken as a result of complications arising from the first procedure (PEG insertion) the family noticed a large hole in the wound from the patient's operation which they believed to be infected.

INVESTIGATION PROCESS

The complainant attempted to resolve her concerns with Alice Springs Hospital in the first instance, however advised the Commission that she and her family had met with the General Manager and relevant medical staff of the hospital but they were still not satisfied that a sufficient explanation had been provided. It was determined that the Commission would investigate the standard of care and treatment provided to the patient in relation to:

- Diagnosis of condition
- Insertion of PEG on 12 April 2007 and consent for the procedures on 12 April 2007 and 20 April 2007
- Resultant complications of the operation performed on 12 April 2007
- Decision to re-operate on 20 April 2007
- Wound and pain management/medication
- Impact of operations on outcome
- All matters incidental and relevant to the above issues.

In undertaking the investigation the Commission:

- Obtained medical records and x-rays
- Obtained correspondence relating to a second opinion
- Obtained the hospital's response to the issues of complaint
- Obtained information from the visiting respiratory specialist
- Interviewed relevant medical staff
- Obtained expert opinions in the areas of surgical and intensive care.

CONCLUSIONS

The diagnosis of the patient's condition, when he first presented in March 2007, was considered appropriate by the experts. Prior to this date, although the patient presented to the hospital with various symptoms, the two expert opinions considered the tests and evaluations conducted at the hospital were sufficient. The two experts did not identify a missed diagnosis. One of the experts also suggested that even if the potential for a stroke was identified earlier *keeping him in hospital would, on the balance of probabilities, not have prevented the stroke, or meant that any treatment would have altered the course of the stroke.*

The operation performed early April 2007 was deemed necessary in order to provide the patient with a more viable method of long term feeding at home. Prior to instructing the surgeons to perform the procedure, specialist advice and clarification of the content of the specialist's letter was not sought. The expert believed that the patient's complications commenced immediately following this operation because the patient's stomach was not pulled firmly enough up against the inner aspect of the abdominal wall. The expert concluded that this aspect of the surgery fell below the standard of care expected by any reasonable person.

Informed consent by the patient to the operation, as required by the Code of Health and Community Rights and Responsibilities, was not provided as options and the consequences of complications on an individual with co-morbidities such as the patient were not discussed with him.

The conservative management and failure by medical staff after the operation to recognize symptoms further exacerbated the complications resulting from the incorrect fitting of the PEG and led to a delay in the intervention of the patient's condition. The incorrect fitting and delay ultimately resulted in the full dislodgement of the PEG and a second operation was performed in late April 2007. The second operation required general anaesthesia and open gastrostomy, two factors recognised by a visiting respiratory specialist as placing the patient at high risk because of existing co-morbidities. The two expert opinions believed the delay in intervention ultimately led to the earlier demise of the patient. The surgery in late April 2007 was deemed necessary and appropriate, however it was considered delayed.

The wound and pain management in addition to the patient's nutrition were considered appropriate by the experts. As was explained by one of the experts, although the holes in the patient's torso looked quite disturbing to the lay person it did not demonstrate inappropriate wound management.

The early prognosis of the patient when he first presented to hospital was considered appropriate, however there was a failure to record advice provided to the family. This was a difficult time for the patient and family when the patient's status was uncertain, however by use of accurate and sensitive words some of the anxiety caused could have been minimized.

RECOMMENDATIONS

The Commissioner made the following recommendations:

1. The surgical consultant at the hospital be referred to the Medical Board for consideration and action.
2. Consent forms be amended to include a section on options discussed and the risks and benefits associated with those.
3. Consent forms be amended to include a section, which records whether verbal consent is provided by a patient and records why the patient did not sign.
4. Medical records be more detailed and attention be given to ensuring dates and, where necessary, times are recorded.
5. The Credentialing Committee Alice Springs Hospital review the surgical consultant's clinical privileges, should he return to the hospital.
6. The Alice Springs Hospital Safety and Quality Unit conduct a root cause analysis of the events surrounding the patient's admission.
7. Review the training provided to medical staff on dealing with families and patients with end of life decisions and/or associated processes.

The investigation revealed that there were several breaches of the Code so recommendations were made to the Department of Health and Families. The matter was also referred to the Medical Board and Coroners Office for further consideration and action.

Prior to closure of the matter the Department of Health and Families indicated that changes to their informed consent form and policy would be effected following their 2010 review.

CESSATION OF LIFE SUPPORT NOT SUPPORTED BY BOTH PARENTS

BACKGROUND

The complainant contacted the Commission stating that he had received a phone call from Police advising him that his daughter aged 14, had been transferred from a Western Australian hospital to Royal Darwin Hospital (RDH) and was in the Intensive Care Unit (ICU). The complainant called the hospital and was advised that his daughter was very sick and might not live. He told the hospital he would be in to see his daughter later that afternoon once he returned from a remote community to Darwin.

After returning to Darwin the complainant visited his daughter in hospital where he was advised that she was very ill and may not have much more time left. The complainant sat with her for a period of time and then left. The next day the complainant returned to the hospital and was told by a different person that his daughter was brain dead but the rest of her body was okay. The complainant was confused by this statement as previously he had been told that his daughter's lungs were not functioning properly and part of her brain was damaged. He was then told that his daughter was on life support which was keeping her alive and sooner or later life support might need to be switched off. The complainant then asked if the life support machine could be kept on until his other daughters, who were on their way to Darwin from interstate, arrived. It was of great cultural importance to the family that her sisters and other family members be present with her before she died.

The next day the hospital contacted the complainant and advised him that the life support machine had been turned off. When the complainant reminded the hospital he had asked them to keep the machine on until his other daughters arrived, he was told it was not possible. The complainant was later told by friends that his daughter's mother had gone to the hospital, allegedly in an inebriated state, and consented to the life support machines being switched off.

The complainant stated there were no court orders for custody/guardianship in place and as his daughter was under 18 years, both he and her mother were equally responsible for decisions to be made about her health, well being and treatment.

INVESTIGATION PROCESS

On receipt of the complaint the Commission undertook preliminary enquiries in order to determine what action was required. These enquiries included:

- Seeking a response to the issues from the Department of Health and Families (the Department).

- Requesting copies of the patient's medical records which were denied because, in the Department's opinion, they needed the consent of the mother in addition to the father. The need to obtain the mother's consent appeared unreasonable to the Commission in the circumstances. Historically when there was no guardianship order, the Department would be forthcoming in providing medical records when one of the parents had provided consent. In this case the father had provided his consent, the mother lived in Western Australia and would be difficult to locate.

Without access to the complainant's daughter's medical records an appropriate assessment of the matter could not be completed by the Commission. It was therefore determined to move the complaint into a formal investigation to allow the Commission to obtain the medical records of the patient by Notice.

A response to the issues of complaint was also sought from the named providers. Neither provider responded.

The Commission sought information from the Children's Commissioner as the Convener of the Child Deaths Review & Prevention Committee to which he responded.

The Chairperson of the Medical Board was also notified of the complaint and he advised that the Board required to be notified of the outcome.

The issues that were investigated were:

- Whether or not ceasing the administration of life support to the complainant's daughter was clinically indicated or within law.
- Whether or not RDH failed to take into consideration family and cultural issues during the complainant's engagement with them following his daughter's admission.
- Whether or not RDH ignored the complainant's explicit request for his daughter to be maintained on life support until her sisters, who lived in other parts of Australia, were able to visit her and spend some time at her bedside before the life support was turned off.
- Whether or not RDH staff gave the complainant conflicting and confusing information regarding the health of his daughter and her prospects of living.
- Whether or not RDH allowed his daughter's mother to enter the hospital and visit her while in an intoxicated state.
- Whether or not RDH failed to refer the complainant to the Aboriginal Liaison Officer at the hospital to assist him following his daughter's admission.
- Whether or not the death was a reportable death within the meaning of the *Coroners Act*.

CONCLUSIONS

The investigation revealed that whilst RDH staff acted in good faith towards the patient's mother and her relatives, their interaction with the complainant was not to the same standard. The Department disagreed with this assessment stating that *'the hospital intensive care unit staff treated (the complainant) with respect and consideration during their interactions with him at the bedside and on the phone'*.

The Department further advised that *'it is unfortunate that he was not present at the hospital as much as (the patient's) mother and therefore did not get the same amount of contact with staff. Every effort was made to keep him informed and there is no evidence that any requests for information or support were denied or that he was spoken to disrespectfully, inconsiderately, callously or unkindly. Unit staff made an effort to keep both parents informed of the situation'*.

The complainant was either misinformed or mistaken that the hospital said it would maintain his daughter's ventilator until her sisters arrived and there is no written record that supports that this request was made.

The Commission accepts that providing comprehensive information about the patient to two different parties, whose relationship was acrimonious, caused staff several problems and would be very time consuming. While RDH staff had been informed by the complainant that he could not be in the same room as the patient's mother, and staff adhered to his request, there was no reason for staff failing to have separate conversations or meetings with the patient's father.

Regardless of whether or not hospital staff were aware that the complainant was waiting for his daughters to arrive, they should have informed him that his daughter's ventilator was to be turned off when he was at the hospital at lunchtime on the day it was to happen.

For the complainant to be subsequently told by telephone that his daughter's ventilator had been turned off and that she had died, without consultation or awareness that this was to occur, must have been extremely difficult for him.

The father had the same right as the mother to say goodbye to his daughter, but he did not get this opportunity.

The complainant advised that if he had been consulted he would have allowed his daughter's organs to be removed and used to save the lives of others. The Department stated that *'(the patient's) mother clearly indicated to staff that she did not want to discuss organ donation and her wishes were respected. It is the usual practice to only proceed with discussions about organ donation in the event of brain death where family consensus exists. It would have been inappropriate to raise the issue with (the father) as it was already known that (the patient's) mother had already indicated she would not consider organ donation*'. There was no record in the medical notes of any discussion with the mother in relation to organ donation. The documents indicated that the daughter was to be cremated.

The death of the complainant's daughter was extremely tragic. The complainant's emotional state at the time was fragile, which in the circumstances was understandable. The complainant was correct in saying he was treated differently to the patient's mother in that he was not provided with the same information or considerations as the mother and he was unaware that RDH had a Social Worker and Aboriginal Liaison Officer.

This case highlighted that when families are divided, additional actions are required to properly inform parents/guardians and to avoid being partial to one party and disrespectful to the other.

RECOMMENDATIONS

The following recommendations were made by the Commission:

1. Department employees, including social workers and Aboriginal Liaison Officers, maintain comprehensive records of their dealings with members of the public including comprehensively documenting conversations, in person or by phone, with patients and their next of kin.
2. A document and policy be promulgated by the Department to take into consideration circumstances where parents of a minor are divided. This document should record the actions and information provided by departmental staff to both parents/guardians and adequately note the response provided by both parties.
3. When a critically ill Aboriginal patient is admitted to hospital the Social Worker and/or Aboriginal Liaison Officer is contacted and provided with the details of the parents/guardians and any referral is noted in the medical records.
4. When entering the name of a person as next of kin in the medical records the source of that information be verified with both parents and it be noted who provided the verifying information.

UNREASONABLE CARE AND TREATMENT PRIOR TO PATIENT'S DEATH

BACKGROUND

The complaint related to an allegation about a patient that died in Royal Darwin Hospital (RDH) because insufficient nutrition was given to her during the duration of her admission. The daughter of the patient approached the Commission with concerns about the standard of care and treatment provided to her mother following her admission, including treatment being undertaken without adequate consent and poor communication with the daughter regarding end-of-life decisions.

INVESTIGATION

After undertaking the investigation the Commissioner concluded that:

1. The overall standard of care and treatment provided to the patient was not reasonable in that:
    - A referral should have been made for the patient to see a speech pathologist on the second day of her admission and this never happened. Early referral to a speech pathologist could have impacted on future decisions relating to nil by mouth and Nasogastric feeds.
    - Procedures to commence nasogastric feeding did not begin on the second day of admission following agreement to this by the medical team and nutritionist.
    - There was no coordination of care between ear, nose and throat and speech pathology.
    - There was a failure to collect next-of-kin demographics and capture and record the current contact information when provided by family members.
    - Intravenous hydrocortisone was not commenced, however this failure was unlikely to have hastened the patient's deterioration or altered the outcome.
2. The non availability of a speech pathologist over the weekend on the fourth and fifth days contributed to further delays in the patient being adequately assessed.
3. The delay in initiating nasogastric feeding and the failure to commence intravenous hydrocortisone did not have any significant affect on the patient's nutritional status or outcome during the course of her admission at RDH.

4. The medical handover processes were not adequate and poorly documented leading to some confusion regarding care and treatment and communication was sub-standard between medical practitioners, the patient and her family.

5. The patient was not capable of giving informed consent to her treatment plan on the day of her admission.

6. It was reasonable for medical staff to presume capacity in their dealings with the patient on the second and third day of her admission as she was probably capable of making decisions during this period.

7. The patient was probably not capable of giving informed consent on the fourth and final day of admission.

8. In the absence of an Advanced Care Directive, the decisions regarding the patient's care and treatment on the fourth and fifth day were for the medical team to make, after consultation with the patient's daughter.

9. The lack of an Advanced Care Directive Information policy and the usual admission process led to the patient's daughter misunderstanding her role in the decision making process regarding her mother's care and treatment.

10. A system, similar to NSW, or Victoria, or South Australia if established for public hospitals in the Territory would enable people to plan in advance for end-of-life care by:

    - Developing an advanced care plan in conjunction with their healthcare professionals while being treated in a care setting.
    - Discussing their preferences for life sustaining treatment with their family before they are acutely ill.
    - Formally appointing and empowering a medical agent of the patient's choice.
    - Writing an advanced care directive binding on the medical agent and treating team.

    This approach would enhance the autonomy of all persons who choose to take advantage of it. Legislation would be necessary to establish the authority of a medical agent and to make a patient's choice paramount.

RECOMMENDATIONS

Based on the findings and conclusions reached throughout the investigation, the Commissioner made the following recommendations:

1. The Minister for Health and the Government consider enacting legislation allowing for decisions about the medical treatment of a person to be made by another person appointed as an agent either by way of:
    - an Enduring Power of Attorney similar to other States in Australia; or
    - nominating persons to have the power of such an agent; or
    - investing a Public Advocate with such authority; or
    - in such manner as the Legislative Assembly deems fit.

2. A review be undertaken of the utilisation and effectiveness of the *NT Natural Death Act 1988*.

3. RDH increase the knowledge and understanding of all their health professionals of the role of the speech pathologist by:
    - Developing procedures to clarify the referral process for obtaining a speech pathology assessment.
    - Ensuring a greater understanding of the speech pathologist's role by placing appropriate information on the RDH intranet and providing adequate training to medical and nursing practitioners about referral processes to obtain services from a speech pathologist.

4. The services of a speech pathologist be available to RDH during a weekend.

5. The Department of Health and Families (DHF) develop and implement an education strategy about advanced care planning. That such a strategy:
    - Is communicated widely throughout the department and to its patients.
    - Makes all parties aware of the current limitations of the NT position in appointing a medical power of attorney.
    - Ensures material and brochures are readily available and accessible throughout departmental facilities and to community health groups.
    - Be adequately resourced to train staff to facilitate discussions about advanced care planning.

6. Priority be given to educating hospital staff of the need to discuss issues such as Advanced Care Planning with patients and their family/carers should the patient's circumstances and medical condition warrant such action. Such discussions should be clearly documented in the medical record.

7. RDH reinforce with medical and nursing practitioners their responsibility to maintain accurate and sufficient records, particularly relating to handovers and discussions with family, carers and next-of kin.

DEPARTMENT'S RESPONSE

A draft investigation report, including the conclusions and recommendations outlined above, was forwarded to DHF for comment and their response was summarised as follows:

> *As you will quickly note there are significant areas of this report where the department does not agree with your conclusions or findings. However, as you will also note frequently throughout my response, we clearly recognise as you do the need for speedy improvement in the areas of communication and documentation.*

Some minor changes were made to the final report as a result of the Department's comments, however on the whole the Commission upheld its findings and recommendations.

In relation to recommendations 1 and 2, the Commission was advised that the Law Reform Committee on 12 January 2009 provided a draft report on their enquiries into the NT *Powers of Attorney Act* and Medical Enduring Powers of Attorney. As pointed out by DHF, the areas set out in recommendations 1 and 2 were under active review and the progress of the review would be determined by the government's legislative agenda. As such the Commission was satisfied that appropriate action was being undertaken to progress these matters and requested DHF to provide the Commission with an update of the situation in three (3) months time.

DHF did not support recommendation 3 and argued that there was already adequate knowledge and understanding of the speech pathologist's role. This position was not supported by the evidence and the Commission will continue to pursue implementation of this recommendation.

DHF agreed recommendations 5, 6 and 7.

ACTIVITY 4: MANAGEMENT OF COMMISSION

OUTPUTS

1. Production of an Annual Report.
2. Compliance with the *Health and Community Services Complaints Act*.
3. Compliance with the *Financial Management Act*.
4. Adhere to policies and procedures associated with:
   - Equal Employment Opportunity;
   - Recruitment and appointment on merit
   - Work Life Balance; and
   - Occupational Health and Safety.
5. Compliance with the *Carers Recognition Act*.
6. Compliance with the *Information Act*.
7. Management of resources.

PERFORMANCE

Performance	Unit of Measure	08/09	09/10
Quality	1. Audit reports clear of major issues.	N/A	N/A
	2. Activities undertaken in accordance with Business Plan	Yes	Yes
Quantity	1. Copies of Annual Report printed.	150	150
	2. Policies and procedures for:		
	• Equal employment	Yes	Yes
	• Occupational Safety & Health;	Yes	Yes
	• Equity and Merit;	Yes	Yes
	• Info Technology	Yes	Yes
Timeliness	1. Annual Business Plan prepared.	June 08	July 2009
	2. Annual Report tabled.	Oct 08	Oct 09
	3. Policies and procedures available at all times	Yes	Yes

CORPORATE GOVERNANCE

LEGISLATIVE FRAMEWORK

The Commission is responsible for the administration of the *Health and Community Services Complaints Act*.

The Commissioner is the accountable officer for the Health and Community Services Complaints Commission and has responsibility under the *Financial Management Act* for the efficient, effective and economic conduct of the Commission.

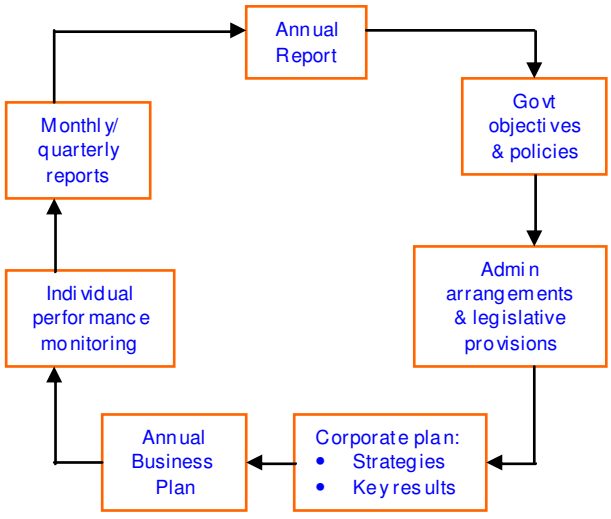
Under the *Health and Community Services Complaints Act*, the Commissioner is independent of the Government and is not accountable to a Minister, but rather to the Legislative Assembly. However, under the Administrative Arrangements Orders, the Minister for Health has administrative responsibility for the Commission.

The Commission is not an agency under the *Public Sector Employment and Management Act*, however this anomaly is being actioned through amendments being considered to the PSEM Act. At present, Commission staff are employed by the Ombudsman and seconded to the Commission.

PLANNING AND REVIEW CYCLE

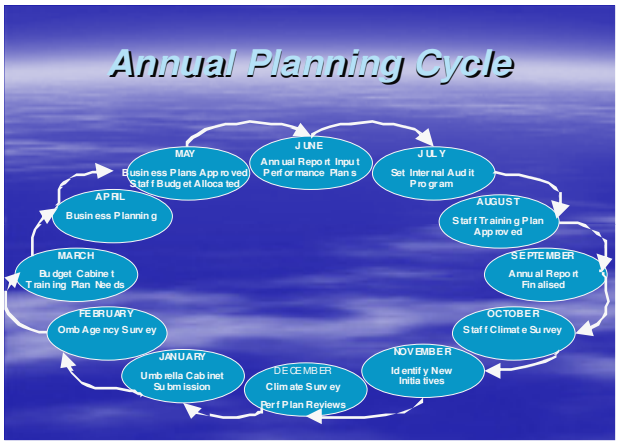
In relation to the strategic planning framework the Commission operates in the following way:

Diagram 1: Strategic Planning Framework



The Commission has developed and adopted a continuous planning and review cycle.

Diagram 2: Planning and Review Cycle



The Corporate Plan for the Commission was developed in mid 1998. It was reviewed in March 2002 and again in 2006. As a result of the review the Plan was amended slightly. The Corporate Plan provides guidance for the Commission and is a reference point for all staff in relation to where the Commission is heading and what the Commission is trying to achieve. The strategic/corporate direction of the Commission was reviewed during the year and the new strategic focus of the Commission is detailed at Appendix 1.

An annual Business Plan is prepared and this provides specific direction and performance indicators. This in turn cascades down into individual performance plans. Performance reports are provided to the Management Board and overall performance of the Commission is reported annually to the Legislative Assembly.

PERFORMANCE MANAGEMENT SYSTEM

There are a number of ways that performance is monitored during the course of the financial year. These can include the following:

- Short weekly meetings with staff to identify priorities and action required.
- Open door policy to discuss day to day management of files and complaints.
- Regular case meetings between each staff member and Deputy Commissioner to discuss and monitor progress on cases and, where appropriate, determine action on the more difficult cases.
- Progress reports relating to the Business Plan being provided to the Management Board and Commissioner as required.
- Annual individual performance measured against agreed performance indicators.
- Achievement of the detailed strategies and performance indicators being reported in the Annual Report.

INTERNAL ACCOUNTING CONTROL PROCEDURES

The internal control procedures expected to be adopted by accountable officers for their agency are defined in the *Financial Management Act and Treasurer's Directions*. Part 3 of the Treasurer's Directions defines the internal control procedures to be established and incorporated into an agency's Accounting and Property Manual.

The Commission has been incorporated into the Office of the Ombudsman's control procedures, which have been determined to conform with these requirements and are recorded in the Ombudsman's Accounting and Property Manual.

EQUAL EMPLOYMENT OPPORTUNITY MANAGEMENT PROGRAM

The Commission has been included in the Ombudsman's Equal Opportunity Plan because it is co-located with, and obtains its administrative support from, the Ombudsman's Office and a detailed report can be found in the 2009/10 Ombudsman's annual report.

In addition, the Commission, through the Ombudsman's Office has an Aboriginal and Career Development Plan and continues to examine how to better utilise the skills of those it employs to improve the Commission's ability to provide culturally appropriate services to Aboriginal people.

MANAGEMENT TRAINING & STAFF DEVELOPMENT PROGRAMS

A performance appraisal framework has been implemented to meet the needs of the Commission. A major objective achieved through the implementation of this program is the design of individual annual training and development programs for Commission staff.

The training and staff development program was implemented in 2009/10 as sufficient funds became available.

Expenditure on staff training and development during 2009/10 for Commission staff is included in the overall staff development and training expenditure for the Ombudsman's Office. This expenditure for Commission staff amounted to $2,315 and comprised 12 training opportunities. Last financial year expenditure amounted to $3,000 and comprised 14 training opportunities.

OCCUPATIONAL HEALTH & SAFETY PROGRAM

The Commission has been included in the Ombudsman's Occupational Health and Safety Management Plan because it is co-located with, and obtains its administrative support from, the Ombudsman's Office. A detailed report can be found in the 2009/10 Ombudsman's annual report.

CARER RECOGNITION ACT REPORTING REQUIREMENTS

In accordance with Section 7 of the *Carers Recognition Act* the Commission reports that it has had no direct involvement with the provision of support and services to people with a disability, the aged, people with a chronic disease and those with mental illness by unpaid carers during the course of the financial year.

FOI ANNUAL REPORTING REQUIREMENTS

Section 11 of the *Information Act* sets out the information a public sector organisation must publish annually in relation to its process and procedures for accessing information. The Commission has been included in the Ombudsman's procedures for accessing information because it is co-located with, and obtains its administrative support from, the Ombudsman's Office and a detailed description of processes and procedures can be found in the 2009/10 Ombudsman's annual report.

During the financial year the Commission received no requests under the *Information Act*.

RECORDS MANAGEMENT

Part 9 of the *Information Act* relates to Records and Archives Management. This section sets out the obligations, standards and management of records and archives to be complied with.

In accordance with Section 134 of the *Information Act,* the Health and Community Services Complaints Commission:

(a) keeps full and accurate records of its activities and operations; and
(b) complies with the standards applicable to the organisation through the implementation of a Records Management Plan.

The Records Management Plan for the Ombudsman's Office incorporates the Health and Community Services Complaints Commission and aims to achieve the following objectives:

- records management staff fully trained;
- adopt new methods and technologies for keeping and managing records; and
- fully compliant with the *Information Act* and the NTG Standards for Records Management.

The records and archives management of information within the Commission accords with the NT Archives Standards.

APPENDIX 1

STRATEGIC FOCUS OF THE HEALTH AND COMMUNITY SERVICES COMPLAINTS COMMISSION

Our Vision

- The rights and responsibilities of users and providers are respected and protected in the provision of health services and community services in the Northern Territory.
- The Commission's services are recognised and respected as best practice.

Our Mission

To serve Parliament and Territorians by:

- Resolving complaints about health service and community service providers quickly, fairly and independently.
- Improving the quality and standard of health services and community services throughout the Northern Territory.

Our Key Stakeholders

- **Parliament**
- **Providers of health services and community services**: including both organisational providers such as the Department of Health and Families and individual providers such as the local GP.
- **Territorians**: the public.

Our Values

We value being;

- **Fair:** We will treat you fairly and with respect, observe procedural fairness at all times, provide our services equitably to all Territorians and keep all parties regularly informed.
- **Independent:** The Commissioner for Health and Community Services Complaints is an officer of the Parliament, independent of the Government of the day and independent of all parties in dispute.
- **Professional:** We will be ethical, honest, and respectful, act with integrity and consistency and provide the highest standard of service possible.
- **Accountable:** We will use our resources lawfully, effectively and in a timely manner, make decisions that are supported by appropriate evidence, be open and transparent in all our dealings and make recommendations that are practical and proportionate to the problem identified.
- **Accessible:** We will ensure all Territorians can readily access our office either in person, in writing, by phone, by email or via the internet, have access to promotional and educational material and have any necessary support required to make a complaint.

Key Outcomes

- Territorians are aware of and satisfied that our services are accessible to all.
- The time taken to resolve complaints continues to improve.
- Providers of health services and community services are accountable for, and improving the quality and standard of their services.
- Our suggestions and recommendations for service improvement are accepted and implemented.
- Parliament and public authorities are aware of, and value our services.

APPENDIX 2

DETAILED COMPLAINT STATISTICS FOR 2009/10

ENQUIRY/COMPLAINT STATISTICS 2009/10

A detailed breakdown and analysis of the enquiries and complaints received follows.

ENQUIRIES RECEIVED

1. Enquiries Open During the Year

As detailed in Table 4, a total of 441 new enquiries were registered during the year.

Table 4: *Enquiries Movement During 2009/10*

ITEM	08/09	09/10
Enquiries received during the year	373	441
Enquiries finalised during the year	276	328
Enquiries becoming formal complaint	70	82
Enquiries still open as at 30 June	**27**	**31**

Of all the active enquiries, 74% were finalised (74% in 2008/09), 19% became formal complaints (19% in 2008/09) and 7% remained open (7% in 2008/09).

2. Providers Subject to Enquiries

Table 5 below provides a breakdown of providers which have been the subject of enquiries over the past year.

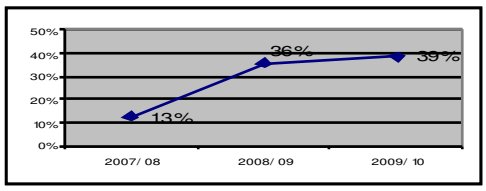
Table 5: *Providers Subject to Enquiries*

PROVIDER	07/08	08/09	09/10
Public Providers:	**167**	**202**	**268**
Acute Services	94	98	111
Health Services	33	30	44
Health Protection	0	2	8
Performance & Resources	0	0	0
Families & Children	0	0	1
Office of the CEO	0	0	1
Corrections Health Service	21	72	103
Community Services [7]	16	0	0
Executive & Legal	0	0	0
Information Services	1	0	0
People Services	2	0	0
Hlth Prof Licensing Auth	0	0	0
Private Providers:	**156**	**173**	**173**
Aboriginal Health Services	6	8	9
Alcohol and Drug Services	2	11	2
Alternative Therapists	0	0	0
Ambulance Services	1	3	3
Audiologists	0	0	0
Carer	1	0	1
Chiropractors	2	0	1
Community Based Support	7	9	12
Dentists	14	21	12
Diagnostic Services	2	3	5
Hospitals	8	6	11
Hostel/Supported Accom	0	4	0
Masseuse	0	0	0
Medical Admin	0	2	0
Medical Centres	0	0	0
Medical Practitioners	65	55	74
Naturopaths	1	0	0
Nurses	4	13	3
Nursing Homes	1	2	3
Occupational Therapists	2	1	0
Optometrists	3	0	0
Osteopath	0	1	1
Palliative Care	0	1	0
Pharmacists	3	2	3
Podiatrists	1	0	2
Psychologists	7	2	7
Practice Managers	1	0	0
Prosthetists/Orthotists	1	0	0
Other	24	30	24
Outside Jurisdiction:	**0**	**0**	**0**
TOTAL	**323**	**375**	**441**

Of the total enquiries received during the year under review, 61% related to public providers (54% in 2008/09 and 52% in 2007/08) and 39% to private providers (46% in 2008/09).

41% of public provider enquiries were about the public hospital system (compared to 48% in 2008/09) while 43% of private provider enquiries were about medical practitioners (31% in 2008/09).

Of particular note is the significant increase in enquiries received from prisoners in relation to Corrections Medical Service.



[7] Due to a reorganisation of this division and those following (Exec & Legal, Information Services, People Services HPLA) no longer exist.

COMPLAINTS RECEIVED

1. Complaints Open During the Year

As detailed in Table 6, of the 131 total active complaints for the year, 110 or 84% were finalised (82% in 2008/09)

Table 6: *Complaints Movement During 2009/10*

ITEM	08/09	09/10
Complaints open as at 1 July	29	20
Complaints received during the year	84	111
Total active complaints for the year	**113**	**131**
Complaints closed during the year	93	110
Complaints still open as at 30 June	**20**	**21**

2. Providers Subject to Complaints

(a) Providers subject to complaints received

Table 7 provides a breakdown of providers that have been the subject of complaints.

Table 7: *Breakdown of providers subject to complaints*

PROVIDER	07/08	08/09	09/10
Public Providers:	**22**	**43**	**62**
Acute Services	16	24	30
Health Services	3	8	14
Health Protection		1	1
Performance & Resources		0	0
Families & Children		0	1
Office of the CEO		0	0
Corrections Health Service	2	10	16
Community Services[8]	1		
Executive & Legal	0		
Health Professions Licensing Auth	0		
Private Providers:	**40**	**41**	**49**
Aboriginal Health Services	0	2	2
Alternate Therapists	0	0	0
Alcohol and Other Drugs	0	1	0
Ambulance Services	0	3	0
Chiropractors	2	0	0
Community Based Support Groups	0	1	3
Counselling	0	1	0
Dentists	1	7	4
Diagnostic Services	2	0	0
Hostel/Support Accommodation	0	1	0
Medical Admin	0	3	1
Medical Practitioners	20	14	20
Nurses	1	3	2
Occupational Therapists	0	0	0
Optometrists	1	0	0
Osteopath	0	1	1
Palliative Care	0	1	0
Pharmacists	0	0	3
Prosthetists/Orthotists	1	0	0
Practice Managers	8	0	0
Private Hospital	3	1	3
Psychologists	0	0	5
Radiographers	0	0	0
Therapeutic Counsellor	0	0	1
Other	1	2	4
Outside jurisdiction:	**0**	**0**	**0**
TOTAL	**62**	**84**	**111**

[8] Due to a reorganisation of this division and those following (Exec & Legal and HPLA) no longer exist.

Of the total complaints received during the year under review, 56% related to public providers (35% in 2008/09) and 44% to private providers (65% in 2008/09).

48% of public provider complaints were about the public hospital system (compared to 56% in 2008/09) while 52% of private provider complaints were about medical practitioners (compared to 44% in 2008/09).

(b) Complaints about hospitals

Around 30% of all complaints related to the hospital system (30% in 2008/09) and, as Table 8 illustrates, 73% of these were against Royal Darwin Hospital (80% in 2008/09).

Table 8: *Complaints about hospitals*

HOSPITAL	07/08	08/09	09/10
Royal Darwin Hospital	10	20	24
Alice Springs Hospital	4	2	3
Katherine Hospital	2	2	2
Darwin Private Hospital	3	1	3
Tennant Creek Hospital	0	0	1
Gove District Hospital	0	0	0
Total	**19**	**25**	**33**

To put the above figures in perspective, RDH is the principal acute care and tertiary referral hospital in the Northern Territory and its Emergency Department is the trauma centre for the Top End.

(c) Complaints by medical specialty

Around 18% of all complaints related to medical practitioners (17% in 2008/09) and, as Table 9 illustrates, 60% of these were against General Practitioners (86% in 2008/09).

Table 9: *Complaints by medical specialty*

MEDICAL SPECIALITY	07/08	08/09	09/10
Anaesthetist	0	0	1
Dermatologists	0	0	0
Emergency Medicine	0	0	0
Endocrinologists	0	0	0
General Practitioners	17	12	12
Medical Administration	0	1	0
Obstetrician/Gynaecologist	0	0	0
Orthopaedics	1	0	0
Paediatrics	0	0	0
Pain Management	1	0	0
Physicians	0	0	1
Plastic/Cosmetic Surgeons	0	1	0
Psychiatrists	0	0	0
Surgeons	1	0	6
Urologists	0	0	0
Total	**20**	**14**	**20**

Many of the complaints received about the public health system (as identified in Table 7 above) often name a specific registered

provider such as a Surgeon, Anaesthetist, etc, but these named providers are not reflected in the figures at Table 9.

(d) Complaints about aged and disability services

As the Commission receives complaints relating to aged services and services for people with a disability it is appropriate that a record is kept of the number of complaints relating to these services. These are detailed in Table 10.

Table 10: *Aged and Disability Services Complaints*

PROVIDER TYPE	07/08	08/09	09/10
Hostel/Supported Accommodation	0	1	0
Nursing Homes	0	0	0
Aged and Disability (public)	0	0	1
Mental Health (Public)	0	0	4
Community Based Support - Disabilities	0	1	1
Total	**0**	**2**	**6**

Six complaints were specifically recorded relating to aged services or disability services.

COMPLAINTS CLOSED

1. Reason for Closure

The *Health and Community Services Complaints Act 1998* allows for complaints to be closed under certain circumstances and information recorded by the Commission about the reasons for such closure. These reasons are summarised in Table 11.

Table 11: *Reasons for Closure*

REASONS FOR CLOSURE	07/08	08/09	09/10
Enquiry concluded	0	7	4
Complaint is resolved	24	32	27
Investigating further is unnecessary	11	29	32
Not resolved with provider	0	4	2
Been before court, tribunal or board	1	1	2
Information under sec 25 not received	0	3	5
Complaint lacks substance	0	0	0
Complaint has been withdrawn	2	5	5
Complaint over 2 years old	0	0	0
Referred to relevant board	13	11	23
Frivolous, vexatious, not in good faith	1	0	0
Not a matter referred to in Sec 23	1	0	0
Not a prescribed service	0	1	0
Total	**53**	**93**	**100**

32% of complaints were finalised following preliminary enquiries because it was found unnecessary or there was insufficient justification to continue with any investigations into those cases (31% in 2008/09). 27% of complaints were closed during assessment because the issues identified in the complaints were satisfactorily resolved between the complainant and the provider (33% in 2008/09). 23% of complaints were referred to the relevant Board (12% in 2008/09).

2. Outcomes of Complaints

Table 12 shows the stage when complaints were resolved.

Table 12: *Complaints resolved by stage*

STAGE OF PROCESS	07/08	08/09	09/10
Point of Service	14	40	36
Facilitated Resolution	9	17	17
Assessment	17	21	22
Referred to Board	7	5	16
Conciliation	4	5	3
Investigation	1	5	6
Total	**53**	**93**	**100**

If closures relating to Board referrals are discounted, 75% of all other complaints were resolved without the need to proceed to the more formal processes of conciliation or investigation (89% in 2008/09).

Table 13 notes the outcomes achieved from closed complaints.

Table 13: *Outcomes of complaints closed*

OUTCOME	07/08	08/09	09/10
Account adjusted	1	4	0
Apology given	7	6	2
Change in procedures/practice	8	8	8
Compensation paid	0	0	2
Complaint withdrawn	9	8	5
Concern registered	2	6	17
Conciliation agreement reached	4	4	5
Disciplinary action taken	0	1	2
Explanation provided	27	69	52
Policy change effected	1	3	2
Referred elsewhere	15	12	34
Refund provided	0	2	0
Service obtained	2	21	12
Undefined	7	10	5
Total	**83**	**154**	**146**

The major outcome received by complainants was to be given an explanation (36%). 23% of cases were closed because the complaint was referred elsewhere.

ISSUES IN ENQUIRIES/COMPLAINTS

Information is recorded about the issues described in every enquiry and complaint, and often more than one issue is recorded against a complaint. Standard issue descriptions are used and these are grouped under categories.

An understanding of the issues raised in complaints serves to highlight areas where service improvement is warranted. Information in Table 14 below provides an overview of all

issues identified in relation to enquiries (441) and complaints (156) received.

Table 14: *Primary Issues Raised in Enquiries/Complainants*

CATEGORY	07/08	08/09[9]	09/10
Access	106	101	94
Communication & Information	44	58	72
Consent	4	8	11
Discharge & Transfers	0	10	16
Environment & Management	23	15	20
Fees, Costs & Rebates	22	26	17
Grievances	9	16	1
Medical Records	0	19	11
Medication	0	46	48
Professional Conduct	38	48	55
Reports & Certificates	0	4	8
Treatment	121	136	223
Out of Jurisdiction	23	17	21
Privacy/Discrimination	27	0	0
Total	**417**	**504**	**597**

As was the case last year, issues dealing with treatment were the major reason why people made enquiries and complaints to the Commission (37%). This was then followed by access issues (16%).

Tables 15 to 25 detail the complaint issues under each major category. Issues identified in enquiries have not been included.

Table 15: *Access Category*

ACCESS	08/09	09/10
Access to subsidies	0	2
Refusal to admit or treat	5	5
Service unavailable	8	4
Waiting list delay	3	1
Total	**16**	**12**

Issues relating to this category constituted 8% of all issues complained about. The major issue complained about was failure to admit or treat (42%) followed by unavailability of service (33%).

Table 16: *Communication & Information Category*

COMMUNICATION & INFORMATION	08/09	09/10
Attitude and manner	16	13
Inadequate information provided	0	7
Incorrect/misleading Information	1	2
Special needs not accommodated		1
Total	**17**	**23**

Issues relating to this category constituted 15% of all issues complained about. Complaints associated with the attitude and manner of a provider continue to be the most significant communication issue (50%) followed by inadequate information being provided (30%).

Table 17: *Consent Category*

CONSENT	08/09	09/10
Consent not obtained or inadequate	2	3
Involuntary admission or treatment	1	0
Uniformed consent	1	2
Total	**4**	**5**

Issues relating to this category constituted 3% of all issues complained about.

Table 18: *Discharge & Transfer Arrangements Category*

DISCHARGE & TRANSFERS	08/09	09/10
Delay	1	0
Inadequate discharge	2	1
Mode of transport	1	1
Total	**4**	**2**

Issues relating to this category constituted 1% of all issues complained about.

Table 19: *Environment & Management of Facility Category*

These complaints are more about how services are administered than the medical or health care/treatment component of the service.

ENVIRONMENT & MANAGEMENT	08/09	09/10
Administrative processes	3	1
Statutory obligations/accreditation	2	0
Cleanliness/hygiene of facility	0	3
Staffing and rostering	0	2
Total	**5**	**6**

Issues relating to this category constituted 4% of all issues complained about.

Table 20: *Fees, Cost & Rebate Issues Category*

FEES, COSTS & REBATES	08/09	09/10
Billing practices	5	0
Financial consent	2	0
Total	**7**	**0**

There were no issues relating to this category.

Table 21: *Grievance Category*

GRIEVANCE	08/09	09/10
Inadequate or no response	6	0
Total	**6**	**0**

There were no issues relating to this category.

Table 22: *Medical Record Category*

MEDICAL RECORDS	08/09	09/10
Access to/transfer of records	3	2
Record keeping	1	1
Total	**4**	**3**

[9] Represents the new categories since 1/7/08

This category constituted 2% of all issues complained about.

Table 23: *Medication Category*

MEDICATION	08/09	09/10
Administering medication	2	5
Dispensing medication	0	3
Prescribing medication	8	5
Supply/security/storage of medication	3	0
Total	**13**	**13**

This category constituted 8% of all issues. Of particular concern were the administration and prescribing of medication.

Table 24: *Professional Conduct Category*

P[ROFESSIONAL CONDUCT	08/09	09/10
Assault	0	1
Boundary violation	0	1
Beach of condition	0	3
Competence	14	7
Discriminatory conduct	1	
Emergency treatment not provided	1	
Financial fraud	0	1
Illegal practice	0	4
Impairment	0	1
Inappropriate disclosure of information	0	5
Misrepresentation of qualifications	1	1
Sexual misconduct	1	1
Total	**18**	**25**

Issues relating to this category constituted 16% of all issues complained about. The main issue complained about being the competence of a provider.

Table 25: *Treatment Category*

TREATMENT	08/09	90/10
Attendance	1	0
Coordination of treatment	2	6
Delay in treatment	7	4
Diagnosis	4	8
Inadequate consultation	0	1
Inadequate treatment	7	23
Infection control	1	2
No/inappropriate referral	4	1
Rough & painful treatment	2	1
Unexpected treatment outcome/complications	4	10
Withdrawal of treatment	1	3
Wrong/inappropriate treatment	3	5
Total	**36**	**64**

Issues relating to this category constituted 41% of all issues complained about (28%) in 2008/09). Issues associated with inadequate treatment were of major concern (36%).

APPENDIX 3

CODE OF HEALTH AND COMMUNITY RIGHTS AND RESPONSIBILITIES

The Code confers a number of rights and responsibilities on all users and providers of health and community services in the Northern Territory.

The rights and responsibilities set out in the Code are not absolute. The obligation imposed on users and providers is to take reasonable action in all circumstances to give effect to the Code.

When a complaint is made, the Commission will consider the reasonableness of the action taken by the provider, in light of the circumstances. The circumstances in a particular case may include the user's state of health or well-being and any resource constraints operating at the time.

The Code does not override duties which are set out in Territory or Commonwealth legislation.

Principle 1: Standards of Service

1. Users have a right to:

a) timely access to care and treatment which is provided with reasonable skill and care[10];
b) care and treatment which maintains their personal privacy and dignity;
c) care and treatment free from intimidation, coercion, harassment, exploitation, abuse or assault;
d) care and treatment that takes into account their cultural or ethnic background;
e) providers who seek assistance and information on matters outside their area of expertise or qualification;
f) services provided in accordance with ethical and professional standards, and relevant legislation;
g) services which are physically accessible and appropriate to the needs arising from an impairment or disability; and
h) services provided without discrimination, as set out in relevant Territory and Commonwealth legislation.

Principle 2: Communication and the Provision of Information

1. Providers have a responsibility to:

a) provide accurate and up to date information responsive to the user's needs and concerns, which promotes health and well-being;
b) explain the user's care, treatment and condition in a culturally sensitive manner, and in a language and format they can understand. This includes the responsibility to make all reasonable efforts to access a trained interpreter;
c) answer questions honestly and accurately;
d) provide information about other services and, as appropriate, how to access these services;
e) provide prompt and appropriate referrals to other services, including referral for the purpose of seeking a second opinion; and
f) provide the user with a written version or summary of information, if requested.

2. Users have a responsibility, to the best of their ability, to:

a) provide accurate and timely information, about their past care and treatment and issues affecting their condition; and
b) inform the provider of issues that might interfere with participation in care or treatment recommended by the provider.

Principle 3: Decision Making

1. Subject to any legal duties imposed on providers, users have a right to:

a) make informed choices and give informed consent to care and treatment;
b) seek a second opinion;
c) refuse care and treatment, against the advice of the provider;
d) withdraw their consent to care and treatment, which includes the right to discontinue treatment at any time, against the advice of a provider;
e) make an informed decision about body parts or substances removed or obtained during a health procedure. This includes the right to consent or refuse consent to the storage, preservation or use of these body parts or substances; and
f) make a written advance directive about their care and treatment.

2. In non-emergency situations, providers have a responsibility to seek informed consent from users before providing care and treatment by:

a) seeking consent specific to the care and treatment proposed, rather than a generalised consent;
b) discussing the material risks, complications or outcomes associated with each care or treatment option;
c) ensuring the user understands the material risks, complications or outcomes of choosing or refusing a care or treatment option;
d) where relevant, explaining the legal duties imposed on providers which prevent users from refusing a type of care or treatment, such as those imposed by the *Mental Health and Related Services Act* and the *Notifiable Diseases Act*;
e) providing users with appropriate opportunities to consider their options before making a decision;
f) informing users they can change their decision if they wish;
g) accepting the user's decision; and
h) documenting the user's consent, including the issues discussed and the information provided to the user in reaching this decision.

3. Providers have a right to treat without the user's consent where:

a) treatment is provided in a life threatening emergency or to remove the threat of permanent disability and it is impossible to obtain the consent of the user or the user's personal representative; or
b) treatment is authorised or required under Territory or Commonwealth legislation.

4. Where a provider reasonably considers that a user has diminished capacity to consent, the user still has a right to give informed consent to a level appropriate to their capacity.

5. Where a provider considers a user lacks the capacity to give informed consent, a provider must, except under specific legal circumstances, seek consent from a person who has obtained that legal capacity under the *Adult Guardianship Act* or other relevant legislation.

[10] Reasonable skill and care refers to the generally accepted standard of health or community service delivery.

Principle 4 : Personal Information

1. Users have a right to information about their health, care and treatment. However, they do not have an automatic right of access to their care or treatment records.

2. Providers may prevent users from accessing their records where:

(a) legislative provisions restrict the right to access information; or
(b) the provider has reasonable grounds to consider access to the information would be prejudicial to the user's physical or mental health.

3 Providers have a responsibility to protect the confidentiality and privacy of users by:

(a) ensuring that the user's information held by them is not made available to a third party unless:
- the user gives written authorisation for the release;
- subject to subpoena or pursuant to legislation; or
- it is essential to the provision of good care and treatment and the provider obtains the user's consent. This may take the form of consent to share information between a treating team.

(b) providing appropriate surroundings to enable confidential consultations and discussions to take place;
(c) having policies and procedures in place, including policies relating to the storage of information, and ensuring all staff are aware of these;
(d) communicating with the user and other providers involved in their care and treatment in an appropriate manner and environment.

Principle 5: The Relationship between User and Provider

1. Both users and providers have a responsibility to treat each other with respect and consideration.

2. Providers have a responsibility to:

a) make clear the standards of behaviour and language acceptable in the relationship between user and provider;
b) make clear the circumstances under which they will restrict or withdraw the services they provide;
c) advise users if and why they are unable to provide a service the user has requested; and
subject to those responsibilities regarding emergency treatment, remove, or seek the removal of any person whose behaviour is considered dangerous to the provider or service users. 3. Users have a responsibility to ensure they do not endanger or deliberately put the safety of the provider or other service users at risk. This responsibility is extended to the user's family members, friends, carers and advocates in their interactions with the provider.

3 Providers have a right to be able to provide care and treatment free from intimidation, coercion, harassment, exploitation, abuse and assault.

Principle 6: Involvement of Family, Friends, Carers and Advocates

1. Users have a right to:

a) involve their family, friends, carer or advocate in their care and treatment;
b) withhold information from family members, friends and carers on their care and treatment, or request the provider do so;
c) seek help from an advocate if required.

2. Providers have a responsibility to:

(a) respect the role family members, friends, carers and advocates may have in the user's care and treatment, and the user's right to withhold information from them; and
(b) recognise the carer's knowledge of the user and of the impact care and treatment options may have on the user's health and well-being.

Principle 7: Research, Experiments and Teaching Exercises

1. Providers have a responsibility to:

a) inform users if the care or treatment offered to them is experimental or part of a teaching or research exercise, of its functions and aims, and of their avenues for complaint;
b) inform users they can withdraw from the research, experiment or teaching exercise at any stage; and
c) accept the user's refusal to take part in research, experiments and teaching exercises.

Principle 8: Complaints and Feedback

1. Providers have a responsibility to:

a) provide a mechanism for users to give feedback or make complaints about their care and treatment;
b) inform users of the complaint process and of how to make a complaint;
c) ensure that complaints are dealt with in an open, fair, effective and prompt manner, and without reprisal or penalty; and
d) provide users with information about external complaint resolution mechanisms and advocates.

2. Users and providers have a responsibility to be fair, truthful and accurate when making or responding to a complaint.

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