Dear Minister

As stipulated by Section 19(1) of the Health and Community Services Complaints Act 1998, the Eleventh Annual Report of the Health and Community Services Complaints Commission, for the year ending 30 June 2009 is submitted to you for tabling in the Legislative Assembly.

Yours sincerely

Carolyn Richards
Commissioner

18 September 2009
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
18 September 2009
FROM THE COMMISSIONER

The purpose of this report is to provide information on the functions of the Northern Territory Health and Community Services Complaints Commission (HCSCC) over the past twelve months.

The ability of the public health system to deliver health care to as many people and communities as it does, ought to be recognised and applauded. On some occasions however, the availability, the method or speed of delivery of health services in the Northern territory, in both the private and public sector, is less than satisfactory. Patients approaching the Commission [HCSCC] during the reporting period have expressed exasperation, a sense of powerlessness, stress and anxiety. Patients outside of the main population centres with a major illness, a chronic illness or the need for diagnosis and associated tests, often face extensive travel and experience major disruption to their lives. This is part of the demographic landscape of the Northern Territory.

Difficulties, waiting lists and delays need no recitation by me. Most people in the Territory are at least aware of them and many have experienced them.

In the twelve month reporting period the number of complaints received by HCSCC was small when compared with the number of services delivered. Four hundred and fifty seven (457) enquiries and complaints were made to the HCSCC.

Unlike in the previous period, more complaints were received about public services than private services, although the difference was not significant (245 public: 212 private). In 2008 Royal Darwin Hospital (RDH) provided 47,280 inpatient; 56,342 emergency department and 94,384 outpatient services. The Commission received 93 enquiries and 20 complaints about RDH: 93 enquiries were resolved by the hospital after HCSCC referred the matter back to RDH. However, although small, the actual number of complaints received about RDH was double that of 2007—08.

It is my duty to investigate those instances when patients believe they did not receive safe, quality care of a standard to be expected. The work of the HCSCC focuses on resolving those complaints, investigating the circumstances and, if necessary, reporting
to Parliament when something cannot be rectified or improved by consultation with a provider of health services. This ought not to distract from the reality that the vast majority of health services are delivered well by committed, skilful professionals.

During the reporting period I published a report which was critical of RDH management. The catalyst for the report was security on the children’s ward and the delay by corporate management in responding to a serious breach of safety and security. The report criticised the Management of the hospital and the lack of accountability of those with responsibility for:

- organising and managing the RDH environment; and
- managing the framework, recruitment, and all aspects of the hospital required to support those who actually deliver care and treatment.

Under current legislation the management of the hospital is assigned to the Board of Management, which is to direct and advise the General Manager. The investigation revealed:

- disparities between that legislation and the reality of the Board of Management's exercise of its statutory functions; and
- that the hospital management had not informed the Board of the incident.

In response to the security report, and several Coroners reports, the Minister for Health commissioned the Australian Council of Health Services to conduct a review of governance arrangements at RDH. The subsequent Review Report is a blueprint for the improvement of governance and consequently for patient care over the next three years at RDH.

The Report confirmed flaws in the management of RDH in other areas apart from security. The Report recognised that, at RDH, “a concerted effort is required to create good governance and clinical governance models and then sustain them”.

It is a matter for the Government to decide whether or not the recommendations of the reviewing experts should be followed.

**NATIONAL INITIATIVES**

There is no single robust and organised body in the Northern Territory that represents the interests of, or which champions, patients and users of health or disability services. At this time in Australia’s history the structure and framework for health and disability services, probably for the next five to twenty years, is being determined by a series of initiatives led by the Federal Government in co-operation with all States and Territories through: the Australian Health Workforce, Ministerial Council and, the Council of Australian Governments (COAG).

The way in which health services will be organised, funded, and their safety and quality improved, is being framed from several sources: the Report of the Australian Health and Hospital Reform Commission; a Review of Maternity Services commissioned by the Federal Minister of Health; the legislation of a National Registration and Accreditation Scheme for all registered health professionals; and the work of the Australian Commission on Safety and Quality in Health.

In the absence of a strong and vocal patient/consumer network or advocacy group in the Northern Territory this Commission has made a number of submissions in an effort to ensure that the voice of the patients and consumers are put before the policy and decision makers involved in the future design of health services. Inevitably, this has placed a strain on the Commission’s human resources, particularly the time of staff and myself. To be effective, each submission must be supported by research and evidence. I am grateful for the generosity of other better resourced Health Complaint Commissioners around Australia for their networking and sharing.

**FUTURE DIRECTION OF HCSCC**

By all indications the Commission’s work is increasing. As a result of the increased work load, the organisation of staff within the Commission has been changed. There are now two deputies to assist me in the role of HCSCC Commissioner and in my position as Ombudsman for the Northern Territory. The Deputy Commissioner, Mr Vic Feldman will concentrate on managing health issues.

In view of the Commission’s significantly increased role, and the need to maintain an effective service, a review of the dual positions of Ombudsman and Health and Community Services Complaints Commissioner is desirable.

The appointment of a Health and Community Complaints Commissioner separate to the office of the Ombudsman should be seriously considered. A separate appointment would:

- remove actual conflicts of interest, as well as public perceptions of conflicts;
• provide the public with a more equitable health complaints service, given that one person cannot adequately perform the duties of both functionaries during this time of reform of the delivery of health services; and
• enable greater and more effective participation in national initiatives.

A significant example of the need for improved participation is the National Registration Scheme. The National Registration Scheme will become operational on 1 July 2010. The model law, agreed to by all States and Territory Health Ministers, has already been passed in Queensland. When enacted, that law is expected to double, if not triple, the number of local complaints the Commission will need to consider, investigate, and deal with at a local level. This will include the establishment of a reporting and consultation process with each National Board for every registered health profession.

Following a meeting of the Ministerial Council on 27th August 2009 a Communiqué announced that the National Registration Scheme will provide a consulting role for all Australian Health Complaints Commissions with the Health Professional Boards. That means, that a Board and HCSCC may disagree about action against a health professional. The action which has the most serious consequences would prevail.

Potentially, the Scheme could place the Northern Territory Commissioner of Health Complaints in a regulatory role overseeing the Board’s function of disciplining health professionals. This will have consequences for the Commission’s workload. The HCSCC does not employ its own health professionals and is unlikely to be equipped to carry out and fulfil its functions effectively under the National Scheme without access to remunerated professionals. Amendments to the Health and Community Services Complaints Act (HCSC Act) are necessary if the National agreement is to be implemented in the Northern Territory.

REVIEW OF THE HCSC ACT

The HCSC Act specifies that a review be carried out 5 years after the Act commenced and every three years after that:

• The Act was reviewed in 2003 by an independent Review Panel appointed by the Minister.
• A Report was delivered to the Minister for Health in April 2004 recommending legislative changes.
• The Report had not been tabled as required by section 106(3) of the HCSC Act at the time of this report. Further reviews of the HCSC Act were due in 2006 and again in 2009.

Reviews were due in 2006 and 2009. Neither review has been undertaken. The 2003 review is now outdated by the National initiatives.

The Northern Territory’s agreement with the Commonwealth and the States needs to be made effective for the National Registration and Accreditation Scheme to be implemented.

It is no longer desirable for the Health and Community Services Complaints Commission to be adjunct to the Ombudsman. The Commission has matured and its workload has surged. The Commission:

• requires skills and professional experience directly aligned to the provision of health services, the quality of those services, and a wide knowledge of health safety issues;
• must be patient-focused; and
• resourced to keep up to date with research and best practice.

Currently, all staff at HCSCC are administrative officers, employed by the Ombudsman. It should be noted that the HCSCC has never been included, by amendment, as an agency under the Public Sector Employment and Management Act. This should be remedied.

REPORT ON SECURITY AT RDH – IMPLEMENTATION - LEGISLATIVE AMENDMENT

A report on an incident at the Children’s ward at RDH was tabled in the Legislative Assembly in November 2008. The report contained recommendations concerning security arrangements in addition to Governance matters, staffing levels and training. The then Minister for Health announced that the recommendations would be implemented. Four reviews were commissioned and, on completion, the independent reports were delivered to the Minister for Health in February 2009.

The reports focused on the Hospital Board and Governance Arrangements and complaint handling procedures. The reports also addressed the need to improve services through learning from errors, complaints, a process of feed-back, nurse-to-patient ratios, and security at RDH.
Progress of Implementing the HCSCC Report

The CCTV cameras have been installed on Ward 5B [and others] in accordance with recommendations: 7 & 15.

Open disclosure, in accordance with Recommendation 3 and the steps necessary to implement it, have not occurred. However, the Department of Health and Families (DHF) have consulted with the Australian Commission on Quality and Safety in Health (ACQSH). Based on my consultations with the ACQSH, there appear to be no impediments to the implementation of the Open Disclosure Standard in the Northern Territory except fear of civil liability. Experience elsewhere, and related research, suggests that open disclosure, if made speedily and respectfully, does not increase a tendency in patients to sue but, in fact, reduces litigation.

Recommendation 2 was to begin negotiations to pay compensation to the infant concerned, and to her parents. I offered the services of a qualified Mediator to the Executive Officer of the Department of Health and Families [DHF] to facilitate negotiations. That offer has been accepted. Under the provisions of the HCSC Act no information concerning the process can be disclosed.

Monitoring Implementation of the Recommendations

The HCSC Act does not provide the Commissioner with the power to investigate whether or not recommendations have been implemented. I am therefore unable to report what recommendations of the Report have been implemented or are in the progress of being implemented.

This, in my opinion, is a flaw in the efficacy of the Health and Community Services Complaints Act and I recommend that, when considering any amendment to that Act, the Minister give due consideration to empowering the Commissioner to seek information about implementation of agreed recommendations and to report further to the Legislative Assembly if appropriate.

I am aware that by June 2009, a locked door to Ward 5B had been installed, with access restricted solely to ward staff or with entry based on:
- recognising a person ringing to gain entry;
- questioning a person’s reason for entering; and
- confirming a person’s identity.

Despite these adoptions, in June 2009 two Ombudsman officers coat tailed another person and entered the ward. The officers approached the Nurses Station where five staff were present: they were not challenged; no-one asked for their identity or their reason for entering the ward. They walked around the ward, into the rooms, and then walked out. I can only speculate about whether or not the recommendations relating to staff training, security and risk assessment, regular review, staff induction procedures and the other risk reduction initiatives recommended in the 2008 Report have been progressed.

PERFORMANCE OVERVIEW

The key performance indicators for the 2008/09 period were:

- The number of approaches to the Commission was 20% more than for the previous year. That represents a 45% increase over the last two years.
- 94% of approaches were finalised during the year.
- 82% of all active complaints were closed compared to 65% in 2007/08.
- The average time taken to finalise a complaint decreased from 98 days to 70 days, a reduction of 30%.
- 96% of approaches to the Commission were resolved without a formal investigation or conciliation process.
- The Commission facilitated the resolution of 45% of complaints received directly between the provider and the complainant.
- Five investigations were completed compared to one the previous year.
- Total visits to the Commission’s website increased by 30%.

This snapshot of the Commission’s activities over the 2008/09 financial year demonstrates that it has continued to improve its performance and productivity while maintaining a high standard of service delivery. Improvements continue to be made in reducing the average time taken to finalise complaints (from 98 days in 2007/08 to 70 days in 2008/09).

CAROLYN RICHARDS
COMMISSIONER FOR HEALTH AND COMMUNITY SERVICES COMPLAINTS
ABOUT THE COMMISSION


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.

SERVICE STANDARDS

The Commission services are of the highest quality, open to scrutiny and accountable. The service standards of the Commission can be found at Appendix 1.

STAFFING

Table 1: By gender and position level

<table>
<thead>
<tr>
<th>Position Level</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner (ECO5)</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Deputy Commissioner</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Administrative Officer 7</td>
<td>0</td>
<td>4$^1$</td>
<td>4$^2$</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

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

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$^1$ One position was staffed by two people on a part-time basis.
$^2$ 3 x full time equivalent positions
ORGANISATIONAL STRUCTURE

Administrative support (through the Business Support Unit) and the handling of some enquiries (through the Resolution Officers) is undertaken on behalf of the Commission by the Office of the Ombudsman. During the financial year, the Commission also utilised the experience and expertise of two Ombudsman’s representatives in Alice Springs to provide initial support and contact for those in the southern region wishing to make a complaint or enquire about health services or community services, however this ceased as at the end of June 2009.

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 actual expenditure for 2008/09 (when compared to the previous two years) was:

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel costs</td>
<td>$427,679</td>
<td>$346,253</td>
<td>$354,215</td>
</tr>
<tr>
<td>Op. costs</td>
<td>$94,090</td>
<td>$78,641</td>
<td>$108,540</td>
</tr>
<tr>
<td>Total</td>
<td>$521,769</td>
<td>$424,893</td>
<td>$462,755</td>
</tr>
</tbody>
</table>

I must continue to highlight the impact the annual reduction associated with the “efficiency dividend” is having on funding available to the Commission.

The commission can only provide this dividend by reducing the funding available for discretionary activities such as access and awareness, staff development, training and travel. 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.

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 were no applications for a review received in the reporting year.
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.

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

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.

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.

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**Complaint process and options explained**

The complainant contacted the Commission for some advice regarding her concerns about a provider. According to the complainant the provider is consistently rude and very unhelpful. The complainant was unsure whether she wanted to lodge a complaint and was thinking of going to another provider. The role of the Commission and how we might assist to resolve her complaint with the provider was explained to her. Despite this explanation the complainant wasn't sure what she wanted to do and advised that she would think about her options. Information about the role, function and jurisdiction of the Commission as well as a complaint form were also forwarded to her.

**Private insurance issue referred to HIC**

The complainant's mother-in-law came to Australia to visit and private health insurance coverage was obtained for her by the son-in-law. During the visit the complainant’s mother in law was hospitalised and as a result he was in dispute with MBF about meeting the costs of the treatment. The complainant was advised that the matter was out of jurisdiction and he was assisted in referring it to the Private Health Insurance Commission.

**Outdated meals on wheels**

The complainant was receiving services under the Aged Care Program for 'Meals on Wheels' following a hospital stay. Whilst the complainant had been happy with the service in the past, some of the package food she received was well out of date. The complainant was concerned about this and the fact that other people using the service may not complain for a variety of reasons, particularly if they thought those managing the program might take offence. After discussing options available, the complainant agreed to speak to the Coordinator of the Meals on Wheels Program in the first instance and come back to the Commission if she was not satisfied with the response. No further action was required by the Commission.

**Fee charged for failure to attend**

The complainant advised that his wife forgot to attend her appointment at a Medical Centre and was sent an invoice for the full fee because of her failure to attend. The complainant wanted to know whether the medical centre could do this. The complainant was advised that the Medical Centre was within their rights to charge fees for non-attendance and there was no limit on what they could charge. In order to do so there was a requirement that the medical centre made their patients aware of this 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 mental illness and forgot things, particularly in recent times. It was suggested to the complainant that he could write to the clinic manager and explain his situation and request a waiver of the fee. The complainant was happy to do this and thanked the Commission for their assistance.

**PATS complaint referred to Ombudsman**

The complainant’s husband was diagnosed with cancer and arrangements were made for him to travel interstate for treatment through the Patient Assistance Travel Scheme (PATS). The complainant also requested PATS funding to accompany her husband and she was initially advised that PATS would provide financial assistance for both herself and her husband. The complainant was unable to arrange the necessary forms or support for the application through the interstate doctor at the time, however, she was advised by PATS that she could submit the application upon their return to Darwin. When the complainant returned from interstate she obtained the necessary forms and lodged her application for PATS assistance. She was advised that her application had not been successful. The complainant subsequently lodged an appeal with the PATS Review Tribunal and was advised that her appeal had not been successful. No reasons were given. The matter was not in jurisdiction because it did not relate to a prescribed health service, but it did relate to the administrative procedures of a government department and the matter was referred to the Ombudsman's Office.
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).

Grandmother misses GP appointment
The complainant's grandmother relied on the provider to take her for her regular GP checkups. According to the complainant, the provider did not attend to her grandmother at the scheduled time and she missed an appointment with her GP. The complainant telephoned the provider to find out why the provider did not attend and alleged that the receptionist was rude to her. The Commission forwarded the complaint to the provider in an attempt to resolve the complaint expeditiously. The provider advised that the failure of the team to collect the complainant's grandmother was the result of a number of staff leaving, including the person who she spoke to and was rude to her. The provider also gave the complainant a call to explain what happened and apologised to her. The complainant advised that she was very happy with the outcome of the complaint and didn't want to make a scene but simply wanted to make sure her grandmother received the care she was supposed to receive as her family were not always able to be there for her.

Medical records finally transferred
The complainant had applied two (2) months previously for his medical records to be transferred from a Mental Health Unit to his Psychologist and it had not happened. The complainant had not followed up his concerns with the provider. He gave permission for the Commission to forward the matter back for point of service resolution. The Commission was subsequently advised by the provider that the complainant's medical records had been sent to his Psychologist. The Commission contacted the Psychologist who confirmed that he had received the medical records from the provider. The Commission also contacted the complainant and advised him of the advice received from the provider and his private doctor. The complainant advised that he was satisfied that his concerns regarding the delay in obtaining his medical records had been resolved and thanked the Commission.

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.

Aboriginal clients provided with improved antenatal services
The complainant was a midwife for an Aboriginal medical service and contacted the Commission on behalf of her clients. According to the complainant, clients of the Aboriginal medical service were experiencing difficulties in contacting the provider's antenatal clinic to follow up on scheduled appointments. The complainant stated that the clinic had arranged appointments for clients at the antenatal clinic which in turn sent out a letter to the clients advising them of their scheduled appointment. However when clients attempt to contact the antenatal clinic to confirm their appointment, re-schedule their appointment or to find out when their appointment was because they had lost the letter from the antenatal clinic they were often unable to reach someone. The Commission facilitated contact between the complainant and the provider and as a result they met and explored options to improve access for clients to the outpatient antenatal clinic, including an outreach antenatal service. In the meantime the provider and complainant agreed upon set times for clients to ring the antenatal clinic and the provider also implementing new initiatives to best utilise the obstetrician’s time, particularly in respect to high risk patients and low risk patients. The complainant advised the Commission that she was satisfied with the response by the provider and thanked the Commission for it's assistance.

Was blood test hygienic?
The complainant recently had a blood sample taken by a pathology service. According to the complainant the staff member was very young and when she made inquiries about the qualifications of the young lady who was taking her blood, the young lady advised her that she had just read some books and received some training from one of her supervisors. The complainant also advised that the young lady taking her blood was only wearing one glove. The complainant was advised that we would make some initial inquiries. The Commission contacted the provider and advised them of the issues of complaint. After looking into the matter the provider advised that she had spoken to the staff member concerned who stated that the complainant made several remarks about her young age to which she became upset and distracted which lead to her failing to use two gloves. The staff member was subsequently cautioned by the provider about the need to maintain hygiene practices under all circumstances. In response to further questions, the provider advised that there was always a senior staff member such as herself or a scientist present that could be consulted in respect to any complications. The Commission advised the complainant that our enquiries revealed, at the time, there were no specific educational prerequisites in order to undergo training in phlebotomy in Australia, the young lady who took the complainant's blood that day had been cautioned about the need for appropriate hygiene practices in respect to taking blood and that their was always a senior staff member present to assist with respect to any procedures or problems. The complainant advised that she had discussed the matter with the response and appreciated the enquiries the Commission had made and the action taken by the provider to address her concerns.

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;
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, 89% were resolved or finalised either before or during the assessment process. Only 10 complaints were finalised after being either conciliated (5) or investigated (5).

### TAKING NO FURTHER ACTION ON COMPLAINTS

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

- the complaint is not related to a matter covered by the Act;
- the complaint is vexatious, frivolous or was not made in good faith;
- the complaint lacks substance;
- the user became aware of the circumstances giving rise to the complaint more than 2 years before the complaint was made and doesn’t have an exceptional reason for the Commissioner to exercise a discretion to consider it;
- the complaint has not been made in good faith;
- 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.

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**Complaint not handled appropriately at point of service**

The complainant attended a GP practice because she was stressed at work. The complaint described the GP’s attitude towards her as rude and dismissive, and she also complained that he was reticent to deal with her because of the possibility of a worker’s compensation claim. (These issues were the subject of a separate complaint). The complainant approached the Commission with concerns about the response she received from the practice manager when she attempted to make her complaint at point of service. The complainant alleged that the practice manager did not respond to her initial approaches and that when a response was received, it was factually incorrect.

The Commission requested a written response from the provider to the issues of complaint. The response received was thorough and detailed, and was forwarded to the complainant for consideration and comment. While the complainant was not entirely satisfied with the response - her recollections of events were quite different - she did acknowledge that further investigation would not assist in resolving the complaint and that the provider had taken reasonable action to address the complaint management issues raised. As a result the complaint was assessed for no further action.

**GP not interested and consultation takes too long**

The complainant attended a GP after being involved in a single vehicle accident some hours earlier. The complainant requested a blood test that was declined. The complainant said that the doctor appeared disinterested in his distress, and ignored him while he prepared a written report. The complainant also alleged that the doctor deliberately extended the consultation so that he could charge more.

The Commission undertook inquiries into the issues of complaint and found that: the explanation provided by the provider, that the expired time between the complainant’s accident and his presentation to the surgery made this testing irrelevant, was detailed and thorough, and appeared reasonable in the circumstances; the provider apologised for his manner being perceived as rude as he concentrated on writing the medical certificate; and the accounts provided by both parties suggested that the provider attempted to end the consultation at the completion of the examination, however, it was extended so that he could provide the complainant with the report he requested.

The Commission determined that no further action would be taken in relation to the complaint.
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 five (5) 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 (5) investigations were completed. Refer to Performance, 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 five (5) complaints were finalised following referral to an appropriate Board.

<table>
<thead>
<tr>
<th>Alleged sexual assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>The complainant attended her regular medical clinic. Allegedly as the provider escorted the complainant to his clinic room he made comments such as “you’re a healthy looking chick”. The complainant advised she was wearing shorts and a t-shirt. The complainant had attended the clinic because she had bad stomach cramps and diarrhoea for several days. The provider’s examination of the complainant was not appropriate and included him touching her lower leg, pushed both his hands up her legs and pushed the fingers of one hand under her shorts and the elastic of her knickers, examined her tummy and pushed her shorts a little way down and quickly touched all around the sides of her breast. She couldn’t think why he was examining her breasts for a stomach problem and she felt very tense and uncomfortable and stated that it was different from any examination she had had before. The complainant did not want the provider to be notified or informed as it is a small community, but she wanted the matter recorded in case there were other similar complaints. Subsequent to other similar complaints received by the Commission the matter was referred to the Medical Board for their review and action.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GP fails to provide Schedule 8 medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>The complainant attended the provider’s office as he suffers from arthritis and was seeking schedule 8 medication. He allegedly showed a letter from his South Australian GP and advised the provider he could call his doctor to verify and discuss his condition. The provider replied “you’re indifferent to me, we get plenty of “you” type from down south, they treat us like wood ducks and there’s plenty of you guys that come in with your ear paged letters from your doctor and there is always some doctor you can call.” The provider did not undertake any type of examination and did not charge the complainant for the visit. The complainant walked out to the reception area and said to the reception staff “there’s no charge as he thinks I’m a drug addict or pusher”. The complainant advised the Commission that due to his situation he felt suicidal as a result of the visit and he did not need to be treated in that way. The complainant stated that he had a family which he had to leave behind to come to a warmer climate in the Territory. The complainant advised that he would have to go back to South Australia as his medication was running out. Details of the complaint were forwarded to the provider, however he failed to respond. Based on the information to hand the matter was referred to the Medical Board for their review and action.</td>
</tr>
</tbody>
</table>
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 Enquiry Officers and Investigation/Conciliation Officers through their skills in communication, negotiation and mediation, combined with flexibility and common sense.
CASE STUDIES

**SCHEDULE 8 MEDICATION DIFFICULT TO OBTAIN**

The complainant lodged an enquiry in relation to schedule 8 pain medication. The complainant advised that he had been suffering from arthritis for many years and had been prescribed with Oxycontin (narcotic pain reliever) for a period of 7 years interstate. The complainant had recently moved from interstate to the Territory. The complainant allegedly possessed a letter from his interstate doctor recommending he be prescribed Oxycontin. The complainant had attended various medical centres in which all doctors had declined to prescribe the medication.

The complainant was advised that the issue was out of jurisdiction in that the Commission could not direct a doctor to prescribe medication. Alternatives were suggested, ie he could contact his interstate doctor to see if he would contact a Territory doctor and establish if they were prepared to accept the complainant as a patient, he could access the pain management clinic or a withdrawal service to see if they could assist in the withdrawal of his pain medication and assist with his pain management, or he could approach a pharmacist for non prescribed pain relief.

The complainant advised that his only option was to contact his interstate doctor and provide him with the names of some GPs to contact. The complainant was advised that our office could not assist him any further.

**GENERIC BRAND NOT ACCEPTED FROM CHEMIST**

The complainant was prescribed Trimethoprim by her GP, however when her husband took the prescription to the Chemist the provider dispensed a generic brand known as Alprim. The complainant had always taken the other brand of medication and did not want the Alprim so she contacted the provider who refused to replace the medication he dispensed.

The Pharmacist advised the Commission that the complainant's prescription did not indicate which brand of Trimethoprim to dispense and as such the generic brand was dispensed. The Commission contacted the complainant and explained the Pharmacists advice and advised her to request a specific brand of Trimethoprim from her GP in future to avoid this happening again. The complainant was satisfied with the explanation and thanked the Commission for its assistance.

**DIFFICULT TO OBTAIN APPOINTMENT WITH PAIN CLINIC**

The complainant's fiancé had been suffering pain and had been to the hospital several times during the past seven (7) days. However the hospital was unable to diagnose what was wrong with the consumer and indicated that it could have been a number of things.

After further enquiries the complainant revealed that the hospital had conducted blood tests, urine tests and performed an ultrasound. Following this the consumer was advised that she would need to be referred to the Acute Pain Clinic. When the consumer tried to make an appointment she was advised that she would need to be referred to the Pain Clinic by her GP.

Given the urgency of the situation and the need to obtain an expeditious resolution, the complainant agreed to the Commission contacting the Patient Advocate at the public hospital. Following this approach to the Patient Advocate the consumer received an appointment with the Pain Clinic as well as a referral to a specialist. She thanked the Commission for its assistance to resolve her concerns.

**MEDICATION WAS NOT TAMPERED WITH**

The complainant, who lived remotely, attended the local health clinic. She had a heart condition and had been in and out of hospital for the last couple of months. She was being treated by a visiting cardiologist. The cardiologist prescribed medication to the complainant to assist with her high heart rate. The complainant alleged that a nurse at the local clinic had been tampering with her medication without consulting a doctor. The complainant further alleged that the nurse was unduly influencing the doctors into making certain medical decisions about the complainant. The complainant also alleged that the nurse had a rude manner and adopted bullying tactics.

A resolution was sought at point of service by obtaining a response from the provider and examining medical records. Resolution was not successful however, due to a lack of evidence to support the respective claims and an adamant denial by the provider. Given there were no contrary findings in the records and information examined, the Commission took no further action.

**PRISONER OBTAINS REVIEW OF PRESCRIPTION MEDICATION**

The Commission received a complaint from a prisoner regarding the provision of pain medication. According to the prisoner two months before he was imprisoned his local GP had prescribed him medication to treat his severe pain. During the first week of his incarceration, he claimed that Correctional Medical Services (CMS) gave him the medication but since then they had stopped dispensing it to him and had been providing him with alternative pain relief to treat the pain instead. According to the prisoner the pain relief he had been receiving was inadequate and he wanted his previously prescribed pain medication regime reinstated.

The Commission referred the matter back to CMS in accordance with the Protocol for the Handling of Complaints between them and the Commission and on the same day the Commission received advice from Correctional Medical Service advising that an appointment had been made for the prisoner to see the doctor in order for his medications to be reviewed.
The complainant's relative was addicted to morphine. She approached the provider to obtain a prescription for Alprazolam to treat her anxiety and difficulty sleeping and found the provider's attitude and manner to be rude and insensitive. However the provider did provide the prescription. Following this visit the relative travelled interstate to consult with a specialist who provided her with an implant to treat her opiate addiction. On returning she made an appointment with the provider to obtain another prescription for Alprazolam, advising him she had had the implant inserted.

According to the complainant, the provider refused to believe that his relative had an implant and refused to issue a prescription. The provider tried to contact the interstate doctor, but was unsuccessful. As a result the provider ordered the consumer to leave the surgery. According to the complainant, the provider's refusal caused his relative to attempt suicide by overdosing and almost caused her death leading to her being admitted to a top end mental health facility.

The complainant sought the assistance of the Commission to facilitate a resolution of the complaint. The Commission’s preliminary enquiries found that the provider could have refused to prescribe the Alprazolam at the first consultation but agreed to do so on a short term basis as part of the relative’s management plan. The provider issued the relative with another prescription for Alprazolam even after he had been cautioned not to do so and despite the fact that he had been non-compliant with the management plan.

The Commission could also find no evidence to support the complaint that the provider failed to treat the relative with respect, dignity, consideration and compassion or that he expelled her from the surgery. The Commission found that the provider spent a considerable amount of time and effort trying to help the relative and arranged appointments with other service providers and a psychologist for counselling. When the provider made it clear that he was not going to issue anymore prescriptions, the relative became angry, threatened to commit suicide and eventually stopped seeing the provider.

The Commission also found no evidence to support the allegation that the provider refused to believe the relative received treatment in Perth. The Commission found that the provider had tried to contact the doctor interstate several times to discuss the relative’s treatment but was unsuccessful. After assessing the complaint the Commission took no further action.
The complainant and his wife took their son (the consumer) to a regional public hospital for a review of his antidepressant medication as he was experiencing side effects. The consumer was seen and interviewed by a foreign doctor, who they found difficult to communicate with. The doctor advised the parents that during the consultation, their son had told him that he would harm himself. The parents disagreed and the son also denied making the comment and stated that he did not understand what the doctor was saying. The parents advised the doctor that the reason they brought their son to the hospital was because they were concerned that he was experiencing side effects from the antidepressant medication he had been prescribed.

The doctor, after seeking advice, advised the family that their son would be kept in overnight for observation and assessment. The consumer was voluntarily admitted to the hospital. The following morning the complainant was contacted by his son who told them that he was being flown to Darwin to see a paediatric specialist. The son was flown to Darwin accompanied by his mother while his father drove.

The son and his mother arrived at the Emergency Department and after a short wait they were taken to a private room where they were advised that the son would be sectioned. Some time later the son, accompanied by his mother, was escorted by a nurse and two security guards to the mental health ward. When the son arrived at the mental health ward, he was instructed to hand over his watch and mobile telephone without any explanation or compassion and separated from his mother. After refusing to relinquish his mobile phone he was stripped naked and admitted to a cell in the Joan Ridley Unit, a secure ward primarily for prisoners and violent patients. The parents later discovered in Darwin that their son had been sectioned under the Mental Health Act prior to coming to Darwin without their knowledge. The parents consider his involuntary admission to Joanne Ridley Unit (JRU) and the treatment he received there to have been inappropriate, abusive, horrific, and disgusting.

The Commission’s preliminary enquiries suggest that the provider may not have explained or provided adequate information to the consumer’s parents regarding his status under the Mental Health & Related Services Act 1998 and his involuntary admission to the hospital under s.34 of the Act. The preliminary enquiries also found that the decision by the provider to transfer the consumer to a specialist inpatient mental health unit in Darwin and to admit him to the JRU pursuant to s.39 of the Mental Health and Related Service’s Act 1998 was reasonable and necessary given the concerns for the consumer’s safety, his attempt to abscond from the regional hospital and his history of depression and suicidal ideation.

However, the Commission’s enquiries suggest that when the provider advised the consumer’s mother that there would be an appropriate facility to accommodate her sons age, it was misleading and probably led to the consumer’s parents believing that their son would be treated by a paediatric specialist and accommodated in paediatric mental health unit.

The Department acknowledged that there was inadequate written information available to the family relating to the Mental Health and related Services Act and that there may have been some misunderstanding regarding the range of child and adolescent services available after hours in Darwin. It was also acknowledged by the Department that staff in the inpatient unit may not have been as clear in their communication or as empathetic as they could have been in their dealings with the family and apologised. The Department also advised that they had put in place processes to ensure that relevant staff would continue to be made aware of the importance of good communication with consumers and their families, including providing comprehensive information on the Mental Health and Related Services Act 1998. These processes included:

- a range of consumer and carer guides to the Mental Health and Related Services Act and a series of pamphlets relating to the various sections of the Act being developed; and
- training being provided to all relevant departmental staff to ensure their knowledge and understanding of current legislative requirements under the Mental Health and Related Services Act was both current and comprehensive.

Given the consumer’s history of self harm, suicidal ideation, attempts to abscond from the regional hospital, unreasonable behaviour in the Darwin hospital’s Emergency Department, combined with the lack of dedicated child and adolescent mental health unit in Darwin, the decision to admit the consumer to the regional hospital under s.34 of the Mental Health & Related Services Act 1998 and his admission to the JDU as an involuntary patient on the grounds of mental illness pursuant to s.39 of the Act for examination by an approved psychiatric practitioner, seemed reasonable and necessary. It did not appear to breach any of the principles of the Code of Health and Community Rights and Responsibilities.

In respect to the action taken by staff to restrain the consumer and place him in seclusion, the Commission’s preliminary enquiries suggested that this action was necessary and reasonable given his aggressive and threatening behaviour when he first arrived in Darwin and during his admission to the JRU and did not appear to have breached any principles under the Code of Health and Community Rights and Responsibilities.

The complainant contacted the Commission to complain that a public hospital did not have a charter of patient rights. The Commission advised the complainant that the hospital did in fact have a Patient Information Guide which outlined patients care, rights and responsibilities and sent a copy of the Guide to the complainant.
The complainant had a vasectomy performed which was unsuccessful. The complainant lodged a complaint with the Commission alleging that the methodology used by the surgeon was not valid, and that for this reason the procedure had failed. He sought an apology and reimbursement for the cost to have the procedure done interstate.

The Commission assessed the complaint by obtaining the medical records, seeking advice from the surgeon about the methodology used, and seeking informal clinical advice from an experienced practitioner in the field. The clinical advice indicated that the methodology used was valid and was one of many ways to perform the procedure and that the procedure had a failure rate, and the surgeon’s failure rate in this case was within acceptable limits. It was therefore not possible to substantiate the claim that it was the method used which caused the failure.

The Commission was satisfied that when the surgeon first met with the complainant after the results of the procedure were known, the surgeon had personally apologised to the complainant. The surgeon had offered to repeat the procedure, and the hospital manager in a later letter offered to arrange for another surgeon at the same hospital to repeat the procedure, if the complainant felt that he had lost confidence in the surgeon who did the first procedure. The Commission found that this offer was sufficient, and that funding for the complainant to have the procedure done interstate was an unreasonable expectation.

The Commission advised the complainant that no further action would be taken and the file was closed.

The complainant (a prisoner) injured his shoulder by tearing the muscles and ligaments (popped shoulder) during exercises in the prison yard. The complainant was to be referred to the visiting Physiotherapist, however there was a delay in obtaining an appointment and the complainant subsequently lodged a complaint with the Commission. The complainant obtained an appointment and at the consultation, the Physiotherapist advised him that the muscles in his shoulders had knotted and calcified. The complainant was concerned that the Physiotherapist did not properly examine him and wanted a scan performed on his shoulder to properly diagnose what was wrong. The complainant was informed by the prison doctor that he would have to see the physiotherapist again before he would refer him for a scan.

In accordance with the Protocol for the Handling of Complaints between the Commission and the provider (Corrections Medical Service), the matter was referred back to point of service for it to be resolved expeditiously. In response the provider undertook the following action:
- to arranged for the complainant to be taken to hospital for scans of his shoulder.
- to arranged for maintenance to inspect the structure of the complainant’s bed to rule out the cause of his pain and discomfort. The inspection discovered that the wire mesh on which the mattress lies was not very supportive and was repaired.
- to arranged another consultation with the Physiotherapist at an earlier date.

The complainant contacted the Commission and advised that he was satisfied with the response by the provider and thanked the Commission for it’s assistance in resolving the matter.

The complainant approached the Commission with a complaint about the standard of care and treatment from the Emergency Department of a regional public hospital. The complainant stated that he was in extreme pain but the medical team did not believe him. He said that he asked to have an x-ray but was told no, and was then given pain killers and sent home. The complainant continued to suffer significant pain, and returned to the hospital. He stated that a nurse yelled at him and he was accused of being abusive because of his own yelling due to his pain and his frustration. The complainant stated that an x-ray was taken which found he had a serious lung infection of some kind. He was admitted to hospital and was still an inpatient at the time of making his complaint. He was about to be transferred to Darwin for further investigations.

The complainant’s main issues of complaint were: that he was not X-rayed on his initial attendance; or when he re-attended; that the nursing staff did not take his complaints seriously; that it took 7 days for him to get the care and treatment he needed; and that he probably wouldn’t be so sick now if he had been properly assessed when he had attended earlier in the week. The complainant advised that he had spoken to ‘a senior nurse’, and this person had said that his complaint would be looked into, but he did not think anything had been done. He was also upset because one of the nurses said she didn’t care if he complained.

A response was sought from the regional hospital which revealed that the complainant had a history of being difficult to deal with and often did not attend follow-up appointments.

The complainant was provided with a copy of the response from the regional hospital, however he disagreed with this. Clinical advice was obtained from a doctor with an expertise in Emergency medicine and this confirmed that the complainant had a history of being difficult to deal with. The advisor also commented that hospital staff possibly had a degree of preconceived negative bias toward the complainant due to his past record. The advice also commented that the delay in diagnosing the complainant may have lead to a worse health outcome. It was agreed that many of the causes for the delay in his diagnosis were likely to have been caused by the complainant.

An assessment of the complainant and all relevant material lead to a determination that no further investigation was justified. The CEO of Department of Health and Families was advised of the determination and it was brought to his attention that despite some patients being difficult to deal with they all should be treated on their medical needs and merits.
The complainant contacted the Commission about the lack of hygiene at a remote Aboriginal health clinic. The complainant alleged that the clinic was not cleaned regularly, the bathroom and toilet were often littered with faeces and urine and the children's toys never appeared to be clean or disinfected allowing germs to be transmitted from one child to another. The complainant stated that she had raised her concerns on several occasions with the Clinical Nurse Manager, the doctor and the Clinic Manager and her concerns were dismissed. After further discussion the complainant revealed that she suspected the unhygienic conditions at the clinic lead to the death of her baby daughter. The complainant stated that she had previously attended the clinic with her two daughters during which time the baby was crawling around the clinic and playing with toys from playroom.

The next day her daughter developed a fever and it continued to get worse necessitating a return to the clinic. While the complainant and her daughter were at the clinic waiting for the Aboriginal Health Worker to ring the doctor, another AHW commented that her daughter probably caught an infection when she was at the clinic last because three other children had also developed the same symptoms as her daughter.

The doctor advised the AHW to prescribe Nurofen for the fever and the complainant was sent home. The complainant's daughter remained very sick and in pain throughout the night. The next morning the complainant discovered that her daughter's glands had increased to the size of golf balls and she returned to the clinic to seek urgent treatment. The baby was subsequently evacuated by air to a public hospital but died later that day.

The complainant was subsequently advised by the Paediatrician treating her daughter at the hospital that she had died as a result of a Group A Streptococcus Bacterial Infection. The complainant's five year old son also developed similar symptoms and was evacuated by air to the hospital where tests revealed that he had developed the same infection as her daughter. He received the appropriate course of treatment and recovered. The complainant believed that the lack of hygiene and infection control at the clinic lead to her daughter developing the infection and that the Clinic failed to adequately investigate her daughter's condition in order to make an accurate diagnosis which would have revealed the infection earlier and would have ensured that the correct treatment was carried out.

As part of it's preliminary enquiries into the complaint, the Commission obtained and reviewed medical records held by the providers, including the results of the post mortem conducted on the daughter. In addition to a written response from the providers, the Commission also sought and obtained the services of a clinical advisor to assist in the identification of clinical issues and appropriate clinical standards and practices. Expert advice was also obtained from the Centre for Communicable Diseases.

The Commissions enquiries found that the complainant’s baby had died from complications arising from a Group A Streptococcus Bacterial Infection that live most commonly in the throat, nose and skin. The likely method of spreading the bacteria is through direct contact between people, such as coughing and sneezing or contact with a skin sore or hands which have been coughed or sneezed upon. It is rare or uncommon for the bacteria to be spread through objects such as crockery or toys, as the bacteria has dried out and is much less able to infect and cause illness in people. Severe, sometimes life-threatening, GAS disease may occur when the bacteria enters into the blood, muscle or lungs and is termed “invasive GAS disease”.

The enquiries suggested that it was most likely that the baby’s elder sister, who had been diagnosed as having a bacterial upper respiratory tract infection, was the source of the baby’s infection or they both shared a common infector. It was apparent from the enquiries made that some people carry the bacteria on their skin or in their throat and may not get sick from it. Others may develop a minor illness such as a sore throat or a skin infection and a small number of people can develop complications such as the complainant’s baby did. Usually, it only takes between 1 – 3 days for the infection to develop in those individuals who develop the disease.

The Commission’s enquiries confirmed that the baby presented mildly unwell and she was reviewed by a Nurse who then consulted with the doctor on call. At that point a diagnosis of viral upper respiratory tract infection was made. The information provided in the medical notes supported this diagnosis and the management instituted accorded with the clinical diagnosis. By the time the baby returned to the clinic it was clear that her condition had deteriorated and the assessment and management then indicated that the practitioners involved were aware of this and that appropriate and supportive antibiotic (IV Ceftriaxone) treatment was administered while immediate evacuation was being arranged. It appeared that the complainant’s baby had developed a virulent or invasive Streptococcal infection which is a rare complication.

The Commission found that the standard of diagnosis and treatment at the clinic was reasonable and the nurse and the doctor on call came to a reasonable diagnosis of viral upper respiratory infection.

The complainant expressed concern that the provider failed to put in place appropriate arrangements to transport the complainant’s five (5) year old son who was accompanied by his aunt to hospital in Darwin for emergency treatment and they were left stranded at the airport and had to arrange and pay for a taxi to the hospital themselves. The Commission’s preliminary enquiries suggest that the travel arrangements failed in Darwin because the provider was not made aware of the situation when the complainant’s son and his aunt arrived in Darwin and as a result the provider did not have an opportunity to make appropriate arrangements. What appeared to have occurred is that the pilot failed to notify the taxi upon his arrival which resulted in the complainant’s son and his aunt having to organise alternative travel arrangements to the hospital.

Based on the Commission's preliminary enquiries in respect to the above issues, the Commissioner determined to take no further action.
The complainant attended the provider’s surgery to have an Implanon® implant inserted in her arm. Following the procedure the complainant began to experience problems with the implant and returned to the provider to have it removed.

According to the complainant, she entered the consultation room, lay on the bed, extended her arm and turned her head away as the doctor began to clean the area. When the provider first commenced the procedure, the complainant thought that he was administering anaesthetic but the pain intensified and she heard a “cracking” sound. The complainant cried out and turned around and grabbed her arm to see what the provider was doing. The complainant discovered that the provider had inserted a thick needle into her arm which had gone underneath the implant and pierced through the skin on the other side of her arm. The complainant was shocked by what she observed and asked the provider why he had done that, to which he replied “I can tend to lose the rod once I make the incision unless I lift it up to find it first”. The complainant was still in shock and in some pain, so she let the provider complete what he was doing after which time he administered anaesthetic which failed to relieve the pain adequately. Initially the provider could not locate the implant, and after further complications finally managed to remove it from the complainant’s arm and left the consultation room without another word to the complainant.

The experience was very unpleasant and as the complainant exited the consultation room, the nurse who had assisted the provider appeared shocked by the incident and apologised to the complainant, adding that she had never seen the provider use that technique before. Following the procedure, the complainant discussed the technique used by the provider with other clinicians and they advised that they were not familiar with the technique.

The Commission’s preliminary enquiries included obtaining copies of the complainant’s medical records from the provider and undertaking extensive desktop research on the Implanon® implant and obtained information from Family Planning New South Wales and the Royal Australian College of General Practitioners. In addition the Commission received a response from the provider and sought advice on the clinical procedure for the removal of the Implanon® Implant from the manufacturers of the product and obtained independent clinical advice.

The Commission’s preliminary enquiries suggested that:
- the provider may have failed to meet a standard of practice by not administering local anaesthetic to the complainant when he began the procedure to remove the implant and may have inflicted unnecessary pain; and
- the provider may have failed to meet a standard of practice during the procedure when he inserted a needle under the implant through to the other side without administering local anaesthetic to the Complainant before commencing the technique.

Based on the Commission’s preliminary enquiries, it was determined that the matter be referred to the Medical Board of the Northern Territory for their consideration and action.

The consumer was admitted to a private hospital for an achilles tendon repair under the care of a visiting medical officer (VMO). During the surgery the VMO became aware that he was operating on the wrong site and proceeded to do the correct site. The consumer unequivocally supported the decision of the VMO to continue the procedure on the correct leg after the mishap was discovered. Hospital staff and treating doctors had spoken to and apologised to the consumer and she was satisfied with the response of the VMO.

In making the complaint the consumer, while confident of making a full recovery without adverse side affects and not seeking financial compensation, was merely wishing to ensure that not only were procedures in place, but also procedures were implemented to ensure no one else has to suffer a similar event. The outcome sought was the correct and appropriate implementation of Time Out procedures in all hospitals, both DPH and Royal Darwin Hospital. The complainant’s concern was the fact that the wrong ankle was operated on, despite protocols at the private hospital supposedly being followed.

The response to the complaint from the private hospital included a copy of the medical records and a risk cause analysis undertaken into the incident by the hospital. The risk cause analysis document took into account a number of factors, however, it did not answer the primary question of why the incident actually occurred. The hospital advised that since the operation they had conducted an education session facilitated by the Director of Nursing with the Quality Manager and Anaesthetist with fourteen theatre nurses attending. During the meeting it was ascertained that gaining compliance from the surgeon (as per the guidelines) was previously difficult, but in future they would ensure that the final verification check would be conducted in the presence of the entire team including the surgeon. The hospital also advised that compliance to site marking by all surgeons was now undertaken and nurses had been directed to refuse to assist a surgeon in an elective surgical case in the absence of a site mark where it was required as per policy. Laminated posters of the protocol had also been placed into all operating theatres to remind staff of what was required of them.

To ensure compliance to the policy and to assess staff understanding of the process, audits were conducted. Observation practice audits were elected as the methodology as opposed to desktop audits to check actual compliance with all five stages of “correct patient, correct site and correct procedure”. 100% compliance has been observed in the audits undertaken to date.

The Commission determined to take no further action in respect to the complaint.
OVERALL PERFORMANCE OF THE COMMISSION

<table>
<thead>
<tr>
<th>Performance</th>
<th>Unit of Measure</th>
<th>07/08</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Quantity</td>
<td>1. Number of access and awareness sessions</td>
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<td>13</td>
</tr>
<tr>
<td></td>
<td>2. Number of enquiries/complaints received</td>
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<td>457</td>
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<tr>
<td>Quality</td>
<td>1. % of reviews of decisions requested</td>
<td>&gt;1%</td>
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<tr>
<td>Timeliness</td>
<td>1. % of inquiries &amp; complaints closed within 180 days of receipt</td>
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<td>Cost</td>
<td>1. Total output costs ($)</td>
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<td>$462,755</td>
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The key performance indicators for the 2008/09 period were:

- The number of approaches to the Commission was 20% more than for the previous year. That is a 45% increase over the last two years.
- 94% of approaches were finalised during the year.
- The average time taken to finalise a complaint decreased from 98 days to 70 days, a reduction of 30%.
- 96% of approaches to the Commission were resolved without a formal investigation or conciliation process.
- The Commission facilitated the resolution of 45% of complaints received directly between the provider and the complainant.
- Total visits to the Commission’s website increased by 30%
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.
5. Educate users and providers about their rights and responsibilities under the Code.
6. Monitor provider’s adherence to the Code.

PERFORMANCE

<table>
<thead>
<tr>
<th>Performance</th>
<th>Unit of Measure</th>
<th>07/08</th>
<th>08/09</th>
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<tbody>
<tr>
<td>Quality</td>
<td>1. Different brochures for user groups, provider groups, and ethnic groups.</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td></td>
<td>2. “Ethnic Brochure” represent majority of ethnic community.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Quantity</td>
<td>1. 1000 brochures sent.</td>
<td>1000</td>
<td>1000</td>
</tr>
<tr>
<td></td>
<td>2. Brochures to at least 10 different groups.</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>3. 20 presentations made.</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>4. Utilise the media: newspaper, radio, television.</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

OVERVIEW

No additional funding was allocated during 2008/09 for this purpose which resulted in very few access and awareness visits.

I am committed to improving the access Indigenous people have to the services of the Commission and have determined to provide additional ongoing funding for this purpose by utilising some of the savings generated by the closing of the Alice Springs Office.

Specifically I propose to:

- Redesign the logo;
- Upgrade the Commissions website;
- Develop new posters and brochures; and
- Increase visits to remote communities.

I have employed the services of a Project Officer who has been tasked, among other things, to develop appropriate promotional and educational material and an access and awareness program which will come into effect during 2009/10.

HIGHLIGHTS

MAINTAIN ACCESS AND AWARENESS AT THE NATIONAL LEVEL

The National Council of Health Complaints Commissioners consists of Commissioners and 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 2008/09, two meetings of the National Council were held. The first in Sydney, NSW on 8 October 2008 and the second in Auckland, New Zealand on 19-20 February 2009. Specific agendas are drawn up and actioned for each meeting. This financial year some of the matters discussed included:

- Reports from Commissioners;
- ACSQHC Consumer Engagement Strategy & Open Disclosure;
- Australian Charter of Health Care Rights;
- Health care accreditation;
- Consumer rights;
- Barriers to open disclosure;
- Lessons from inquiries and investigations;
- Engagement with Maori and Aboriginal people; and
- National Registration and Accreditation.

3 Not including Aboriginal people who make up approximately 30% of the NT population.
ACCESS AND AWARENESS THROUGHOUT THE TERRITORY

Access and Awareness Sessions

During the year, staff from the Commission undertook minimal education sessions throughout the Territory. Specific visits were undertaken in Darwin, Alice Springs, and Katherine. A total of 13 presentations (10 in 2007/08) 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. Around 1000 pamphlets were distributed to 7 groups throughout the year.

As reported in the previous financial year, there continues to be 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 be given priority next financial year and funding will be provided from the savings made as a result of closing the Alice Springs Office.

Advertising

The Commission did place some newspaper advertising during the year. No use was made of television or radio advertising. The Commission placed a total of 6 newspaper advertisements in Territory publications during the year. These advertisements aimed to increase public awareness of the Commission’s existence and advise people on how they can access the Commission.

Website

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:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>10,226</td>
</tr>
<tr>
<td>2007/08</td>
<td>11,869</td>
</tr>
<tr>
<td>2008/09</td>
<td>15,381</td>
</tr>
</tbody>
</table>

Visits to our website continue to increase, with a 30% increase this financial year. The Commission’s website will be going through a major overhaul early next financial year

6% of complaints were received via the website in 2008/09 (10% in 2007/08)
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.
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

<table>
<thead>
<tr>
<th>Performance</th>
<th>Unit of Measure</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>1. Approaches finalised</td>
<td>92%</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td>2. Enquiries/complaints informally resolved</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td></td>
<td>3. Recommendations supported</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Quantity</td>
<td>1. Enquiries and complaints received</td>
<td>385</td>
<td>457</td>
</tr>
<tr>
<td></td>
<td>2. Approaches finalised</td>
<td>373</td>
<td>365</td>
</tr>
<tr>
<td></td>
<td>3. Approaches</td>
<td>337</td>
<td>387</td>
</tr>
<tr>
<td></td>
<td>4. Investigations finalised</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>5. Conciliations finalised</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Timeliness</td>
<td>1. Average time to close a complaint</td>
<td>98 days</td>
<td>70 days</td>
</tr>
</tbody>
</table>

Explanation regarding approaches

- Approaches registered as an enquiry: 373
- Less enquiries moved to a complaint: 70
- Total complaints received: 303
- Approaches registered as a complaint: 14
- Total approaches for 2008/09: 387
- PLUS enquiries moved to a complaint: 70

Although the number of approaches increased substantially, productivity and efficiency gains continued to be made during the year in relation to the average time taken to finalise a matter. 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, i.e. the 373 enquiries and 84 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 53:47.

This is the first time since the Commission commenced that complaints from males has outnumbered females.

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 373 enquiries were received during 2008/09 of which 70 (19%) became registered complaints. An additional 14 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 387 approaches (refer to explanation below) to the Commission, 22% resulted in a formal complaint being registered (18% in 2007/08).

There has been an increase in the number of approaches this financial year, from 337 to 387. In numbers, that is a 20% increase.
**GEOGRAPHIC SOURCE OF COMPLAINT**

Chart 3: Geographic source of complaint

The majority of enquiries/complaints came from Darwin (44%), then Alice Springs (11%) and interstate (12%). The total number of enquiries/complaints received from Katherine, Tennant Creek and Nhulunbuy are still very low (6%).

**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 number of written approaches continues to decrease and is now only 7% of approaches (16% in 2006/07 and 9% in 2007/08). The number of electronic complaints decreased from 9% to 6%. Only 8% of complainants made their complaint in person.

**SERVICES PEOPLE COMPLAIN ABOUT?**

Public providers received 53% of enquiries/complaints this financial 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 31% (43% in 2007/08), followed by Dentists at 13% (8% in 2007/08). The category “Other” includes complaints received about 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 (50% of all public health complaints). This is a decrease from last financial year when it was 58%.

There has also been a substantial increase (60%) in the number of complaints received about Correctional Medical Service (CMS) when compared to 2007/08.

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 2008/09.

<table>
<thead>
<tr>
<th>Number</th>
<th>Access</th>
<th>Communication/Information</th>
<th>Consent/Decision Making</th>
<th>Discharge</th>
<th>Medical Records</th>
<th>Professional Conduct</th>
<th>Reports</th>
<th>Treatment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>136</td>
<td>46</td>
<td>48</td>
<td>19</td>
<td>16</td>
<td>15</td>
<td>10</td>
<td>8</td>
<td>26</td>
<td>8</td>
</tr>
</tbody>
</table>

It can be seen that issues associated with treatment were the major concern (27%) followed by access issues (20%). These are similar results to last year. Issues relating to communication made up 11% of the complaints received (same as 2006/07 and 2007/08).

OUTCOMES OF FINALISED COMPLAINTS

Being provided with an explanation was the outcome most achieved (44%), followed by obtaining a service (14%) and referred elsewhere (8%). Changes to policies and procedures accounted for 7% of the outcomes. It should be noted that there were 93 complaints closed during the year and 154 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 32% of complaints were resolved directly between the provider and complainant thanks to the assistance of the Commission (33% in 2007/08). 13% 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 Bilu 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 accessing services (31%) and the quality of treatment (23%) continue to be the major concerns of users of health services throughout the Territory. Complaints about poor communication make up 16% of issues complained about.

Table 2: Comparison between Commission and Prescribed Providers – Issues

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>HCSCC</th>
<th>DHCS</th>
<th>DPH</th>
<th>A/S Con</th>
<th>Wurli</th>
<th>Miluj</th>
<th>Danila</th>
<th>Anyi</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>101</td>
<td>222</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>325</td>
</tr>
<tr>
<td>Communication &amp; Information</td>
<td>58</td>
<td>83</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>143</td>
<td></td>
</tr>
<tr>
<td>Consent</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Discharge &amp; Transfer</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Environment &amp; Management</td>
<td>15</td>
<td>55</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Fees, Costs &amp; Rebates</td>
<td>26</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Grievances</td>
<td>16</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Medical Records</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>46</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Professional Conduct</td>
<td>48</td>
<td>45</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>Reports &amp; Certificates</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>196</td>
<td>105</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>238</td>
<td></td>
</tr>
<tr>
<td>Out of Jurisdiction</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>504</strong></td>
<td><strong>516</strong></td>
<td><strong>10</strong></td>
<td><strong>2</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>1</strong></td>
<td><strong>1033</strong></td>
<td></td>
</tr>
</tbody>
</table>

Some complaints have more than one issue

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.

The most effective means of resolving complaints was to provide an acceptable and reasonable explanation (23%).

Table 3: Comparison between Commission and Prescribed Providers – Outcomes

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>HCSCC</th>
<th>DHCS</th>
<th>DPH</th>
<th>A/S Con</th>
<th>Wurli</th>
<th>Miluj</th>
<th>Danila</th>
<th>Anyi</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service obtained</td>
<td>33</td>
<td>250</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>283</td>
</tr>
<tr>
<td>Explanation provided</td>
<td>95</td>
<td>279</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>380</td>
</tr>
<tr>
<td>Apology given</td>
<td>6</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Counselling/mediation</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Concern registered</td>
<td>157</td>
<td>32</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>189</td>
<td></td>
</tr>
<tr>
<td>Change in procedures/ practice</td>
<td>13</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Policy change effected</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Account adjusted</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Disciplinary action</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Conciliated</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Compensation paid</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Complaint withdrawn</td>
<td>17</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Resolved</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Referred elsewhere</td>
<td>85</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>98</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>- pending</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>- unresolved</td>
<td>73</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>505</strong></td>
<td><strong>571</strong></td>
<td><strong>10</strong></td>
<td><strong>2</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>1</strong></td>
<td><strong>1189</strong></td>
<td></td>
</tr>
</tbody>
</table>

Some complaints have more than one issue

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

<table>
<thead>
<tr>
<th>Performance</th>
<th>Unit of Measure</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>1. Number of providers who improved their practice following implementation of investigation recommendations.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2. Percentage of providers responding to recommendations.</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>3. Number of referrals to registration boards.</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Quantity</td>
<td>1. Number of recommendations made.</td>
<td>10</td>
<td>32</td>
</tr>
</tbody>
</table>

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 32 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 2008/09.

CASE STUDIES - INVESTIGATIONS

POOR CONSULTATION BETWEEN MEDICAL TEAM AND INFECTIOUS DISEASES UNIT

BACKGROUND

The complainant was concerned about the nursing and medical care his teenage son (the consumer) received at a public hospital following his admission with septic arthritis, (presenting as cellulitis) and right foot pain with swelling of the 1st Metatarsalophalangeal (MTP) joint.

The consumer underwent initial arthroscopy and washout of the joint and cultures were taken. Non-multi-resistant, oxacillin resistant staphylococcus aureus (NORSA) was identified. The results of the cultures led to the cessation of the intravenous (IV) flucloxacillin and commencement of oral Bactrim DS. The consumer remained an inpatient with his leg elevated, only mobilising when necessary for personal care. His wound was dressed daily.

Due to recollection of infection, the consumer underwent a second washout and debridement of the wound with similar pathological results. Following this, the complainant expressed his dissatisfaction to hospital staff about the level of care and treatment his son was receiving, and advised he was considering transferring his son to interstate for treatment. A week after the second washout the Orthopaedic Registrar received approval to commence Vancomycin and this was then administered.

The complainant transferred his son to an interstate hospital. The results of an MRI performed at this hospital were consistent with recently washed out septic arthritis of the 1st MTP joint as well as an early osteomyelitis of the proximal phalanx of the great toe. Vancomycin was continued, and the complainant stated that after two week’s treatment interstate his son’s condition improved and he was discharged.

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6 Septic arthritis is an inflammation of a joint caused by a bacteria infection other than gonorrhea.
7 Cellulitis is an acute inflammation of the connective tissue of the skin, caused by infection with staphylococcus, streptococcus or other bacteria.
8 Osteomyelitis is an acute or chronic bone infection, usually caused by bacteria.
The complainant initially complained direct to the public hospital and several meetings were organised between the complainant and the Orthopaedic team to try and resolve his concerns. These meetings were unsuccessful in resolving the issues of complaint. Subsequently a complaint was made to the Commission about the following issues:

- Quality of care and treatment provided to the consumer during his period at the public hospital for an infected right foot.
- Lack of communication from the hospital to the complainant on his son’s condition.
- After 5 weeks of hospitalisation and going to theatre twice at the public hospital, there was no sign of progress which led to the complainant transferring his son to a hospital interstate.
- Missing or no documented incidents in the consumer’s medical record relating to him allegedly “fitting” post his first theatre presentation.
- The complainant not being informed prior to son going into theatre for the second time. (Written parental consent was given some three weeks earlier).
- Lack of consistency of information provided to the complainant by nursing staff, overseeing Doctor and Consultant Surgeon and no one to liaise with about his son’s treatment.

The Commission initially undertook preliminary inquiries into the complaint and this resolved a number of the issues. The Commission then assessed the complaint and determined to investigate the following issues on the basis that the complaint appeared to raise significant issues of public health and safety relating to the management of infectious diseases at the public hospital:

1. The appropriateness of choice and dose of medication administered by the public hospital to the consumer for treatment of septic arthritis in his right foot until he was transferred interstate.
2. Whether the consumer should have had a MRI scan whilst at the public hospital.
3. Whether adequate protocols were in place between the public hospital’s Infectious Diseases Unit and treating teams.

**INVESTIGATION PROCESS**

The Commission's investigation included further consultation with the parties to the complaint, a review of the medical records from the public and interstate hospitals, a review of the Australian therapeutic guidelines, and a review of relevant current national and international literature relating to the diagnosis and management of septic arthritis, osteomyelitis, and NORS/A infection.

To assist consideration of all treatment issues, the Commission obtained clinical advice from several practitioners in the Northern Territory, New South Wales, and Queensland, and an independent expert opinion from a Queensland Orthopaedic Surgeon and a Director of Pathology.

The draft Investigation report was referred to the CEO of the Department of Health and Families and the Orthopaedic Surgeon. No response was received from the Surgeon and the Department had no substantial concerns with the draft report.

**ISSUE 1 - THE APPROPRIATENESS OF CHOICE AND DOSE OF MEDICATION ADMINISTERED AT AT THE PUBLIC HOSPITAL**

The Commission was satisfied that the Orthopaedic team made the decision to commence oral Bactrim DS without any consultation with the Infectious Diseases Unit and that the dose prescribed was, based on the expert’s advice, reasonable.

The Commission was also satisfied that the commencement of intravenous Vancomycin (in addition to the Bactrim DS) following the second procedure was reasonable. However the Commission was concerned that it took the Orthopaedic Team seven (7) days from the receipt of the culture report to consult with the Infectious Diseases Unit regarding the report and gain their approval to the use of Vancomycin.

The Commission was unable to conclude that the consumer would have had an improved outcome had the Vancomycin been administered earlier.

The Commission did conclude that the documentation in the medical records, specifically regarding any consultation with the Infectious Diseases Unit, was totally inadequate.

**ISSUE 2 - WHETHER THE CONSUMER SHOULD HAVE HAD A MRI SCAN WHILST AT THE PUBLIC HOSPITAL**

The Commission was satisfied that an MRI scan would not have changed the consumer’s diagnosis or choice of antibiotic treatment. It was also satisfied that up until the second procedure on 18 May 2007 it was reasonable for the Orthopaedic Team to not have performed an MRI scan.
ISSUE 3 - WHETHER ADEQUATE PROTOCOLS WERE IN PLACE BETWEEN THE PUBLIC HOSPITAL’S INFECTIOUS DISEASES UNIT AND TREATING TEAMS

The Commission concluded that if there was indeed a protocol in place relating to consultation with the Infectious Diseases Team by other medical teams it was not used in this case by the Orthopaedic Team. There was also no documented evidence detailing any discussions by the Orthopaedic Team with the Infectious Diseases Unit.

OTHER ISSUES ARISING FROM THE COMPLAINT

In addition to the above three issues, a number of other related issues arose during the course of the investigation.

1. Communication

The complainant complained about the poor communication between the orthopaedic team and himself regarding his son’s care and treatment.

The Commission found that the public hospital’s communication with the complainant was not to an acceptable standard. There was a need for the hospital’s medical teams to be proactive in initiating communication with patients, carers and family members about a patient’s care and treatment. There was also a need for a known point of contact to be identified within a ward should patients, carers or family members wish to discuss any issues or raise concerns about the care and treatment being provided to a patient.

2. Documentation

A number of deficiencies in relation to the documentation on the medical file were noted:

- There were no documented incidents in the medical file relating to the consumer’s alleged “fitting” following his first operation. These were all documented retrospectively after being brought to the attention of the hospital following preliminary inquiries into the complaint.
- No documentation regarding the nature of any consultation between the Orthopaedic Team and the Infectious Diseases Unit.

The Commission concluded that record keeping and documentation at the public hospital was not to an acceptable standard.

RECOMMENDATIONS

Based on the conclusions made above the Commission made the following recommendations which were supported by the department and hospital:

1. That, within 3 months, the hospital develop guidelines and a documented process for obtaining assistance or advice from the Infectious Disease Unit including referral procedures, creating and storing records, history given, advice given and any other action and disseminate the guidelines and details of the process to all relevant staff.

2. Medical teams and, in particular the Orthopaedic Team, be reminded about the need to review and action pathology reports, where appropriate, within 24 hours of them being made available.

3. Each ward has documented and known communication procedures regarding regular contact with patients, carers and family members, including the identification of the staff member/s responsible for such contact.

4. All medical and nursing staff be reminded by the hospital, in writing, about their responsibility to maintain accurate and sufficient records and to comply with the Medical Record Standards, particularly relating to infectious diseases consults and discussions with patients, carers and family members.

5. That a copy of any notice to all nursing and medical staff referred to in recommendation 4 be provided to the Health and Community Services Complaints Commission with details of the date and manner by which it was communicated to all staff.
SUB STANDARD SECURITY ARRANGEMENTS CONTRIBUTE TO RAPE OF INFANT IN PAEDIATRIC WARD

SCOPE OF INVESTIGATION

On 30th March 2006 a five month old female infant was raped while an inpatient in the Paediatric Ward 5B at RDH. The Commission investigated the arrangements in place at Ward 5B for the protection of patients as well as any action taken by RDH in response to the severity of the incident.

CONCLUSIONS OF THE COMMISSIONER

The Commission concluded that:

1. On 30th March 2006:
   - There were no arrangements in place on the Paediatric Ward to ensure the safety and inviolability of vulnerable patients.
   - No risk assessment had been conducted.
   - The arrangements in place did not comply in any aspect with the Australian Standard which sets the benchmark for proper security.
   - There was no control on access to the Ward or to the patients.
   - The staff had not received adequate training, and possibly none at all, about the risks arising from lack of security arrangements.
   - In 2002 RDH had commissioned and received an expert consultant’s assessment and report on security arrangements at RDH. The Terms of Reference did not require 5B to be assessed. By 30 March 2006 the recommendations in the report had not been implemented in Ward 5B. This failure can only be described as shameful.
   - Following the rape of the infant police were not notified for about 2 hours.

2. Action taken by RDH after the rape to improve security was:
   (a) Slow;
   (b) inadequate, and
   (c) had not been adequately evaluated or reviewed to determine its effectiveness.

3. RDH had a Security Manager on site as well as an NT Police member stationed at the hospital. Neither had been asked to evaluate the security on the Paediatric Ward either before or after the rape of the infant.

4. Staff working on the Paediatric Ward had not been trained at their induction on the elements of security arrangements to reduce the risk to vulnerable patients nor had there been adequate ongoing training of staff before or after the 30th March 2006 incident.

5. In 2007 the same expert safety and security consultant, as in 2002, was engaged to assess security arrangements at RDH. He was not informed of the rape of the infant in March 2006 nor was he asked to report specifically on arrangements in the Paediatric Ward.

6. On 21 November 2007 two investigation officers from the Commission visited the Paediatric Ward by prior arrangement. They were able to enter the Ward and wander around, have entry to every part of it and stand at the nurse’s station, for about 25 minutes without anyone asking who they were and why they were there.

7. Management’s lack of commitment to the proactive identification of risks and to taking appropriate action has not created a culture where each member of staff takes responsibility for identifying and reporting risks and developing safe practices.

8. A security review of RDH was carried out by an expert hospital safety and security consultant who issued a report in 2007. The Security Manager of DHCS (DHF) was not given a copy even though he requested it. The Commission enquired of RDH management why he was not given a copy and RDH offered no explanation. On 31 October after this report was published to RDH and DHF the CEO of DHF advised this Commission that he had finally been given a copy and that he had seen a draft copy.

9. RDH Maternal and Child Health Clinical Risk Management Committee considered security in the Paediatric Ward following the incident. The Committee met on 16th May 2006, 2.5 months after the rape of the infant. It met a further 4 times. It submitted an action plan to the General Manager of RDH in July 2006. At its last recorded meeting on 5 September 2006 there had been no response from the General Manager on the recommendations, particularly with respect to installing CCTV cameras with recording facilities on the Paediatric Ward. There were still no recording cameras on the Paediatric Ward as at June 2008 although a CCTV system had been installed in the kitchen area to deter the pilfering of food. Dr David Ashbridge on 31 October 2008 advised, when responding to a draft of this report, that CCTV cameras were installed in Paediatrics on 25 August 2008.
10. The surveyors from the Australian Council of Health Standards which accredits RDH probably did not receive all relevant information about the incident of 30 March 2006 and what action RDH were taking. Those surveyors on 13 October 2006 were informed by RDH that the patient information pamphlet and admission interview were being reworded to reflect the changes to ward access. There was no verification throughout the investigation that any action had been taken by RDH to implement the recommendations of the review. Neither the report of ACHS nor records of information given to ACHS were provided to the Commission. DHCS (DHF) was invited to provide the Commission with those relevant documents in response to this draft. No response was received on this issue from DHF or RDH. According to the published information of ACHS the accreditation survey commenced with a self-assessment by the hospital concerned. This Commission specifically requested details and copies of the information provided to the ACHS surveyors but no response was received from either the CEO of the Department or the General Manager of RDH.

11. The governance arrangements at RDH did not promote adequate transparent accountability of the General Manager and the Department of Health and Families for the operation of the hospital. Control of all aspects of the day to day management of RDH rested in the hands of three individuals. This includes staff recruiting, training, security, nursing and medical services, procurement, record keeping, financial accountability and risk management. Such specialist management groups as exist are subordinate to the General Manager’s authority. The General Manager reported to the Director of Acute Services who reported to the CEO of the Department. The Commission were unable to find out what role the Royal Darwin Hospital Board had since its last annual report to 30 June 2006.

In response to the draft of this report the Commission received documents about the “realignment” of the hospital’s clinical governance and management structure in October 2007. That restructure still preserved the day to day control of the hospital by the three individuals.

What was notable was the absence in the October 2007 re-alignment of the RDH management and clinical structure of any reference to the role of the Royal Darwin Hospital Board of Management. The RDH is a hospital declared to be so on 2 June 1987 by a declaration made under the Medical Services Act. The RDH therefore was required to comply with the Hospital Management Boards Act. The Management Board must consist of:

- The Manager of the hospital.
- The medical practitioner in charge of having principal responsibility for providing medical services at the hospital.
- The person in charge of nursing services at the hospital.
- Five other persons appointed by the Minister.

When a person is appointed as a member the appointment must be notified in the Government Gazette. Appointment of members could not be for more than three years but they were eligible for re-appointment. As at 30 June 2006 the annual report of the Board states there were three members of five required and out of twelve meetings the attendance rate was less than 50%.

There had to be five members present for a quorum and the Board SHALL meet not less frequently than once a month at the RDH. The Minister may attend any meeting. Minutes must be kept of all meetings. The functions of the Board of Management were:

“Section 22 –
(1) (a) to give directions and offer advice, not inconsistent with the Public Sector Employment and Management Act or the Financial Management Act or the directions of the Minister, to the Manager of the hospital with respect to any matter relating to the operation of the hospital;
(b) to fix and supervise the standards of service provided by or through the hospital;
(c) to advise and make recommendations to the Minister on any matter relating to the operation of the hospital, including the needs of the hospital in relation to its future development;
(d) to co-ordinate the use of resources in the hospital;
(e) to raise money, and spend and pay out any money raised, for such uses in the hospital as are approved by the Minister;
(f) to accept and receive money donated to the hospital, and spend and pay out any money donated, for uses in the hospital;
(g) to maintain liaison with other persons or bodies in the area served by the hospital; and
(h) to exercise and discharge such powers, duties and functions as are conferred or imposed on it by or under this or any other Act.
(2) For the avoidance of doubt, it is declared that the powers of direction of a Board do not include powers to give directions for or in relation to –
(a) the recruitment, management and discipline of staff; or
(b) the financial management of the hospital.
(3) The Manager of a hospital shall consider any advice and comply with any directions given to him under subsection (1).”

The RDH Management Board was also required to furnish to the Minister, not later than 30 September in each year a report on its operations and the operations of the RDH. The Minister must then table the report within 10
sitting days of the Legislative Assembly after it has been so furnished. It was the responsibility of the General Manager of RDH to “ensure” that a person was available to carry out secretarial services for the Board.

A notice to provide information and documents was served on the General Manager of RDH on 14 January 2007. It specifically required him to produce to the Commission:

“Any copy of all materials, reports and minutes of the Board of Management relating to the sexual assault within the Paediatric Ward 31st March 2006.”

No document, agenda, minutes or report from or to the Management Board was produced.

The Commission could only conclude from this that the incident of the rape of a five month old child was not considered important enough by the General Manager to report it to the Management Board. It was the function of the Management Board under legislation to give directions to the General Manager except on financial management and recruitment management and discipline of staff.

It was the Commission’s view that how RDH was managed, what leadership it had and how decisions were made, not only about clinical matters but about management, directly impact on the lack of security arrangements that led to the rape of the infant.

In response to the report the then Minister for Health, the Hon C Burns MLA stated that all recommendations would be implemented. He commissioned a review of the governance arrangements at RDH, including the role of the Department of Health and Families. The report by the review team for the Australian Council of Health Services was delivered on 29 February 2009. That review agreed with the Commission’s conclusion that governance at RDH needed strengthening and “a concerted effort is required to create good governance and clinical governance models and then sustain them”. In my opinion the 26 recommendations of the review team are incorporated in the following words from recommendation 7 “In conjunction with DHF and other key stakeholders and under the supervision of the Board, RDH should prepare a five year strategic plan”. The Review Report sets out a blueprint for improving safety and quality of care at RDH over the next 3 – 5 years. During that period the Commission will be evaluating complaints about RDH by reference to the extent of implementation of those recommendations.

CATHETER INSERTION NOT UP TO SCRATCH

BACKGROUND

The complainant approached the Commission with concerns about the standard of care and treatment provided to her at a public hospital. The complainant underwent Cystoscopy9 and Urethral10 Dilatation11 surgery in September 2006.

Whilst in the hospital’s recovery unit, eight attempts were made to insert a catheter whilst the complainant was fully conscious. This was attempted with no pain relief, shortly after surgery. As a result an indwelling12 urethral catheter was inserted by further general surgery as no person was able to insert the catheter initially. The complainant was sent to the ward overnight and the catheter was removed the next morning and she was sent home. The complainant tried to tell the doctor that she shouldn’t be discharged as she hadn’t urinated but despite her objections she was discharged. The complainant returned to the hospital’s Emergency Department the same afternoon as she was still unable to urinate.

Over the next seven weeks the catheter was removed and replaced five times, each time without pain relief. The surgeon then decided that a suprapubic13 catheter (Bonnano) should be inserted. At this time the complainant alleged that the questions she asked were skirted around and not directly answered by the surgeon. There was no mention of what would occur after the surgery as far as care was concerned.

During visits to the surgeon after the catheter was replaced the complainant developed vaginal ulcers. The complainant also asked the surgeon a number of questions but was not satisfied with the responses. A decision was made to replace the leg bag with a spigot14. The surgery for this procedure was due to take place in January 2007.

Whilst waiting for the surgery the complainant required a re-sew of stitches around the catheter on three separate occasions. On attending the hospital’s Emergency Department in relation to the third re-sew, she was spoken to by a doctor who indicated having the area stitched again was not appropriate and something more permanent

9 The use of a cystoscope to examine the bladder.
10 The canal that in most mammals carries off the urine from the bladder - urethral /-thr/'l adjective.
11 The condition of being stretched beyond normal dimensions.
12 Left within a bodily organ or passage to maintain drainage, prevent obstruction, or provide a route for administration of food or drugs -- used of an implanted tube (as a catheter).
13 Situated, occurring, or performed from above the pubis.
14 a faucet or cock for controlling the flow of liquid from a pipe or the like.
should be done. A message was left for the surgical personnel to attend and review the matter. The complainant indicated that a doctor attended and informed her he could tape the area and to return to surgery a few days later as was previously planned.

The complainant at this time was emotionally upset and at the end of her tether. Because of this she was placed on an earlier surgical list. Another Surgeon attended prior to the surgery and looked at the suprapubic (Bonnano) catheter and said to the complainant "I haven’t seen one of those for 20 years". The complainant indicated that the Surgeon turned up at her bedside after the operation and said ‘well you’ve got what you wanted now so things should be okay’. The complainant felt the Surgeon was speaking in a condescending tone at the time.

The complainant alleged she received little or no information about the care of the new catheter by the surgeon or hospital staff.

An assessment was conducted by the Commission and a determination was made to investigate the following issues:

- Whether a treatment plan was in place for the complainant.
- If a plan was in place, was it reasonable in all the circumstances and was the complainant informed of the plan.
- Whether the suprapubic (Bonnano) is regularly used as a temporary catheter.
- Why it took eight attempts to insert an indwelling catheter after the original surgery.
- Is it usually difficult to insert catheters in patients after Cystoscopy surgery?
- What procedures were in place at the public hospital in relation to the discharging of patients? Were patients usually discharged without them having voided.
- The standard of record keeping at the public hospital in relation to patient information.

**INVESTIGATION PROCESS**

As part of the investigation the Commission:

- notified the Medical Board of the Northern Territory, Chief Medical Officer and the complainant;
- obtained copies of the complainant’s medical records;
- sought response to the complaint from the providers; and
- obtained expert opinion from a Urologist at the Brisbane Private Hospital.

A copy of the draft investigation report was forwarded to the Department of Health and Families (DHF), the Surgeon and the complainant for comment. All three parties provided a response to the draft investigation report and these were taken into account in the final report.

**ISSUE 1: WHETHER A TREATMENT PLAN WAS IN PLACE AND, IF IN PLACE, WAS IT REASONABLE IN ALL THE CIRCUMSTANCES AND WAS THE COMPLAINANT INFORMED OF THE PLAN.**

**Background**

The complainant was seen by the Surgeon at the Surgical Outpatients Department in June 2006 after being referred by her GP. In September 2006 the complainant was admitted to hospital for surgery which involved a cystoscopy and gentle urethral dilation. The surgery was performed by the Surgeon’s registrar under his supervision.

**Conclusion**

Based on the responses received at the Commission and the expert report the Commission was satisfied that the treatment plan was reasonable in the circumstances.

Whilst the Commission concluded that the treatment plan as described was reasonable, there was no evidence, apart from the memory of the treating doctors, that the complainant was ever advised of the plan. There was nothing in the medical records that showed the treatment plan in written form. The Commission was of the view that medical practitioners needed to document and keep records of treatment plans for patients, to inform patients of the details of the plan, and a senior surgeon especially needed to ensure that any other medical practitioner seeing the patient, whether in the Emergency Department or at Outpatients, knew from the medical notes details of that plan.

**ISSUE 2: WHETHER THE SUPRAPUBIC (BONNANO) IS REGULARLY USED AS A TEMPORARY CATHETER.**

**Background**

After the initial surgery the complainant was seen at the Surgical Outpatients department by the Surgeon’s registrar who suggested a trial of void after removal of the catheter. The trial was unsuccessful and the complainant subsequently required a number of changes to the indwelling catheter in the Accident and
Emergency Department of the hospital. On each of these occasions the complainant needed sedation to have the catheter inserted.

The complainant further consulted with the Surgeon on a number of occasions at the Outpatients department after which the Surgeon discussed the matter with an interstate Urologist. After this discussion, a trial of the suprapubic (Bonnano) catheter was suggested as the complainant was unable to self-catheterise and this commenced. As stated by the then Medical Superintendent of the public hospital, “This was not intended for long term use as it was only a trial measure and therefore the Bonnano catheter was used.”

The complainant continued to have difficulties with the suprapubic (Bonnano) catheter and subsequently in January 2007 had further surgery at which time the suprapubic (Bonnano) was removed and replaced by a Foley’s catheter.

Conclusion

The Commission was satisfied that the use of the suprapubic (Bonnano) catheter was appropriate in the circumstances.

The Commission also concluded in the draft investigation Report that it was not satisfied that the suturing used in the treatment of the complainant was to the required standard given all of the circumstances. Following the receipt of comments from DHF and the Director of Surgery and further information provided by the Surgeon it became clear that there were a number of contributing factors which could have lead to the sutures becoming loose and in view of the comments, the Commission could not, based on the material provided in the responses, form the view in the final report that the sutures were tied to less than the required standard.

ISSUE 3: WHY DID IT TAKE EIGHT ATTEMPTS TO INSERT AN INDWELLING CATHETER AFTER THE ORIGINAL SURGERY AND IS IT USUALLY DIFFICULT TO INSERT CATHETERS IN PATIENTS AFTER CYSTOSCOPY SURGERY.

Background

The complainant underwent a cystoscopy at the hospital in September and was placed in the recovery room. After a period of time the complainant had to return to surgery to have a urethral catheter inserted.

The complainant alleged that approximately eight attempts were made to insert the catheter by staff prior to her being returned to surgery. Each attempt was undertaken whilst she was fully conscious and no pain relief was administered.

Conclusion

Whilst it took a number of attempts to catheterise the complainant after the original surgery, the Commission was satisfied, based on the medical records, response of the Surgeon and the expert opinion that the code had been complied with, that the care and treatment provided was to the required standard.

ISSUE 4: WHAT PROCEDURES WERE IN PLACE AT ROYAL DARWIN HOSPITAL IN RELATION TO THE DISCHARGING OF PATIENTS. ARE PATIENTS USUALLY DISCHARGED WITHOUT THEM HAVING VOIDED.

Background

The complainant underwent a cystoscopy at the hospital in September 2006. Whilst in the recovery unit difficulties were encountered by staff attempting to insert a catheter. Subsequently she was returned to surgery and a catheter was inserted. She was then admitted overnight and discharged the next day.

The complainant as part of her complaint to the Commission alleged she was discharged without having urinated despite advising doctors of this fact.

Conclusion

The Commission was satisfied that the complainant had voided prior to her release from hospital. However, her concerns that she was not voiding properly as noted in the medical notes should have been raised with a doctor and further examination/action taken. Greater emphasis should have been placed on obtaining and recording the volumes and ease with which the complainant voided prior to her discharge, and the significance of her need for analgesia and blood in her urine should have been referred to the Surgeon as it was not something considered in the treatment plan. The Commission concluded that a proper treatment plan should have included directions for treatment of normal or unexpected consequences and direction on what symptoms should prompt contact with the Visiting Specialist.
ISSUE 5: THE STANDARD OF RECORDING KEEPING AT THE PUBLIC HOSPITAL RELATING TO PATIENT INFORMATION.

Background

The complainant was admitted to the hospital for surgery and treatment between September 2006 and January 2007. She was concerned that her age had been incorrectly recorded on one of the hospital records and this might have impacted on “medicine calculations” and “could lead to tragedy through lack of care”.

Conclusion

The Commission found that the error had occurred as a result of the author of the document miscalculating the age of the complainant and thereby incorrectly recording her age. There was no evidence that this was a deliberate act. It was also not considered a danger to her medicine calculations as the form related to the discharge summary and not to a treatment plan or prescription related document. All of the other medical records relating to the care and treatment of the complainant reflected and recorded her age and date of birth correctly.

The Commission did conclude that the standard of record keeping relating to treatment plans and observations of the complaint’s voiding were deficient and below a reasonable standard.

RECOMMENDATIONS

Based on the above conclusions the Commission made the following recommendations.

1) That doctors and nurses at the public hospital are reminded regularly of the need for diligence when recording patient information so that it is accurate, comprehensive, and records significant items of history and observations so as to be readily understood by other practitioners relying on the patients notes.

2) Doctors involved in the treatment of patients be reminded to clearly and fully document any treatment plan, and especially a plan supervised or formalised by a Visiting Medical Specialist or Consultant and anyone not full time at public hospital. Such a plan should contain contingency arrangements if complications or any adverse event occurs, together with clear guidance to nursing staff, RMO’s and Registrars about when the Visiting Medical Specialist or Consultant, or other senior medical practitioner should be consulted.

3) Treatment plans, when formulated, to be a separate document, not entries interspersed ad hoc among other notes and so as to be readily available for easy reference.
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

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<td>2. Policies and procedures for:</td>
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<td>3. Policies and procedures available at all times.</td>
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CORPORATE GOVERNANCE

LEGISLATIVE FRAMEWORK

The Commission is responsible for the administration of the Health and Community Services Complaints Act 1998.

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 1998, 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. The Commission’s staff are now 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.
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. It is my intention to review the Strategic/corporate direction of the Commission in the first half of next financial year.

An annual Business Plan is prepared and this provides specific direction and performance indicators and 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 during the week.
- 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.
- Individual performance being measured at least annually 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 2008/09 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 2008/09 as sufficient funds became available.

Expenditure on staff training and development during 2008/09 for Commission staff is included in the overall staff development and training expenditure for the Ombudsman’s Office. This 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 2008/09 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 2008/09 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 (2003) 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

SERVICE STANDARDS OF THE HEALTH AND COMMUNITY SERVICES COMPLAINTS COMMISSION

THE COMMISSION’S STAKEHOLDERS:

The Commission’s stakeholders are:

• Users and providers of health services and community services in the Northern Territory.
• Health Professional Registration Boards, community and consumer groups and professional associations.
• The Minister for Health and Community Services.
• The Legislative Assembly of the Northern Territory.

THE COMMISSION’S COMMITMENT:

1. Visibility

The Commission will promote its opening hours, contact details and the services it provides in a manner which facilitates access to the Commission and takes into account the diversity of the Northern Territory population.

The Commission also undertakes to:

• take enquiries and complaints between 8.00 am and 4.30 pm Monday to Friday; and
• visit each regional centre once a year to take complaints.

2. Accessibility

The Commission undertakes to provide services that are accessible and appropriate by:

• assisting those with special needs to prepare and lodge complaints;
• using trained interpreters as necessary;
• enabling complainants to lodge oral complaints;
• visiting regional centres regularly; and
• providing and advertising a toll free telephone number.

3. Fairness and Impartiality

The Commission will ensure fairness and impartiality in its operation by:

• not favouring either those making or those responding to complaints;
• giving equal regard to all complaints;
• being independent of any individual, group or organisation subject to a complaint;
• acting with respect for the interests of the public;
• promoting open and transparent decision making by providing reasons for its decisions and outlining the factors taken into account in reaching a decision; and
• providing an independent review mechanism.

4. Timeliness

The Commission will operate in a timely manner and will:

• answer calls and correspondence promptly
• carry out assessment of complaints within 60 days; and
• give information to people involved in a complaint about the process of the complaint every six to eight weeks.

5. Lawfulness

At all stages of the complaint process the Commission will act within its statutory powers and abide by the principles of natural justice.

6. Staff of the Commission

The Commission undertakes that its services are provided by staff who are courteous and professional and will:

• identify themselves and provide their contact details in telephone calls and correspondence;
• perform their work conscientiously, with honesty and integrity;
• be competent to carry out the tasks required of them; and
• clearly inform those who contact the Commission of the limits of their powers and resources, and the services they are unable to provide.
7. Information

The Commission, through its staff, promotional material, web site and annual reports, undertakes to provide:

- accurate and reliable information on its services, policies, procedures and statutory authority;
- information on the complaints process and the options available within the process; and
- information on alternative services and how to access these services.

8. Accountability

The Commission is committed to continuous improvement and undertakes to:

- develop and implement a system for gathering feedback from those who access the Commission;
- inform all users and providers of the mechanism for reviewing the process by which the Commission handles complaints and reaches decisions;
- monitor the adequacy of action taken by providers in response to the Commission’s recommendations; and
- provide, in its annual report, information on the Commission’s effectiveness in securing compliance with recommendations.

9. Privacy and Confidentiality

The Commission will maximise the privacy and confidentiality of those using its services by:

- handling material provided to the Commission with consideration as to the effect it may have on both individuals and organisations;
- subject to legislative requirements, releasing information only with the prior permission of the individual or organisation providing that information; and
- publishing data which does not identify those using the Commission’s services.
APPENDIX 2

DETAILED COMPLAINT STATISTICS FOR 2007/08

ENQUIRY/COMPLAINT STATISTICS 2007/08

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 373 new enquiries were registered during the year.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carried Forward</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Enquiries received during the year</td>
<td>323</td>
<td>373</td>
</tr>
<tr>
<td>Total active enquiries for the year</td>
<td>323</td>
<td>389</td>
</tr>
<tr>
<td>Enquiries finalised during the year</td>
<td>259</td>
<td>276</td>
</tr>
<tr>
<td>Enquiries becoming formal complaint</td>
<td>48</td>
<td>70</td>
</tr>
<tr>
<td>Enquiries still open as at 30 June</td>
<td>16</td>
<td>43</td>
</tr>
</tbody>
</table>

Of all the active enquires, 71% were finalised (80% in 2007/08), 18% became formal complaints (15% in 2007/08) and 11% remained open (5% in 2007/08).

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>
<thead>
<tr>
<th>PROVIDER</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Providers:</td>
<td>122</td>
<td>167</td>
<td>202</td>
</tr>
<tr>
<td>Acute Services</td>
<td>53</td>
<td>94</td>
<td>98</td>
</tr>
<tr>
<td>Health Services</td>
<td>29</td>
<td>33</td>
<td>30</td>
</tr>
<tr>
<td>Health Protection</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Performance &amp; Resources</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Families &amp; Children</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Office of the CEO</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Corrections Health Service</td>
<td>27</td>
<td>21</td>
<td>72</td>
</tr>
<tr>
<td>Community Services&lt;sup&gt;15&lt;/sup&gt;</td>
<td>13</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Executive &amp; Legal</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Information Services</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>People Services</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Hlth Prof Licensing Auth</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Of the total enquiries received during the year under review, 54% related to public providers (52% in 2007/08) and 46% to private providers (48% in 2007/08).

48% of public provider enquiries were about the public hospital system (compared to 56% in 2007/08) while 31% of private provider enquiries were about medical practitioners (42% in 2007/08).

Of particular concern is the large increase in enquiries related to Dentists. They have doubled over the last two years and now represent 12% of all private provider enquiries.

---

<sup>15</sup> Due to a reorganisation 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, 84 new complaints were received during the year. Of the 113 total active complaints for the year, 93 or 82% were closed (65% in 2007/08)

Table 6: Complaints Movement During 2007/08

<table>
<thead>
<tr>
<th>ITEM</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints open as at 1 July</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td>Complaints received during the year</td>
<td>62</td>
<td>84</td>
</tr>
<tr>
<td>Total active complaints for the year</td>
<td>82</td>
<td>113</td>
</tr>
<tr>
<td>Complaints closed during the year</td>
<td>53</td>
<td>93</td>
</tr>
<tr>
<td>Complaints still open as at 30 June</td>
<td>29</td>
<td>20</td>
</tr>
</tbody>
</table>

As at 30 June 2009 the age of the open complaints was as follows:


2. Providers Subject to Complaints

(a) Breakdown of providers subject to complaints received

Table 7 below provides a breakdown of providers that have been the subject of complaints over the past year. Of the total complaints received during the year under review, 35% related to public providers (47% in 2006/07) and 65% to private providers (53% in 2006/07).

Table 7: Breakdown of providers subject to complaints

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>06/07</th>
<th>07/08</th>
<th>08/08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Providers:</td>
<td>44</td>
<td>22</td>
<td>43</td>
</tr>
<tr>
<td>Acute Services</td>
<td>21</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>Health Services</td>
<td>6</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Health Protection</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance &amp; Resources</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Families &amp; Children</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office of the CEO</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrections Health Service</td>
<td>10</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Community Services(^{16})</td>
<td>7</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Executive &amp; Legal</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Health Professions Licensing Auth</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Private Providers: 50 40 41

- Aboriginal Health Services: 1 0 2
- Alternate Therapists: 0 0 0
- Alcohol and Other Drugs: 0 0 1
- Ambulance Services: 0 0 3
- Chiropractors: 1 2 0
- Community Based Support Groups: 1 0 1
- Counselling: 0 0 1
- Dentists: 5 1 7
- Diagnostic Services: 0 2 0
- Hostel/Support Accommodation: 0 0 1
- Medical Admin: 0 0 3
- Medical Practitioners: 27 20 14
- Nurses: 3 1 3
- Occupational Therapists: 1 0 0
- Optometrists: 4 1 0
- Osteopath: 0 0 1
- Palliative Care: 0 0 1
- Pharmacists: 0 0 0
- Prosthetists/Orthotists: 1 0 0
- Practice Managers: 1 8 0
- Private Hospital: 3 3 1
- Psychologists: 1 0 0
- Radiographers: 0 0 0
- Other: 2 1 2

Outside jurisdiction: 0 0 0

TOTAL 94 62 84

56% of public provider complaints were about the public hospital system (compared to 73% in 2007/08) while 34% of private provider complaints were about medical practitioners (compared to 50% in 2007/08).

(b) Complaints about hospitals

Around 30% of all complaints related to the hospital system (31% in 2007/08) and, as Table 8 illustrates, 80% of these were against Royal Darwin Hospital (RDH).

Table 8: Complaints about hospitals

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>06/07</th>
<th>07/08</th>
<th>08/08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Darwin Hospital</td>
<td>16</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Alice Springs Hospital</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Katherine Hospital</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Darwin Private Hospital</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Tennant Creek Hospital</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gove District Hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Total 24 19 25

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.

\(^{16}\) Due to a reorganisation this division and those following (Exec & Legal and HPLA) no longer exist.
(c) Complaints by medical specialty

Around 17% of all complaints related to medical practitioners (32% in 2008/09) and, as Table 9 illustrates, 86% of these were against General Practitioners (89% in 2007/08).

Table 9: Complaints by medical specialty

<table>
<thead>
<tr>
<th>MEDICAL SPECIALITY</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatologists</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Endocrinologists</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>General Practitioners</td>
<td>16</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>Medical Administration</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Obstetrician/Gynaecologist</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pain Management</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Physicians</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plastic/Cosmetic Surgeons</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Surgeons</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Urologists</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>27</td>
<td>20</td>
<td>14</td>
</tr>
</tbody>
</table>

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 can receive 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

<table>
<thead>
<tr>
<th>PROVIDER TYPE</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostel/Supported Accommodation</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mental Health (Public)</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Support - Disabilities</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disability Services (Public)</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Only two 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

<table>
<thead>
<tr>
<th>REASONS FOR CLOSURE</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enquiry concluded</td>
<td>5</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Complaint is resolved</td>
<td>36</td>
<td>24</td>
<td>32</td>
</tr>
<tr>
<td>Investigating further is unnecessary</td>
<td>33</td>
<td>11</td>
<td>29</td>
</tr>
<tr>
<td>Not resolve complaint with provider</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Been before court, tribunal or board</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Information under sec 25 not received</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Complaint lacks substance</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Complaint has been withdrawn</td>
<td>5</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Complaint over 2 years old</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Referred to relevant board</td>
<td>20</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Frivolous, vexatious, not in good faith</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Not a matter referred to in Sec 23</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Not a prescribed service</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>106</td>
<td>53</td>
<td>93</td>
</tr>
</tbody>
</table>

31% 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 (21% in 2007/08). Around 33% of complaints were closed during assessment because the issues identified in the complaints were satisfactorily resolved between the complainant and the provider (42% in 2007/08). 12% of complaints were referred to the relevant Board (24% in 2007/08).

2. Outcomes of Complaints

Table 12 shows the stage when complaints were resolved.

Table 12: Complaints resolved by stage

<table>
<thead>
<tr>
<th>STAGE OF PROCESS</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point of Service</td>
<td>40</td>
<td>14</td>
<td>40</td>
</tr>
<tr>
<td>Facilitated Resolution</td>
<td>14</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Assessment</td>
<td>25</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td>Referred to Board</td>
<td>14</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Conciliation</td>
<td>6</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Investigation</td>
<td>7</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>106</td>
<td>53</td>
<td>93</td>
</tr>
</tbody>
</table>

If closures relating to Board referrals are discounted, 89% of all other complaints were resolved without the need to proceed to the more formal processes of conciliation or investigation (87% in 2007/08).

Table 13 notes the outcomes achieved from closed complaints.
Table 13: Outcomes of complaints closed

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account adjusted</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Apology given</td>
<td>11</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Change in procedures/practice</td>
<td>8</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Compensation paid</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Complaint withdrawn</td>
<td>10</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Concern registered</td>
<td>21</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Conciliation Agreement Reached</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Disciplinary action taken</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Explanation provided</td>
<td>52</td>
<td>27</td>
<td>60</td>
</tr>
<tr>
<td>Policy change effected</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Referred elsewhere</td>
<td>41</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Refund provided</td>
<td>5</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Service obtained</td>
<td>18</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>Undefined</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>178</td>
<td>83</td>
<td>154</td>
</tr>
</tbody>
</table>

The major outcome received by complainants was to be given an explanation (45%). 14% of cases were closed as services were obtained.

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. As of the 1 July 2008 the grouping of issues changed following discussions between all Australasian health complaints commissions.

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 (373) and complaints (84) received.

Table 14: Primary Issues Raised in Enquiries/Complainants

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>90</td>
<td>106</td>
<td>101</td>
</tr>
<tr>
<td>Communication &amp; Information</td>
<td>43</td>
<td>44</td>
<td>56</td>
</tr>
<tr>
<td>Consent</td>
<td>15</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Discharge &amp; Transfers</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Environment &amp; Management</td>
<td>30</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>Fees, Costs &amp; Rebates</td>
<td>18</td>
<td>22</td>
<td>26</td>
</tr>
<tr>
<td>Grievances</td>
<td>6</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Medical Records</td>
<td>0</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>Medication</td>
<td>0</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>Professional Conduct</td>
<td>25</td>
<td>38</td>
<td>48</td>
</tr>
<tr>
<td>Reports &amp; Certificates</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Treatment</td>
<td>123</td>
<td>121</td>
<td>136</td>
</tr>
<tr>
<td>Out of Jurisdiction</td>
<td>8</td>
<td>23</td>
<td>17</td>
</tr>
<tr>
<td>Privacy/Discrimination</td>
<td>13</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>371</td>
<td>417</td>
<td>504</td>
</tr>
</tbody>
</table>

As was the case last year, issues dealing with treatment were the major reason why people made enquiries and complaints to the Commission (27%). This was then followed by access issues (20%).

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

Table 15: Access Category

<table>
<thead>
<tr>
<th>ACCESS</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refusal to admit or treat</td>
<td>5</td>
</tr>
<tr>
<td>Service Unavailable</td>
<td>6</td>
</tr>
<tr>
<td>Waiting list delay</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
</tr>
</tbody>
</table>

Issues relating to this category constituted 12% of all issues complained about. The major issue complained about was the unavailability of services.

Table 16: Communication & Information Category

<table>
<thead>
<tr>
<th>COMMUNICATION &amp; INFORMATION</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude and manner</td>
<td>16</td>
</tr>
<tr>
<td>Incorrect/misleading Information</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
</tr>
</tbody>
</table>

Issues relating to this category constituted 13% of all issues complained about. Complaints associated with the attitude and manner of a provider continue to be by far the most significant communication issue.

Table 17: Consent Category

<table>
<thead>
<tr>
<th>CONSENT</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent not obtained or inadequate</td>
<td>2</td>
</tr>
<tr>
<td>Involuntary admission or treatment</td>
<td>1</td>
</tr>
<tr>
<td>Uniform consent</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
</tr>
</tbody>
</table>

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

Table 18: Discharge & Transfer Arrangements Category

<table>
<thead>
<tr>
<th>DISCHARGE &amp; TRANSFERS</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay</td>
<td>1</td>
</tr>
<tr>
<td>Inadequate discharge</td>
<td>2</td>
</tr>
<tr>
<td>Mode of transport</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
</tr>
</tbody>
</table>

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

17 Represents the new categories since 1/7/08
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.

<table>
<thead>
<tr>
<th>ENVIRONMENT &amp; MANAGEMENT</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative processes</td>
<td>3</td>
</tr>
<tr>
<td>Statutory obligations/accreditation</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
</tr>
</tbody>
</table>

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

Table 20: Fees, Cost & Rebate Issues Category

Issues relating to this category constituted 5% of all issues complained about.

<table>
<thead>
<tr>
<th>FEES, COSTS &amp; REBATES</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing practices</td>
<td>5</td>
</tr>
<tr>
<td>Financial consent</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 21: Grievance Category

Issues relating to this category constituted 4.5% of all issues complained about.

<table>
<thead>
<tr>
<th>GRIEVANCE</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate or no response</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 22: Medical Record Category

This is a new category and it constituted 3% of all issues complained about with accessing and transferring records being the major concern.

<table>
<thead>
<tr>
<th>MEDICAL RECORDS</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to/transfer of records</td>
<td>3</td>
</tr>
<tr>
<td>Record keeping</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 23: Medication Category

This is also a new category and constituted 10% of all issues. Of particular concern was how medication was being prescribed.

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administering medication</td>
<td>2</td>
</tr>
<tr>
<td>Prescribing medication</td>
<td>8</td>
</tr>
<tr>
<td>Supply/security/storage of medication</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 24: Professional Conduct Category

Issues relating to this category constituted 14% of all issues complained about. The main issue complained about being the competence of a provider.

<table>
<thead>
<tr>
<th>PROFESSIONAL CONDUCT</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence</td>
<td>14</td>
</tr>
<tr>
<td>Discriminatory conduct</td>
<td>1</td>
</tr>
<tr>
<td>Emergency treatment not provided</td>
<td>1</td>
</tr>
<tr>
<td>Misrepresentation of qualifications</td>
<td>1</td>
</tr>
<tr>
<td>Sexual misconduct</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 25: Treatment Category

Issues relating to this category constituted 28% of all issues complained about. Issues associated with inadequate treatment and delay in treatment were of major concern.

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance</td>
<td>1</td>
</tr>
<tr>
<td>Coordination of treatment</td>
<td>2</td>
</tr>
<tr>
<td>Delay in treatment</td>
<td>7</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>4</td>
</tr>
<tr>
<td>Inadequate treatment</td>
<td>7</td>
</tr>
<tr>
<td>Infection Control</td>
<td>1</td>
</tr>
<tr>
<td>Non/inappropriate referral</td>
<td>4</td>
</tr>
<tr>
<td>Rough &amp; painful treatment</td>
<td>2</td>
</tr>
<tr>
<td>Unexpected treatment outcome/complications</td>
<td>4</td>
</tr>
<tr>
<td>Withdrawal of treatment</td>
<td>1</td>
</tr>
<tr>
<td>Wrong/inappropriate treatment</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
</tr>
</tbody>
</table>
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;
   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 and 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.

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.
**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:
   - legislative provisions restrict the right to access information; or
   - 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:
   - 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.
   - providing appropriate surroundings to enable confidential consultations and discussions to take place;
   - having policies and procedures in place, including policies relating to the storage of information, and ensuring all staff are aware of these;
   - 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:
   - make clear the standards of behaviour and language acceptable in the relationship between user and provider;
   - make clear the circumstances under which they will restrict or withdraw the services they provide;
   - 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.

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

1. Users have a right to:
   - involve their family, friends, carer or advocate in their care and treatment;
   - withhold information from family members, friends and carers on their care and treatment, or request the provider do so;
   - seek help from an advocate if required.

2. Providers have a responsibility to:
   - 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
   - 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:
   - 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;
   - inform users they can withdraw from the research, experiment or teaching exercise at any stage; and
   - 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:
   - provide a mechanism for users to give feedback or make complaints about their care and treatment;
   - inform users of the complaint process and of how to make a complaint;
   - ensure that complaints are dealt with in an open, fair, effective and prompt manner, and without reprisal or penalty; and
   - 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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