Health Services Commissioner

Annual Report
2000/2001

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STAFF OF THE HEALTH SERVICES COMMISSION AT 30 JUNE 2001

Office Manager	Michael McDonald has responsibility for the resource management functions of the office.
Conciliators	Keith Jackson, Teresa Punshon and Kath Kelsey assist parties to a complaint to a resolution in a confidential and privileged setting
Investigators	Orysia Ckuj, Pamela Gilbert and Lynn Griffin assess complaints, which have not been resolved in the initial stages, to determine what is required to bring about a resolution.
Registrar	Shiranee Sinnathamby is responsible for the case management of all complaints and inquiries and supervises the work of the inquiry officers.
Inquiry Officers	Heather Andrew, Jill Aitken and Piotr Nyczek are responsible for the handling of complaints and inquiries and provide advice to health service users and providers during the initial stages of the complaints resolution process.
Aboriginal Liaison Officer	Melanie Fraser is responsible for supervising and monitoring complaints concerning indigenous Australians and conducting outreach work. She also acts as an Inquiry Officer.
Systems Administrator	Philip Punshon is responsible for managing the office computer network and providing strategic information technology advice.
Executive Assistant	Kay MacAlister and Suzie Aron provided executive, administrative and keyboard support to the Commissioner and carries a small caseload.
Receptionist	Kate Kennedy, Julie-Anne Balash, and Sandra Popovski (Mental Health Review Board) provided receptionist duties for the office in the 2000/2001 financial year.

COMMISSIONER'S SUMMARY

This has been a year of progress and consolidation within the office of the Health Services Commissioner (HSC). Some important restructuring has taken place internally to ensure the requirements of our legislation are met as effectively as possible in the public interest. Much of the work undertaken during the latter half of the year under review will bear fruit in the next financial year. This has included staff restructuring.

Complaints handling is confidential and most are resolved in the early stages through mediation. Beginning in the next financial year more cases will go into conciliation much earlier in the process in the hope they can be resolved quickly in a confidential and privileged setting. This has meant responses to complaints are required sooner from health service providers than was previously the case. I take this opportunity to thank all providers, especially hospital management and staff, who have cooperated with us. Complaints that deal with issues of professional standards or allegations of misconduct are referred to the twelve disciplinary boards including the Medical Practitioners Board, the Dental Practitioners Board and the Nurses Board. Discussions with these Boards have been constructive and helpful at a policy level as well as during complaints handling.

Once again I thank all the consumers and advocacy services and the health service providers who have assisted my officers and I to resolve disputes by providing expert opinions and referring people to the HSC. We have received assistance from the medical, dental and other health professions who have assisted us willingly and ably. We could not have the success rate we currently do without this important assistance.

Health Records Act 2001

The *Health Records Act* 2001, passed in April 2001, has conferred significant new responsibilities on the office of the HSC and I am delighted that Victoria's Government has had the confidence to entrust us with this important work. The legislation recognises the extreme sensitivity of health information, establishes privacy principles and gives patients a legal right of access to information about them in medical records. The *Health Records Bill* 2001, as it then was, received the support of the Opposition and this bipartisan approach will be important in its implementation. Concerted efforts have begun in consulting with all relevant stakeholders to provide training, develop guidelines and ensure the legislative requirements are widely appreciated. The emphasis will be on assisting health service providers to comply with the requirements, advising consumers of their rights and conciliating complaints.

Complaints Liaison Officers

The HSC exists to provide an accessible and independent mechanism to receive and resolve health complaints with a view to improving the quality of health services. I continue to have a strong interest in quality assurance processes and encourage all providers to include the complaints liaison officers (CLOs) on their quality assurance committees to ensure complaints information is used constructively. I do, however, have some real concerns about the status of the CLOs in some hospitals. Research by Kay Currie (see page 20 of this report) has indicated they are bearing high work loads

and are not always receiving the support they need from management. The importance of including consumer representation on boards and committees is being increasingly acknowledged in hospitals and other health service provider organisations.

Policy Role

Efforts have continued during the year under review to make HSC more accessible to Aboriginal Australians and people from non-English speaking backgrounds. Outreach visits and exchange of information continues, however many patients still do not have access to trained interpreters and inappropriate use of family members occurs. Information about HSC and the *Health Records Act* 2001 will be provided in plain language and in translations. HSC has also been consulting with consumer groups and Government to contribute to policy initiatives. Close cooperation continues with important peak bodies like the Health Issues Centre Inc., which has initiated consultations and research into, among other things, mental health policy, consumer information and privacy. The HSC has also been a member of several Ministerial Advisory Committees.

During the year under review Michael Gorton as President of the Health Services Review Council (HSRC) has assisted my office with expertise, encouragement and advice. Council members have considerable expertise and I use this at every opportunity. I thank them for their assistance. They also provide an important line of accountability by reporting directly to the Minister for Health.

The relationship between the HSC and the Department of Human Services remains a partnership that respects the independence of the Commissioner and I am grateful for the expertise and advice of Department personnel. My staff and I have benefited, once again, from internal training seminars at which invited guests have presented information that has answered our many questions in an informal setting. The Commissioner thanks the following people and organisations:

Dr Mark O'Brien, Holy Spirit Hospital
Sitesh Bhojani & Tom Fahy, Australian Competition and Consumer Commission
Kirsten James, Consultant, Complementary Therapies
Roberta Honigman, Social Worker and Consultant
Roger Crowe, Ombudsman's Office, Victoria
Greg Lyons, Victorian Administrative and Claims Tribunal (VCAT)
John Snowden, Philips Fox
Kathy Liddell & Dianne Scott, DHS, *Health Records Act* 2001.

No organisation can function without the cooperation, loyalty and hard work of the staff. I take the opportunity to thank the staff of the HSC who have continued to carry out their work in an exemplary fashion.

Tribute to Liz Gallois

Liz Gallois commenced work with the HSC on 30 September 1991 until her retirement on 28 February 2001. I thank Liz for her significant contribution to the Commission in complaints handling and policy work. Liz had a particular interest in women's health and in breast screening programs. In her retirement she has (among

other things) pursued her considerable abilities in creative writing and, I and her colleagues, thank her and wish her well in her future endeavours.

Beth Wilson
Health Services Commissioner

HEALTH SERVICES REVIEW COUNCIL
PRESIDENT'S REPORT 2000/2001

I am pleased to report that the past year has been another active one for the Council.

The Council, working closely with the Health Services Commissioner, provides advice and support in relation to the issues dealt with by the Commissioner under the *Health Services (Conciliation and Review) Act* 1987.

In particular, the Act requires the Council:

- To advise the Minister on the health complaints' system and the operations of the Commissioner.
- To advise the Minister and the Commissioner on issues referred to it by the Commissioner.
- With the Minister's approval, to refer matters relating to health services' complaints to the Commissioner for inquiry.

Membership

As at 30 June, 2001, the Council comprised:

Mr Michael Gorton (President)
Dr Paul Nisselle
Mr Neil Wighton Naismith
Ms Pamela Barrand
Ms Dimity Fifer
Mr Anthony Seyfort
Ms July Rolfe
Dr Helen Rabbette

The composition of the Council ensures a broad representation of the interests and experience of providers in the health system, users of the health system and other members who bring an independent view.

We note the resignation during the year of Ms Anita Tang, who provided a valuable contribution to the work of the Council over her short period of tenure. Unfortunately, due to a move interstate, Ms Tang was unable to remain on the Council, and we offer our best wishes to her for the future.

We have recently welcomed Ms Marcia Coleman as a new Member.

Review of the Act

During the year, the Minister released a Discussion Paper in relation to the reform of the Act, importantly including:-

- increased functions and powers for the Commissioner;
- amendment to the role and functions of the Council;
- administrative changes to the processes under the Act;
- proposals and options for addressing complaints concerning unregistered providers of health services, which are not otherwise currently dealt with under the Act.

The Council was represented on the Working Party which assisted in the development of the Discussion Paper. The Council assisted in the promotion and dissemination of the Discussion Paper to ensure proper consultation throughout the community in relation to the issues raised.

The Council undertook much work in preparing its own submission in relation to the Discussion Paper, and we are pleased that the Council has had an opportunity to discuss its submissions with representatives of the Department of Human Services.

At the time of this Report, we note that proposed reform legislation is being developed. We are pleased that the Council has been consulted in relation to the development of the amending legislation and are confident that the *Health Services (Conciliation and Review) Act* 1987 will be strengthened and improved as a result.

Working with the Commissioner

The Council enjoys a strong working relationship with the Commissioner and her staff. Over the past year, the Commissioner has again played an important role in informing the community, consulting with the medical profession, and otherwise promoting the work of her office. We believe that, as a result, the office of the Commissioner is valued highly by the community, and is generally recognised as ensuring a fair and transparent process for the handling of complaints within our health system.

In particular, we note the strong work of the Commissioner in recent times dealing with difficult issues raised from complaints about cosmetic surgery. We note the active role taken by the Commissioner in promoting the need for greater communication between health providers and consumers. A significant number of the complaints received by the Health Services Commissioner relate to poor communication between provider and patient.

Importantly, during the year, the Commissioner, with the assistance of the Council, conducted a major conference in Melbourne. The Third National Health Care Complaints Conference "*Getting Better Together - Using Complaints to Improve the Quality of our Health Services*" was an important and successful event, with a large number of significant papers and presentations. It was a worthwhile contribution to the ongoing debate and development of complaint handling systems within the health

sector. The Conference culminated in a "hypothetical", which provided an all too real response from a broad range of participants for the fictitious scenario considered. The Commissioner and her staff should be congratulated for conducting such an important conference.

Health Records Act 2001

The Council has also been involved in consultations with the Commissioner in relation to the implementation of the *Health Records Act* 2001.

This important piece of legislation provides a new scheme to deal with issues of privacy and confidentiality of health records, access by patients and others, as well as the role of the relationship between doctors and patients.

The new legislation also, importantly, restructures the Council by the addition of two new members to specifically represent the issues involved with this legislation.

Although the new legislation will not be fully implemented until early next year, much work has already been undertaken by the Commissioner's office, and much consideration has already been commenced by the Council in relation to the requirements of the legislation. The Council has been fully briefed on the implementation program by the Commissioner.

Training and Prevention

The Council has also spent time in recent months developing a proposal to support the training and education functions of the Commissioner. The Council views prevention as being preferable to cure. It is developing proposals to create and adapt kits and materials for hospitals and healthcare providers to enable them to more properly deal with healthcare complaints at source, thereby obviating the cost, delay and effort required in dealing with formal complaints once they arise. Council's experience clearly indicates that, if complaints are dealt with at source, they are more readily resolved, more likely to address the concerns of all parties involved, and substantially reduce the costs to the institution or health provider associated with the complaint.

Specific Issues

The Council is also involved, on an ad hoc basis, in advising the Commissioner on a number of particular issues that arise. The Council, and individual Members of the Council, have been able to provide support and assistance to the Commissioner in relation to specific complaints and investigations conducted by the Commissioner's office. The Council assists in the development of submissions made by the Commissioner's office, and receives much material from the Commissioner's office in relation to current developments, legal issues and progress of work.

Thanks

Finally, we recognise that the work of the Council could not proceed without the support of a number of people.

First, we again recognise the tireless work of Beth Wilson, the Health Services Commissioner. Her consultative approach to her role is well recognised in the

healthcare industry. Her office provides support to healthcare providers, as well as assisting in advocating for users, particularly those less able to advocate for themselves.

We are grateful for the work of the Commissioner's staff, who are available at all times to assist the Council in its work.

We are particularly grateful for the support of the Minister and the Department, who have provided strong support for Council initiatives over the past twelve months, and consulted with the Council on each of the major developments that have occurred during that time.

Finally, I thank my fellow Council Members for their time and effort on so many tasks. We look forward to an active twelve months ahead.

Michael Gorton
President
Health Services Review Council

STATUTORY FUNCTIONS

THE ROLE OF THE COMMISSIONER

The Office of the Health Services Commissioner (HSC) was established in Victoria in 1988. The Commissioner's role is to receive, investigate and resolve complaints from users of health services, to support health care services in providing quality health care and to assist them in resolving complaints. The legislation also requires that information gained from complaints should be used to improve the standards of health care and prevent breaches of these standards.

The *Health Services (Conciliation & Review) Act* 1987 (the Primary Act) states that the Commissioner is to:

a) deal with users' complaints; and

b) suggest ways in which the guiding principles may be carried out and help service providers to improve the quality of health care.

The purposes of the Act include:

a) to provide an independent and accessible review mechanism for users of health services; and

b) to provide a means for reviewing and improving the quality of health service provision.

GUIDING PRINCIPLES

The guiding principles of the Primary Act promote:

a) quality health care given as promptly as circumstances permit; and

b) considerate health care; and

c) respect for privacy and dignity of persons being given health care; and

d) the provision of adequate information on services provided or treatment available in terms which are understandable; and

e) participation in decision making affecting individual health care; and

f) an environment of informed choice in accepting or refusing treatment or participation in education or research programs; and

g) reasonable access to information in records relating to personal use of the health care system except information which is expressly prohibited by law from being disclosed or information contained in personal notes by a person giving health care; and

h) the confidentiality of personal health records.

EXPECTATIONS AND STANDARDS

The guiding principles establish the range of responsibilities for health services and the basis upon which a person might complain that a breach of these responsibilities has occurred. They establish a framework for the HSC to become involved in improving health services and to report on the problems identified and improvements made.

OTHER STATUTORY ROLES

The HSC provides training to a wide range of health service users and providers. This is in accordance with our functions as outlined in section 9 of the Primary Act. A supportive working relationship exists between the HSC and the complaints liaison officers at public hospitals and many other health services in Victoria. Dialogue continues between the HSC, consumer representatives including the Health Issues Centre Inc. and health service providers and their associations.

In April 2001 the Government passed *the Health Records Act* 2001 (the HRA) which is a health specific piece of legislation designed to protect the privacy of health records and to give users of health services a right of access to health information about them. The HRA does not override existing legislation and the *Freedom of Information Act* 1982 (FOI) continues to apply to the public sector. The FOI legislation has been amended to ensure consistency with the HRA. The HSC will place a strong emphasis on working closely with all stakeholders to ensure the HRA is well understood.

LIAISON, TRAINING & PROMOTION

The HSC consults regularly with registration boards about complaint handling in accordance with section 19(6) of the Act. Regular meetings between the HSC and the Boards are held to determine the most effective and efficient ways of handling complaints about registered practitioners. This process avoids double handling and ensures the legislative requirements are met. The Commissioner also discusses relevant issues with the Ombudsman, the Mental Health Review Board, the Intellectual Disability Review Panel, the Office of the Public Advocate, the Coroner, the Commissioner for Equal Opportunity and other relevant authorities. These links assist our work, especially where the management of complaints involves more than one office.

The Commissioner places strong emphasis on promotion and training to improve accessibility of the HSC to the public and health service providers. During the year under review the HSC has been represented at many conferences and venues to promote the work of the Office. The Commissioner gave addresses, lectures and training at over 100 venues. Also other staff of the HSC delivered lectures and conducted workshops. Consumers of health services from the non metropolitan regions, children and adolescents, Koori and Aboriginal Australians and people from non English speaking backgrounds have been under represented as complainants and an outreach program has been introduced to make the service accessible to them. The employment of a full-time Aboriginal liaison officer has assisted with this. Her report appears on page 32.

The HSC is also committed to assisting students by providing placements and supporting research. During the year under review the following students were assisted:

Naomi Lillis - candidate for Masters of Health Psychology from Swinburne University of Technology. Co-supervised by member of HSC staff whilst undertaking qualitative and quantitative research evaluating the HSC complaints process. This research is expected to be completed in 2001 and results will be reported in the 2000/2001 annual report.

Roberta Honigman - candidate for Graduate Diploma in Conflict Resolution from LaTrobe University. Research involved a qualitative survey of "lost to follow-up" clients. That is, people who fail to confirm, an apparently serious complaint, in writing with the HSC.

Rhian Parker - Ph D candidate from Monash University, women's experiences of cosmetic and plastic surgery.

Natasha Guyfer - Melbourne University, women and prisons.

Elmira Nurmatova – Chisolm Tafe, Identification of and outreach to non-English speaking background community groups.

The Commissioner, Lynn Griffin, Professor Paul Mullen and Dr Grant Lester have been granted ethics committee approval for a research project: “The Unusually Persistent Compliant.”

THIRD NATIONAL HEALTH CARE COMPLAINTS CONFERENCE

On 29-30 March, 2001 the HSC hosted the Third National Health Care Complaints Conference, “Getting Better Together: Using Complaints to Improve the Quality of Our Health Services”. Over 240 delegates registered for the Conference, which was held at the Victoria University and opened by the Minister for Health, The Honourable John Thwaites MP.

Those in attendance heard keynote addresses from Professor Paul Mullen, Emeritus Professor Margaret Bennett AM, Dr Mark O’Brien and Dr Rowan Story. They participated in a number of sessions on complaint handling and listened to the highly entertaining and thought provoking hypothetical “The Black Stump Hospital scandal: Infection control, whistle blowers and the role of the media,” facilitated by Professor Graham Brown of Royal Melbourne Hospital.

OVERVIEW OF COMPLAINTS

Throughout this Annual Report anecdotal information has been used to illustrate the types of complaint received. **Details have been altered to protect confidentiality** and, wherever possible, actions taken or resolutions achieved have been indicated. Outcomes cannot be indicated where the matter is still in progress and the HSC does not make judgements or decisions about who is right or wrong. Instead HSC helps parties to resolve complaints themselves through mediation.

FORMAL INVESTIGATIONS

Last year HSC conducted two formal inquiries.

Investigation Into Repressed Memory Treatment

In March 1999 the HSC was contacted by Ms A, a resident of the United Kingdom. She was in Australia because of concerns about the well-being of her sister, Ms B (a trained nurse in her late thirties), who was residing in a Victorian country town (the Town). According to Ms A, her sister was a patient of a medical clinic (the Clinic) where she was being treated for amongst other things, depression. She was also receiving psychotherapy from a psychologist, Mr J. Ms A reported she was shocked at what she found when she visited her sister. Ms A said her sister appeared to be in a state of exhaustion. Issues raised by Ms A included possible financial and sexual exploitation of her sister. She questioned too, the medication which had made her sister very difficult to communicate with and counselling sessions which lasted for hours. She mentioned a "blackmailing" letter demanding money that had been sent to her father by a psychologist, Mr J.

Ms A was told that as HSC had no complaint from Ms B the Office could not intervene. She was told she could call the Crisis Assessment and Treatment Team (CAT Team) if she had concerns for her sister's mental health and she was advised of the roles of the Medical Practitioners Board of Victoria (MPBV) and the Phycologists Registration Board (PRB).

Under section 19(6) of the *Health Services (Conciliation and Review) Act* 1987 (the Act): "If a complaint relates to a registered provider the Commissioner must refer the complaint to the appropriate registration board if after consultation with the provider's registration board the Commissioner considers that the board has power to resolve or deal with the matter is not suitable for conciliation under the Act".

After consulting with the MPBV and with the PRB and after taking advice form the Health Services Review Council the HSC decided to request the Minister for Health to make a reference to HSC under section 9(m) of the Act asking the Commissioner to conduct a formal investigation of the Clinic.

The Minster was advised that HSC had received a complaint from the sister of a patient at the Clinic which involved allegations of possible financial and sexual exploitation. It had been brought to HSC's notice that the police at the Town also had some concerns about the practices at the Clinic. While the PRB and the MPBV have jurisdiction to deal with matters related to registered providers the Clinic also

employed people who were not registered practitioners. HSC can investigate any health provider whether registered or not.

On the 23 November 1999 HSC received the following advice from the Minister for Health:

> *"…The allegations you have outlined are of a serious nature and it is important that an investigation of the practices of [the Clinic] is undertaken in order to assess the accuracy or otherwise of these allegations.*
>
> *I therefore request that the Office of the Health Services Commissioner undertake a formal investigation of [the Clinic] in line with the advice you have received from the Medical Practitioners Board of Victoria, the Psychologists Registration Board and the President of the Health Services Review Council".*

The issues for investigation were:

- Is the health and/or safety of any user of the clinic services at risk?
- Is there any substance to allegations that the clinic is or was engaged in financial and/or other exploitation?

During the course of the investigation the Clinic closed. After extensive inquiries the HSC found that because the Clinic had closed the health and/or safety of any user was not currently at risk. With regard to the second term of reference the HSC found no evidence of financial exploitation by the Clinic but it noted that the clinical management of the patient by the general practitioner, Dr C and the psychologist, Mr J raised a number of concerns. The HSC decided that Dr C had allowed his judgement to be clouded. He told the HSC he had assisted Mr J in keeping the patient away from traditional psychiatric services. He said there was an agreement between himself and Mr J regarding this: "Dr C said he had an agreement with Ms B that they would do anything to prevent her involuntary admission. However, she had to agree to certain treatment conditions".

The Mental Health Act 1986 (Vic) governs the provision of care to involuntary patients with mental illness. It contains strict criteria which must be met before a person can receive a treatment as an involuntary patient. It also makes provision for independent review by the Mental Health Review Board. Dr C cannot come to private arrangements to "contract out" of the legislation or to use the purported agreement to get Ms B "to agree to certain treatment conditions."

Dr C was also aware of late night counselling sessions Mr J conducted with Ms B. Dr C visited her at the Hospital during this time and was aware of the medication she was on and the fact that she was in a state of exhaustion. He nonetheless did nothing to stop what was happening and appears instead to have encouraged it. His notes on her Hospital file include: "She states if there is anything more to be dug out I will not be able to stand for it". Eventually it was the nursing staff, not Dr C, who called a halt to the late night removal of the patient by Mr J. The HSC recommended that Dr C's management of Ms B be referred to the Medical Practitioners Board of Victoria for action.

The HSC had serious concerns about the psychologist, Mr J's, conduct and considered he put the health and safety of his patient at risk. As a registered psychologist he had a duty to uphold the standards of his profession and behave in an ethical way. HSC decided there was *prima facie* evidence that Mr J either created the illness in his patient, Ms B, or contributed to its longevity and seriousness. There is evidence in the form of the letter to Ms B's father that he did this for financial gain. The letter "requesting" payment of $30,000 in fees also contained a threat that legal action would be taken if the money was not paid. The HSC considers it was inappropriate for Mr J to seek fees from the patient's father in this way.

The HSC noted, "The area of repressed memory therapy is fraught with controversy and Mr J's treatment regime with the late night visits, the exhausted state of his patient, the claims of thousands of memories recovered from the age of two years following therapy sessions lasting for hours could not be described as professional. Mr J himself told the HSC that the recovery of so many memories was, amazing, incredible and difficult to believe."

While Mr J told HSC in the first interview with him he was not currently working as a psychologist he subsequently changed this and said he was treating some patients. This led HSC to find him not to be particularly credible.

The HSC recommended that Mr J's management of Ms B be referred to the Psychologists Registration Board for action.

HSC was particularly impressed with the evidence of Ms H, the trainee psychologist at the Clinic. Ms H was on placement at the Clinic where she found herself in a difficult situation. Although only recently qualified Ms H behaved professionally throughout and her oral evidence and notes indicate she clearly understood the importance of setting boundaries and of not being involved in treatment, which she considered to be unprofessional. She was criticised by Mr J for this but she remained steadfast to the professional standards of her training.

Monash Medical Centre – Infection control

On the 24 March 2000, HSC received a letter from the Minister for Health requiring an Inquiry under section 9(1)(m) of the Act. The terms of reference were:

1. Whether the systems in place at Monash Medical Centre (MMC) are adequate to ensure appropriate monitoring of hospital-acquired infections in the neonatal special care nursery and cardiac surgical unit; and

2. Whether actions taken to reduce hospital acquired infection rates in these two units have been adequate and successful and whether any further action is necessary.

HSC interviewed many experts and noted that:

In late 1999, Bill Birnbauer, *The Age*, made a FOI request to the Southern Health Care Network (HCN), concerning infection rates in the neonatal special care nursery and the cardiac surgical unit at MMC. On 27 February 2000 a newspaper article by Bill

Birnbauer was published in *The Sunday Age*. The article was about infection rates in the neonatal special care nursery and the cardiac surgical unit at the MMC and based on the information supplied under the FOI request.

The HSC received the terms of reference for the Inquiry on 24 March 2000, under section 9(1)(m) of the *Health Services (Conciliation and Review) Act* 1987.

The DHS, Quality Branch, had taken steps, since October 1999, to improve infection control in public hospitals, including requiring all public hospitals to provide a plan of their infection control strategies and protocols. A panel of experts had reviewed the plans and the Quality Branch, at the time of the Inquiry, was in the process of providing feedback and/or requiring further detail. The process included the MMC.

In April 2000, a comprehensive plan to improve infection control in public hospitals in Victoria was Tabled in Parliament by the Minister for Health. The range of infection control measures included the requirement of all Metropolitan Health Services and hospitals to develop a Strategic Management Plan for submission to the DHS.

<u>Discussion</u>

Infection control is a vital part of hospitals and public health services. If under-resourced, or if carelessness and poor attitudes prevail, the health and safety of the public are put at risk. While there will always be some risk, processes need to be in place to ensure that these risks are minimised. Infection control has not always been given the highest, or integrated, priority in our health services as hospitals strive to meet all demands. Media attention to the issue, for example, Bill Birnbauer's reporting in *The Age*, has been useful in increasing the awareness of hospital administrators, staff and the public to the importance of allocating adequate resources and improving infection control practices, monitoring and reporting.

Effective infection control requires changes in attitude, ownership of the problems and changes in behaviour in all areas of hospitals including – food services, rubbish collection, theatre procedures and sterilisation techniques, and the use of re-usable or single use items.

There is a dearth of risk-adjusted and validated data available on infection control and prevention in Victorian public hospitals. The situation is beginning to change with the DHS proposal for the establishment of an independent co-ordinating centre to provide advice and support for the Victorian Nosocomial Infection Surveillance System (VICNESS). It is envisaged that the Centre will "collect, feedback and publish aggregated, risk-adjusted, procedure specific infection rates and provide education and training to participating institutions.

The Southern HCN, its Board, MMC and the Infection Control Advisory Committee have been proactive in facilitating infection control best practices and in researching methods of evidence based proactive to contain and control infections.

A considerable amount of work has already been progressed in 2000 by the DHS, Quality and Continuity Care Branch concerning all Victorian public hospitals. The MMC, and the Board of Southern HCN, have been eager to identify and address

infection control issues. The Southern HCN Board has identified, in its Infection Control Strategic Management Plan 2000-2003, the need for additional financial resources in order to implement the Plan.

There are comparative, risk adjusted, data on deep sternal wound infection rates available from five cardiac surgical units, including MMC, as collected and analysed by the Victorian Infection Control Surveillance Project (VICSP). The most recent data are for the period August 1998 to May 2000. The statistics for MMC are almost identical to the aggregate for the five hospitals. There is no significant difference between the five hospitals.

MMC provided data on cardiac surgery surgical site infections for the period February 1999 to September 2000. These show the number of people having cardiac surgery by month, the number of infected patients and those who developed deep sternal wound infections. The data are not risk adjusted. Deep sternal wound infections appear to be an uncommon event, with 13 cases from almost 600 surgical procedures (or 2.2%), between February 1999 and September 2000.

Data are collected on in-patients only. Because only in-patient data are collected the possibility exists, therefore, that discharged cardiac surgical patients may have a nosocomial infection but not be counted in the statistics. This may lead to undetected rates of nosocomial infections (excluding deep sternal wound infections) as lengths of stay decrease. Hospitals performing cardiac surgery, including MMC, should consider measuring nosocomial infection rates following discharge. ~~Ultimately this is a resource issue which needs to be addressed.~~

MMC provided data on levels and groupings of staff, from senior clinicians to ward cleaners, who had attended in-service/orientation on infection control. The information provided indicated that nursing staff regularly attended infection control training and up-dates. However, medical staff were not proportionally represented in the data. It appears that more needs to be done to ensure that medical staff are educated in infection control and prevention.

<u>Findings</u>
In response to the first term of reference –

1. Whether the systems in place at Monash Medical Centre (MMC) are adequate to ensure appropriate monitoring of hospital-acquired infections in the neonatal special care nursery and cardiac surgical unit;

The monitoring of nosocomial infections is clearly recognised by health care professionals to be an ongoing challenge. It has been identified as a current priority area and is receiving extra resources from the DHS. These initiatives are supported by Government policy, receive DHS support and leadership in the arena of infection control and prevention. MMC has submitted an infection control plan, to the DHS, which has resource implications.

The DHS has recently completed a review of all public hospital infection control Plans and will advise MMC, and all other public hospitals, of their suitability and acceptability.

The MMC Cardiac Surgical Unit and New Born Services have identified, through regular meetings and audits, infection control and prevention and important changes have been implemented.

The MMC has identified, in its recent Infection Control Strategic Management Plan 2000-2003, that the systems in place are not "adequate to ensure appropriate monitoring of hospital-acquired infections". Further "There is obviously a need, as recognised by an external review, for an effective coordinated Southern Health infection control service that meets the needs of all sites and programs." The Southern HCN is seeking resources considered necessary to implement (world) best practice in respect of infection control and prevention. HSC considers that infection control is a core function within all hospitals.

In response to the second term of reference –

2. Whether actions taken to reduce hospital acquired infection rates in these two units have been adequate and successful and whether any further action is necessary.

The definition of "successful" is taken to be a reduction in the number of infections detected, or the proportion of people who become infected.

As a generalisation, further action will always be necessary and constant vigilance required to address and support infection control and prevention issues.

The review of infection control services of the Southern HCN, commissioned by the Board and authored by Professor Wesselingh and Ms Harrington, provides expert opinion on the optimal structure for the delivery of an effective infection control service for the Network. The recommendations are reflected in the Network's Infection Control Strategic Management Plan 2000-2003, August 2000.

Recommendations

The HSC endorses and supports the measures of the DHS in implementing Government policy on infection control and prevention utilising best practice. These proposed changes and improvements (towards best practice) have resource implications which are being addressed by the DHS and Government. Provision of risk adjusted, validated data to allow for comparison between hospitals is of paramount importance.

Recommendations that could be made for improvement of the cardiac surgical unit and newborn services are already addressed in the DHS documents and Southern HCN Strategic Management Plan 2000-2003.

The standardised (Statewide) system of definitions, collection, monitoring and reporting on hospital acquired infections Victoria wide – reportable to VICSP/VICNISS or similar – for cardiac surgery, neonates and other procedures, of all nosocomial infections is currently being pursued.

The Victorian Advisory Committee on Infection Control (VACIC) should continue to address the issue of infection control orientation and on-going training of medical, nursing and other staff groups within the public hospital system. This process could include standardisation of course content, duration and quality processes which ensure active involvement of all staff, particularly medical staff.

Consumers have a right to expect the achievement of world's best practice in infection control and prevention and the right to know if it is not being achieved, and the reasons why. Publication of infection control risk adjusted data, for all procedures, is recommended following a reasonable pilot period of adjustment.

PUBLIC INTEREST ISSUES

Complaints can indicate trends within the health care system that have implications for the general public. Public interest is defined by the following criteria:

1. The circumstances outlined in the complaint are likely to affect a significant number of people.

2. These circumstances impact on certain population groups.

3. The complaint is indicative of a systematic flaw, the result of a deficiency in policy or procedures.

4. The complaint raises an issue that is individual in nature but that occurs unreasonably often, suggesting that a systemic problem exists.

These criteria have been used to highlight complaints as they move through the system so the public interest issue may be given appropriate attention in conjunction with the individual's complaint. A review of complaints so labelled has highlighted a number of issues.

MEDICAL RECORDS

Most of the complaints received by the HSC contain failures of communication. The Commissioner has concerns about the poor state of record keeping by many health practitioners. The courts in Australia have made it clear in cases like *Kite v Malycha* SASC 6702, 10 June 1998 that poor record keeping could be the basis of a medical negligence claim. Frequently the writing is difficult to understand which has the potential to cause further mistakes and to damage patients. Sometimes there are serious omissions in medical records with doctors saying they are too busy to complete the record. This places doctors at risk of medical negligence claims and the patients may be harmed because valuable information is not available. Medical practitioners need to take into account the fact that the *Health Records Act* 2001, which will begin operation in March 2002, will grant patients a legal right of access to information in records about them. The legislation also obliges organisations that handle health information to do so in accordance with eleven privacy principles which appear in the schedule to the Act. Good record keeping is part of good health care. Some providers who counsel families adopt the risky practice of keeping one set of

notes. This is problematic where the family subsequently separates and one side may subpoena the records for a court hearing.

STATUS OF COMPLAINTS LIAISON OFFICERS

In Victoria, there are over 150 complaints liaison officers (CLOs) who work in the public and private hospitals and other larger medical practices. It is the responsibility of these officers to deal with complaints at the local level so they might be resolved quickly. These people receive support and training from the HSC and many have attended for orientation days. Information technology support is also provided. Their work is difficult and very important.

In the year under review a thesis for the degree of Masters of Public Health, Monash University was completed by Kay Currie. This indicated that the status of CLOs in some of our hospitals is poor. The best CLOs are those who receive good support from management of their facilities. It is the experience of the HSC that the best hospitals also have well trained and supported CLOs. Kay Currie's research is summarised below.

Mechanisms to resolve point of service complaints in acute public hospitals are variable between as well as within organisations. Complaint processes are not specified in legislation or by accompanying regulation; consequently, what mechanisms there are, tend to reflect the underlying culture and philosophy of the organisation. There may be a centralised system closely allied to quality or risk management activities or alternatively, complaint handling may be disseminated throughout the organisation, with prime responsibility resting with individual supervisors and unit managers. The *Health Services (Conciliation & Review) Act* 1987 does state that where reasonable and appropriate, complaints should be resolved directly with the service provider in the first instance. Additionally, the Act suggests that complaints management should be associated with quality assurance (section 10f) but is unclear on how this is to be achieved.

The aims of this study were to:

- Look at the different models of complaint management in acute care metropolitan and regional public hospitals in Victoria.
- Profile CLO's in terms of their background, training and structural position within their organisations, and
- Determine the relationship between models of complaint management in acute care metropolitan and regional public hospitals in Victoria and the number of complaints received by that hospital.

There is only limited general research on the staff that handle complaints in acute health care settings and little is known about their qualifications, skills or training in Victoria. There has never been a statewide evaluation of the mechanisms applied in point of service complaints management in acute public hospitals and therefore little evidence on which to determine what might constitute a best practice model.

CLOs at metropolitan and regional acute care public hospitals were asked to complete a survey questionnaire after Chief Executive Officers were informed about the study.

A focus group of six CLOs was also conducted on a range of issues around the handling and resolution of complaints.

Complaint Liaison Officer was a designated specialist role in 78% of metropolitan hospitals but only 10% of regional hospitals had a specialist role. Most were female (70%) and aged between 40 – 59 (77%). The median length of time in the CLO position was under 2 years. Complaint staff had little in common on skills, background, or qualifications, but 86% had a tertiary qualification, not specific to their role in a diverse range of fields. While 63% of complaint liaison officers had undertaken some training in complaint management, this was principally related to 1 - 3 days orientation provided on initial appointment. Only 46% of CLOs specified a particular model of complaint management with most of these (78%) being from metropolitan hospitals. Specialist CLOs were significantly more likely to be members of a peak body. Where there was a specialist complaints management role, complaint issues categories relating to ***access to care*** were significantly higher but ***treatment issues*** were lower. There were also significantly more complaints received and recorded in hospitals with a specialist CLO than those without.

In the focus group discussion CLOs reported often feeling under prepared for the range of tasks required, inadequate training opportunities and a lack of organisational and senior management support. Stress and "burn out" were issues of concern and 61% had access to internal debriefing services. Given the sensitivity of the issues handled and staff involvement it was surprising that access to external debriefing was the exception. The CLOs indicated the data generated was under-utilized by the organisation and often devalued as a quality indicator. While there was consensus in the group on the need for better training, there was little agreement on the priorities or what was the most appropriate type of training with the exception of counselling skills.

This study highlighted some of the differences in approach to complaint management and suggests that many hospitals consider patient complaints a low priority. The diversity in the qualifications and seniority of CLOs, and in their education, training and skills, levels of autonomy, and degree of involvement in organisational quality processes, demonstrated the different models or frameworks used by hospitals to manage patient complaints. The lack of supporting evidence of the effectiveness of the different models would suggest that much more research is required. In an era of evidence-based medicine, it seems reasonable to require practice not to be just based on available evidence but also to seek to establish such evidence through rigorous research.

UNREGISTERED PROVIDERS

Last year the HSC was involved in a court case, *R v Patterson*. This dealt with the issue of an unregistered provider being charged with sexual offences under s51 of the *Crimes Act* 1958. The provider was subsequently acquitted. When the HSC is dealing with registered practitioners, and matters of sexual misconduct arise, these can be referred to the relevant medical registration board for formal inquiry and investigation. There are no boards available to deal with complaints about unregistered providers. In Victoria it is possible for a person to be deregistered for professional misconduct but to subsequently practice as a counsellor or even

psychotherapist. While the HSC has jurisdiction over these practitioners it is often difficult to resolve complaints because there is no registration board.

RURAL ISSUES

HSC has been contacted by patients from the regional areas of Victoria who complain that waiting lists are very long in the regions and hospital managers in Melbourne do not understand their situation nor cater to their needs. As a result people from places like Mildura prefer to travel to Adelaide where hospitals are apparently more sympathetic to rural concerns.

A woman required surgery. She paid over $350 in airfares to travel to Melbourne and her accommodation was booked. When she arrived, she was told the surgery was cancelled and she should return to the Hospital in a week. There was no consideration given to the fact that she lived so far away, nor to the expenses she had incurred.

A patient had multiple polyps in her nose that caused discomfort and was embarrassing. The condition had disadvantaged her socially and in her search for work. The waiting list at her local regional hospital was two years. The woman felt she had no option but to have the operation in a private hospital in Melbourne that was expensive and inconvenient.

The Commissioner is aware that the Minister for Health has asked the Department of Human Services and the Advisory Committee on Elective Surgery to develop a set of protocols to address this problem. The protocols are expected to be completed early in the next financial year and HSC considers these should be implemented as a matter of urgency.

ANALYSIS OF COMPLAINT TRENDS

2000/2001 SUMMARY

Complaints and enquiries are received on the telephone, by mail and in person. Some of these can be handled immediately and are recorded as enquiries. The total number of enquiries and cases for 2000/2001 is 9786 compared with 9654 in 1999/2000.

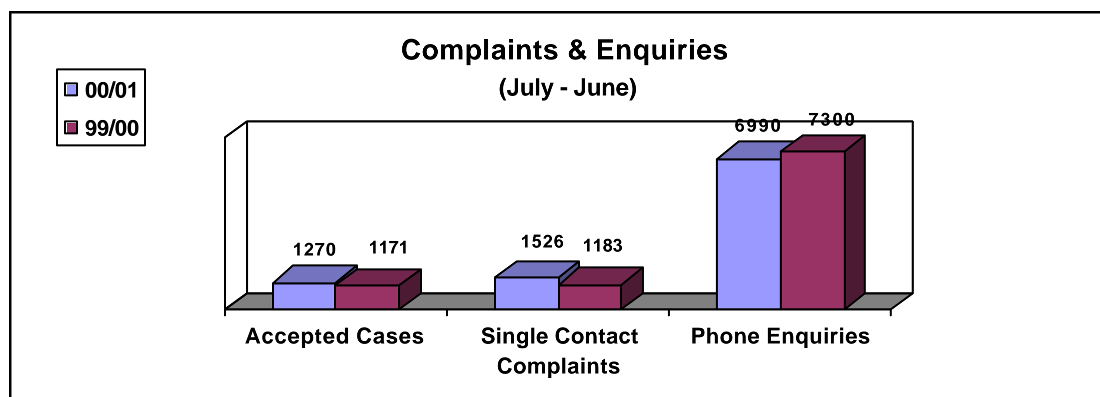
As is consistent with previous years a timely response and explanation, accompanied, where appropriate by an apology, is the best way to resolve disputes quickly. On the other hand delays, secretiveness, a refusal to apologise and unnecessary delays escalate disputes. The Commissioner is grateful to all providers who responded to complaints and assisted in their resolution. Thanks are also due to consumers who take the time and effort to lodge a complaint. All parties are encouraged to view complaints in a positive way so they can lead to quality improvements.

Table 1 below shows the complaints and enquiries received by the Commissioner during 2000/2001 and the figure gives the number of complaints and enquiries for the past two years.

Table 1. New Complaints and Enquiries

Enquires by telephone	Complaints		Total
	Single contact	Accepted Cases	
6990	1526	1270	9786

Figure 1. Complaints & Enquiries



In 2000/2001 the total number of enquiries was 6990 compared with 7300 in the previous year. This is a decrease of 310 or 4.25% over the previous year. As in previous years approximately half of the complaints and enquiries received by the HSC are closed following a single contact. The other half proceed to be accepted cases.

ENQUIRIES

An enquiry is defined as a contact with the Office that does not develop into a complaint case. A telephone enquiry can often be resolved immediately. The caller is given advice or referred appropriately. Potential cases, where the caller makes initial contact to receive advice or information about a health complaint but makes no further contact accounted for 1836 of these enquiry calls.

Table 2. Telephone enquiries

	Total	%
Potential Cases	1836	26%
Assistance & Referrals Given	5154	74%
Total calls	**6990**	**100%**

In the period from July 2000 to June 2001 the Office received 6990 telephone enquiries. Seventy four percent of these callers were assisted or referred to other agencies. Of these:

- 13% related to fees
- 13% to food and environmental health issues
- 35% were matters outside the HSC jurisdiction in which the caller was referred to another agency

- 6% concerned access to records

- 5% were about health insurance issues and the remaining related to public hospital waiting lists, Aboriginal enquiries and other non-specified matters.

SERIOUSNESS

Although all complaints are serious to the individuals concerned, and all are handled with diligence, for management purposes complaints are rated on a scale for seriousness when they are first accepted by the Commissioner and again when they are closed. It is often difficult to assess seriousness at the start of a complaint. This practice of revising the rating at the time of closure has led to fewer complaints being rated as serious or substantial and to more being rated lower on the scale.

Seriousness Rating

1. Trivial: frivolous, vexatious, obviously misconceived or where an investigation is unwarranted.

2. Minor: the problem is easily resolved by a phone call or letter and an explanation is sufficient

3. Routine: there has been a misunderstanding; issues frequently involve access to records, disputes about costs, discourtesy, diagnostic or treatment errors without serious sequel.

4. Substantial: there are significant quality assurance implications, changes in practice are needed to avoid a recurrence or there is a need for policy development.

5. Serious: usually associated with personal injury, professional misconduct, unlawful or unethical acts, lack of informed consent with adverse outcomes

Table 3. Seriousness by Issue at Closure 2000 - 2001

	Trivial	Minor	Routine	Substantial	Serious	Total
Access	52	81	140	30	7	310
Administration	11	21	24	4	1	61
Communication	39	104	202	21	8	374
Cost	28	66	46	1	0	141
Rights	23	59	147	34	21	284
Treatment	176	249	824	394	67	1710
Not spec	71	3	20	3	1	98
Total Closed	**400**	**583**	**1403**	**487**	**105**	**2978**

During the period under review 2978 complaints were closed of which 1403 (47%) were regarded as routine, 583 (20%) minor, 487 (16%) substantial, 105 (4%) serious and 400 (13%) trivial. Of the substantial and serious complaints 461 (78%) involved

treatment issues, 55 (9%) rights issues, 37 (6%) access issues, 29 (5%) communication issues and 5 (1%) administration issues.

Treatment issues regarded as serious or substantial primarily consisted of negligent treatment (27%), inadequate treatment (25%), inadequate diagnosis (17%) and unskilful or incompetent treatment (13%).

Serious Complaint

A man injured his hand while playing sport. He went to a nearby emergency department of a public hospital where an x-ray was taken and a doctor examined him. He was told the hand was not broken and he should rest it. A support and sling were provided. The pain continued over the following week, so the man visited his usual doctor for advice. On examination the doctor thought the hand was broken and ordered another x-ray that confirmed the fracture to the base of the thumb. A review of the first x-ray showed an undisplaced fracture at the site. The doctor from the Hospital apologised, acknowledged the fracture had been missed and explained it was hard to see on the x-ray as the hand had been too swollen to examine properly at the time. The Hospital offered to provide some physiotherapy to assist the man in recovery and this offer was accepted.

Substantial Complaint

A woman from a non-English speaking background was admitted to a hospital for the birth of her first child. The labour was long and difficult and the baby was born unwell and spent considerable time in intensive care. Eventually the child appeared to be doing well. The woman complained that this could have been avoided if the Hospital had conducted a caesarean delivery rather than allowing her to deliver that baby vaginally. The HSC asked an independent expert to review the woman's anti-natal and labour records and to comment on the care provided. The expert advised that the baby had some identified problems prior to birth and there would have been less risk to the child if a caesarean section delivery had been performed. The Hospital apologised to the woman and said that the doctor involved had been counselled and they would ensure an experienced doctor would be available at all times in the future. The woman delayed her compensation claim because the child was too young to be assessed at that time.

COMPLAINTS

In the twelve months under review the Office received 2796 new complaints comprising 1526 single contact complaints, where the complainant is encouraged to approach the health service provider to seek a resolution, and 1270 complaints (accepted cases), which were confirmed in writing. This represents a 7% increase over the previous year.

WHO COMPLAINED?

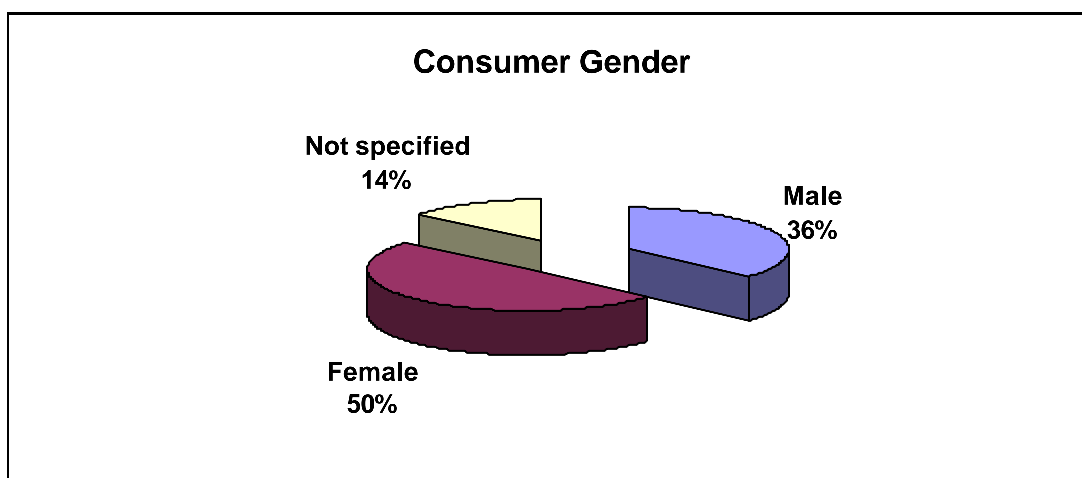
A complainant is defined as the person who makes the complaint. This is most often the patient or user of the health service. In the period under review 67% (1872) complaints were lodged by the user, 23% (649) complaints by a recognised

representative (where the user is a minor, or has a legal guardian), 8% (215) were made by a chosen representative of the user and in 2% (56) were unspecified. Health service providers lodged four complaints on behalf of patients. Complaints from providers can only be accepted where the patient nominates the provider to represent them and the Commission accepts that they have a sufficient interest or where the patient cannot complain because of, for example, incapability.

Table 4. Consumer Profile

	Female	Male	Not specified	Total
Under one	10	14	2	26
1-4	24	29	4	57
5-14	24	30	3	57
15-24	34	33	1	68
25-34	93	48	1	142
35-44	103	41	1	145
45-54	76	39	3	118
55-64	43	36	1	80
65+	121	77	2	200
Not specified	867	668	368	1903
Grand Total	1395	1015	386	2796

Figure 2. Consumer Profile



Consistently more complaints are received from women than from men. Women tend to come into contact with health services more often and they are frequently carers complaining on behalf of others.

HOW COMPLAINTS ARE MANAGED

The Act requires that complaints made on the telephone or in person be confirmed in writing. Assistance is offered to people needing it, however many preliminary complaints are not confirmed in writing. The legislation anticipates that consumers will attempt to resolve issues themselves wherever possible and staff advise

complainants, where appropriate, to make direct contact with the service provider. It is hoped that many of the unconfirmed complaints are resolved in this way.

RESOLUTION BY ENQUIRY OFFICERS

The enquiry telephone line operates from 9am to 5pm, five days a week. At other times messages may be left on the answering machine. Enquiry officers are usually the first point of contact for members of the public and have a broad knowledge of health issues and, where appropriate, provide referrals to other agencies if the enquiry does not come within the jurisdiction of the HSC.

When enquiries are received by telephone, an enquiry officer listens and assesses the issue/s the caller is presenting. If the complaint is about a health service provider, and the complainant is unable to resolve the matter directly, a complaint form is sent out. The caller is asked to complete the form and give details of the complaint.

Enquiry officers record all potential complaints on the database. If a complaint is not confirmed in writing, the matter is closed. If a complaint is from a person from a non-English speaking background the enquiry officer may access interpreter services and assist the complainant in lodging the complaint. Enquiry officers also interview prospective complainants when they present in person.

Confirmed complaints are entered on the database in detail, including a summary of the complaint. A hard file is made up and an acknowledgment letter sent to the complainant. An accepted complaint is sent to the health service provider who is asked to respond within 28 days. A response may be in writing directly to the complainant or sent via the HSC depending upon the circumstances. The majority of accepted complaints are resolved at this stage. A provider may prefer to arrange a meeting with the complainant in an endeavour to resolve the matter.

If the complainant remains dissatisfied, HSC requires a response from the user outlining the unresolved issues. If the complaint requires further assessment or is close to resolution an extension of time by another 28 days may be granted.

Enquiry Officers carry a caseload of approximately 75 cases each.

Table 5 below shows the broad resolution categories for these complaints.

Table 5. Resolution by Enquiry Officers

Outcome	1999/00	2000/01
Declined	26%	17%
Referred elsewhere	5%	2%
Withdrawn by user	6%	6%
Investigation unwarranted	0%	1%

Unsubstantiated	0%	0%
Remedial action	4%	1%
Fee waived/reduced	4%	3%
Procedural change	2%	5%
Explanation offered	51%	62%
Apology	2%	3%

The most effective means of resolving complaints is where the provider responds in a timely and empathetic way. An apology, where appropriate, is also useful. **Most people who do lodge complaints want to know what went wrong and why, and they want to make sure the same thing does not happen to someone else. In other words, they are seeking quality improvements.**

A man lodged a complaint about a podiatrist because the podiatrist had been rough, he hurt him and made his toe bleed. The man wanted his money refunded. The HSC sent the complaint to the podiatrist who contacted the man and said he would refund the service fee. He also apologised. The podiatrist refunded the money quickly and within five days of receiving the complaint it was closed with both parties satisfied with the outcome.

RESOLUTION BY INVESTIGATORS

The Investigators' role includes acting as team leaders for the Inquiry Officers and this means the reading and accepting or declining of all new complaints into the office and giving advice on the management of accepted complaints.

Most complaints (approximately two thirds) are resolved in the initial stages by sending them to the service provider and asking for a response. Those that are not resolved by this process are then assessed by the Investigators to see how they might be resolved.

The options for resolution are informal resolution during assessment, referral to conciliation or investigation by the Health Services Commissioner or external referral to a professional registration board.

Resolution during assessment might involve the investigator contacting other treating health services, obtaining medical records and reports, seeking expert opinions and conducting meetings between the parties. Complainants may be assisted to obtain their own evidence to support their case where they remain dissatisfied with explanations offered by the service providers.

A family complained to the HSC, following the death of an elderly man, that his general practitioner had failed to diagnose and treat his condition. The man had collapsed and had been admitted to hospital but had died soon after admission. The cause of death was heart failure that had been present for a number of years.

In his response to the family, the general practitioner said that his patient had been well aware of his heart condition but had declined to have any treatment

other than medication to manage his blood pressure. The family found it hard to accept that their father would have kept his condition hidden from them and wanted to pursue their complaint.

In assessment, the investigator spoke first to the general practitioner, and then to a cardiologist who had seen the man for regular check ups. The cardiologist agreed to speak to the man's family. The records were discussed and the cardiologist was able to confirm that it had been his patient's wish that his family were not "burdened" with information about his illness. The family accepted the man's care had been appropriate and the case was closed.

Complaints are referred to conciliation if the parties agree to the process and their understanding of the issues to be addressed is similar. Commonly, issues of compensation would be referred to a conciliator but other issues might also be addressed.

Many health service professionals are registered providers. This means they must be registered to work in their profession. Examples of registered providers are doctors, nurses, dentists and psychologists. Referrals to professional boards occur where there appears to be an issue of professional standards to be considered or where the matter is clearly not suitable for conciliation. If a registered service provider refuses to respond to a complaint, or responds inappropriately, sometimes a referral to the relevant board is the only option.

The attitude of the complainant is also a deciding factor in whether a complaint needs to be referred to a Board. If the complainant is not conciliatory and is seeking a disciplinary outcome, or a judgement from the profession, these are outcomes that may be more appropriately pursued through the boards.

Where a matter is not suitable for conciliation but is related to an unregistered provider, the Commissioner may ask an investigator to conduct a formal investigation. The investigator acts as the Commissioner's delegate in collecting evidence to decide if a complaint is justified. Investigation includes powers to require attendance and the production of documents, hear evidence on oath and obtain warrants to inspect premises and examine witnesses. After an investigation the Commissioner will make recommendations for the resolution of a complaint.

In fulfilling these roles, the investigators rely on the assistance of a range of professionals who provide expert advice in the resolution of complaints. This assistance is greatly appreciated by the Commissioner and her staff.

In the year 2000/2001, 476 complaints were not resolved in the initial stages and so were referred on to investigators for assessment. Of these, 306 (65%) were resolved in the assessment stage, 97 (20%) were referred on to conciliation and 73 (15%) to professional boards or other agencies.

In 2000/2001, the investigators resolved 304 or 10% of complaints. Of these, the greatest number (153) were resolved with a further explanation received from the provider.

Investigators participate in policy development, in the training and/or orientation of hospital complaints liaison officers and other staff, and represent the Commissioner in giving talks and in training community and professional groups, and attendance at conferences.

Table 6. Resolution by Investigators

Outcome	1999/2000	2000/01
Declined	13%	12%
Referred elsewhere	3%	2%
Withdrawn by user	5%	2%
Investigation unwarranted	1%	2%
Unsubstantiated	14%	7%
Remedial action	3%	4%
Fee waived/reduced	7%	4%
Procedural change	6%	3%
Explanation offered	47%	59%
Apology	1%	5%

Investigators collect further information about complaints such as medical records, reports and opinions, so complaints are more frequently closed as unsubstantiated at this stage.

CONCILIATION REPORT

The year under review has been particularly challenging as preparations in the latter half were made for future changes that will significantly expand the conciliation team.

Conciliation continues to be regarded by health service consumers and providers as a successful mechanism for the resolution of complaints, including matters that might otherwise be dealt with by litigation. Of all complaints unable to be resolved in the initial stages, 20% were referred to conciliation.

The willingness of public and private hospital staff across the State to participate fully in the conciliation process, assists the timely resolution of hospital complaints to the satisfaction of the participants.

Issues about communication continue to be a common cause of complaints. The open and honest exchange which is encouraged during the conciliation process goes a long way towards addressing these problems.

An uninsured woman went to a public hospital as a private patient to give birth. Following the delivery, her daughter suffered complications and was taken to the special care nursery for treatment for a lengthy period of time. The woman's obstetrician referred the baby's management to a paediatrician of the same cultural background as the parents, to encourage smooth communication. The family were very happy with the paediatrician's care and thought it was all part

of the excellent service provided by the hospital. Subsequently, with both mother and baby safely home, the woman received bills from the hospital for herself and her daughter who was not covered by any private insurance. The woman's husband complained that she had not been given the option of deciding whether their daughter was to be treated as a public or private patient. In any case, the paediatrician who treated his daughter was also the consultant on duty.
The hospital tried to reduce the bill by encouraging the paediatrician to accept the Medicare rebate only. However, the doctor refused on account of the succession of heated arguments that he had with the woman's husband. The hospital then instituted recovery proceedings. During the conciliation process it was discovered that the hospital staff had failed to arrange for the patient to elect the private/public status of the baby. They acknowledged that their communication procedures had failed. As a result they changed their admission processes and agreed to waive the outstanding account.

Once again we would like to acknowledge the vital role of the independent consultants who provide opinions for conciliation purposes. The opinions are invariably provided willingly and are essential to the continued success of conciliation in the HSC.

The conciliation process often involves close liaison with lawyers for all parties and relations with the legal firms involved have generally been excellent.

As in previous years, senior conciliators continue to provide mentorship for the conciliators in the equivalent organisations interstate and this has resulted in a consistent approach to conciliation of health complaints.

Table 7. Resolution by Conciliators

Outcome	1999/2000	2000/01
Agreement reached	87%	89%
Withdrawn by user	9%	8%
Withdrawn to go to law	4%	3%

REGISTRAR'S REPORT

The major function of the Registrar for the year ending June 2001 was consulting with all registration boards in relation to consumer complaints. Internal case management, managing the enquiry function and considering Freedom of Information requests are also the responsibility of the Registrar. Three requests under the *Freedom of Information Act* 1982 were processed with full access being granted.

The practice of registration boards faxing through to HSC all consumer complaints as soon as they are received for the purpose of early discussion, and referral where appropriate, has continued. Regular meetings with the Registrars of all Boards have been ongoing. This exchange of information has resulted in complaints received by boards which are suitable for conciliation by the HSC being referred to the Commissioner without delay and complaints received by the Commissioner which

may fall into the category of unprofessional conduct being referred by the Commissioner to the relevant registration board either following a response by the health service provider or upon receipt, dependent on the nature of the complaint. Sexual misconduct complaints are referred by the Commissioner when they are received. Although complaints are referred to boards, complainants are aware that, following a boards' processes, they may approach the Commissioner for re-activation of their file in the event that unresolved issues remain which were not considered by a registration board. The health service provider is also aware of this possibility.

During the period under review 73 complaints received by HSC were referred to Registration Boards. Of this, 59 were referrals to the Medical Practitioners Board of Victoria of a total of 1107 complaints received about the standard of care provided by medical practitioners.

The Registrars Meetings which commenced in December 1998, continue to be held regularly. These meetings generate much interest and are seen as a useful forum for registrars of health registration boards to share ideas and plan for the provision of improved and enhanced services to consumers of health services as well as registrants.

ABORIGINAL LIAISON OFFICER'S REPORT

During the 2000/2001 year, the Aboriginal Liaison Officer ("ALO") held a multi-faceted role within the Office. She continued to promote the services of the Office to Aboriginal communities and attended to complaints from indigenous health service consumers. She also attended to mainstream enquiries and provided a consultative role to other staff members within the Office on culturally sensitive issues.

In the year under review approximately 80 enquiries were received from Aboriginal and Torres Strait Islander people and 14 of these, went through the full HSC process. This is a considerable increase over previous years. These complaints covered a range of issues including:

- access to medication and services
- communication issues
- discrimination
- failure to consult
- inadequate/wrong treatment
- negligence
- breaches of confidentiality.

The majority of the complaints related to services received in public hospitals. There were also a number of complaints about general practitioner, pharmacy and community health services.

A man who had recently been detained in custody complained that he was not being provided with access to appropriate medication for his epilepsy condition. He had initially spoken to the health service provider within the prison system, but claimed they would not allow him access to the particular medication he had been using prior to his detention. He complained to the HSC that the medication

he was being given (which he had previously tried) did not adequately control his condition and caused him significant side effects. Contact was made with the provider to clarify the situation. Following a number of discussions, the health service provider apologised and agreed that the man should have access to his usual medication.

A woman complained to the HSC that she took her elderly mother to a public hospital after a fall at home. Her hip was x-rayed and a brain scan was taken as she had previously suffered a stroke. After 6 hours of waiting in accident and emergency for a diagnosis and treatment, the daughter had to leave to collect children after school. She was advised to take her mother with her because there were no beds available. However the daughter insisted that they look after her mother and undertook to return immediately. Nevertheless after waiting a total of 9 hours the elderly woman was sent home without medication or advice other than to return in a few days if pain persisted.

The following day the daughter took her mother to their regular G.P. who arranged for immediate admission to hospital for an urgent operation. The complaint was sent to the provider and a response was sought. The provider met with the woman's daughter shortly after she had lodged the complaint with this Office. She discussed her concerns with the Director of Medical Services in the presence of the Koori Hospital Liaison Officer and it was acknowledged that her concerns were valid. The provider advised that it would emphasise the importance of the matters raised by the woman with Hospital staff. The woman contacted the Office to advise that she was satisfied with the action taken by the Hospital and did not want to pursue the matter any further.

There were a number of visits to both Metropolitan and Country areas to raise the awareness of the Office amongst aboriginal communities. The HSC is committed to increasing awareness and accessibility for indigenous people and hopes to significantly increase these visits in the forthcoming year.

PRISONER COMPLAINTS

Complaints from prisoners have risen to 116 which is an increase of 50% over the same time last year. This is possibly due to prisoners increased awareness of the presence of the HSC. Five metropolitan and country prisons were been visited over the last 12 months, with further visits being planned up to 30 December 2001. Again this has contributed to the increase in numbers of complaints.

Issues prisoners complain about remain the same with the majority of complaints being about medication regimes, waiting times to access services, and general treatment issues.

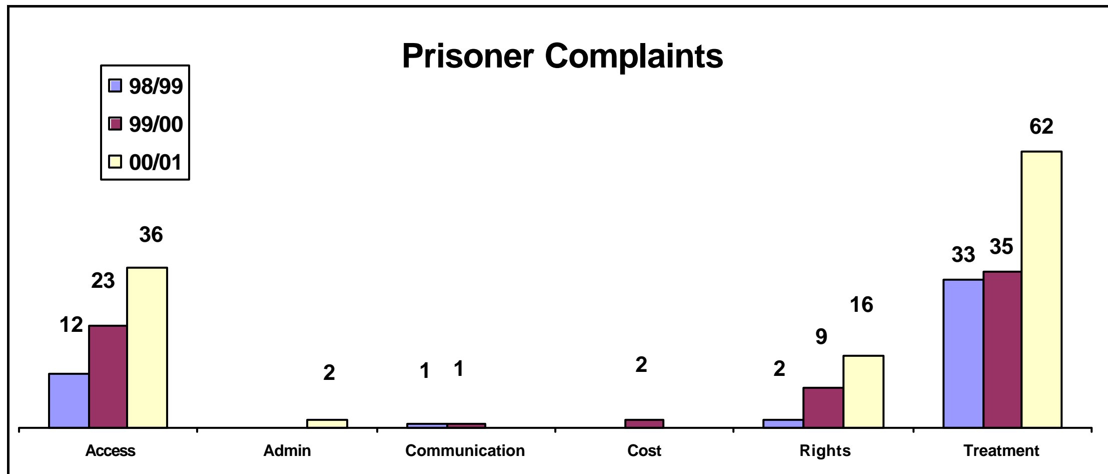
A prisoner complains of not yet having seen a dentist when he had lodged an application to see one 7 weeks previously.

A prisoner complained about not having access to medication (Rivitril 2mg). Prior to being incarcerated, the prisoner took this medication to alleviate behavioural problems.

Prisoners remain reluctant to transfer from one facility to another for tertiary medical/dental treatment.

The protocols set up between HSC, the State Ombudsman and the Prisoner Healthcare Unit at the Department of Human Services remain effective, with the Ombudsman routinely forwarding complaints received about health service provision to the HSC and the Prisoner Health Care Unit being routinely notified of complaints.

Figure 3. Prisoner Complaints



OUTCOMES

HOW WERE THE COMPLAINTS RESOLVED?

During the period under review 2978 complaints were closed. Eighty four percent (2504) were handled at the point of service or locally, that is, between the health service provider and the user of the service. A further ten percent (304) were finalised at the assessment stage and three percent (97) closed in conciliation. Two percent (73) of cases were referred to registration boards or other agencies.

Table 8. Complaint Resolution by Stage

Stage of Complaint Process	Number of Complaints
Enquiry Stage	2504
Assessment	304
Conciliation	97
Referral to Registration Boards & other Agencies	73
Total Number of Complaints	**2978**

REASONS FOR COMPLAINTS

Complaints received by the Commissioner are classified according to their underlying issues. The broad categories are as follows:

Access	refers to availability of services in terms of location, waiting times and other constraints that limit use of the service;
Treatment	refers to diagnosis, testing, medication and other therapies provided;
Communication	refers to manner of communication such as rudeness, disinterest, quality and quantity of information provided about treatment, risks and outcomes and prognosis;
Cost	refers to information about costs and fees, discrepancies between advertised and actual costs, charges and rebates;
Rights	refers to rights to privacy and dignity, consent to treatment, reasonable access to records; and
Administration	refers to support services for providers such as reception, waiting lists, cleaning services, etc.

Most complaints identify only one of these as an issue but approximately one in three raises concerns about more than one issue. Please note that in 114 complaints an issue was not specified.

Primary issues in complaints 2000/2001

While the most frequently nominated issue was treatment nearly all complaints also include failures of communication. This year complaints about treatment accounted for 57% of all complaints, a total of 1583 compared with 1356 complaints in 1999/2000. Inadequate treatment complaints featured most prominently.

Table 9. Treatment

Treatment	57%
Inadequate diagnosis	191
Inadequate treatment	585
Medication	149
Negligent treatment	285
Other	72
Rough treatment	57

Unskillful/incompetent treatment	147
Wrong diagnosis	75
Wrong treatment	22
Total Treatment	**1583**

The largest number of complaints about medical practitioners and hospitals were in the area of inadequate treatment. Many of these complaints could have been avoided if more care had been taken to listen to the concerns of the patients and/or the carers and, to conduct a more thorough examination.

A woman took her infant son to a medical clinic on a Sunday morning as the child had been vomiting all night. She was seeking treatment for the child and reassurance that she was managing him appropriately. It took an hour before she saw a doctor and when the doctor did finally see her, he asked her what she had come for? She explained the child had been very sick all night. The doctor did not examine the child and was curt with the woman, saying she should not be bothering him and if she had concern about her infant she should take the child to casualty at the nearest hospital. No treatment or advice was given.

Table 10 below sets out the communication issues. Communication continues to be a serious problem.

Table 10. Communication

Communication	**13%**
Absence of caring	64
Failure to consult	59
Inconsiderate/undignified service	76
Other	33
Poor attitude/discourtesy	77
Wrong/misleading information	41
Total Communication	**350**

The number of complaints identified as being primarily about communication issues increased from 331 in 1999/2000, to 350 in 2000/2001. Once again the most frequently mentioned communication issue is poor attitude and discourtesy. As mentioned in previous Annual Reports a study by HSC investigator, Lynn Griffin, has established that there are elements of communication problems in every complaint received and this continues to be an issue in the resolution of complaints.

A young female patient went to consult a dentist about stain removal from her teeth. The dentist said he could clean and de-scale her teeth and she agreed to the procedure, but warned him that she was very anxious and could become panicky if she thought she could not breathe during the treatment. The dentist told her if she became distressed for any reason she should simply raise her left hand and signal to him. She did this twice during the treatment and the dentist stopped as agreed and allowed her to sit up and take a break. On the third occasion he became angry, threw an instrument across the room, swore at her and told her she was too pathetic to help and to go elsewhere for her treatment.

When contacted by the HSC the dentist claimed he was an excellent communicator and no-one else had ever complained about him. He accused the woman of having mental problems. He said, he would not respond to her in writing as it was too much trouble and she was the one in the wrong. Because of this response, the matter was not suitable for conciliation and was referred to the Dental Practice Board of Victoria. After speaking with the Board and his professional association the dentist telephoned the HSC and offered to apologise to the woman and refund her fee.

A man went to a naturopath because of pain in his shoulders from playing golf. The naturopath massaged the man's shoulders and manipulated his neck. He felt an immediate sharp pain which worsened over the next few days. He went back to the naturopath who explained he might feel worse for a while before he began to feel better. The pain decreased over time and eventually disappeared, but the man felt angry he had not been warned of the possibility of the pain becoming worse. He had also been fearful some permanent harm had occurred. The naturopath agreed she had not warned him adequately on this occasion, although she normally did do this. She agreed to refund the fees he had paid her and he decided not to pursue the matter further.

Table 11 below shows the types of complaints made in relation to rights.

Table 11. Rights issues

Rights	10%
Accuracy of records	9
Access to records	20
Assault	35
Discrimination	17
No/insufficient consent	19
Unprofessional conduct	45
Other	21
Privacy/confidentiality	64

Refusal to treat	43
Total Rights	**273**

Rights issues accounted for 273 or 10% of all complaints compared with 225 for 1999/2000. Rights issues included breaches of confidentiality and privacy, unprofessional conduct and failure to provide reasonable access to records. The access to records problem will be addressed next year when the *Health Records Act* 2001 comes into force, giving users of health services a legally enforceable right of access to health information about them.

A woman complained her GP sent irrelevant information to a specialist. She had had a traumatic, abusive childhood and once, many years ago, harmed herself. Many years later, following a car accident, she sought a referral in order to see a rheumatologist. The referral letter included the self harm incident. The woman believes this information should not have been passed on. After the doctor explained his clinical reasons for passing on the information and apologised for not having discussed the matter with her beforehand, she was satisfied and decided not to pursue the matter further.

A man complained that the receptionist at a medical clinic discussed his son's outstanding bill during a social club gathering. The receptionist denied the allegation. However during investigations by the HSC witnesses to the conversation in question confirmed the complainant's story. At a conciliation meeting, the receptionist apologised to the complainant and his son. The practice manager reassured the family that this would never happen again and agreed to waive part of the outstanding bill.

Table 12 below sets out access issues raised in complaints

Table 12. Access issues

Access	**10%**
Delay in admission	40
Delay in treatment	55
Discharge arrangements	15
Transfer	18
Non attendance	36
No/Inadequate service	77
Other	8
Refused admission	9
Refused to refer	1
Transport	2
Waiting list	9
Total Access	**270**

Complaints about access to services increased in the year under review to 270 or 10% compared with 197 in 1999/2000. Issues raised included unavailability of services or treatment/admission delays.

A man was diagnosed with a serious condition requiring urgent surgery. His family complained his surgery had been cancelled on three occasions and the man was too fearful to leave his home, thinking he could die at any minute. The HSC contacted the complaints liaison officer of the Hospital and discussed the issues with her. She agreed to make inquiries on the man's behalf. The Hospital explained that a special device needed to be manufactured for the surgery and this was where the delay had occurred. Soon after the family contacted the HSC to say the surgery had been successful and the man was recovering well.

Table 13 below sets out the cost issues raised in complaints.

Table 13. Cost issues

Cost	**5%**
Amount charged	23
Billing practices	61
Fraud	0
Information on costs	24
Other	8
Over-servicing	13
Health insurance	4
Public/private election	5
Total Cost	**138**

There were 119 complaints about costs in 1999/2000, compared with 138 or 5% this year. Complaints about costs are not accepted unless the complaint raises issues in addition to costs. Once again, communication is important. As noted in last year's Annual Report it would be helpful if health service providers posted lists of charges in waiting areas. Members of the public also have a responsibility to ask about costs before agreeing to a service, although this is not possible in emergency situations. The predominant complaints about costs were billing practices and amounts charged.

A woman arranged to buy some reading glasses from an optometrist. She paid a small deposit and agreed to pay off the balance over a three month period. The optometrist told her he would not start making the glasses until she paid most of the fee. Soon afterwards she learned she was entitled to have the cost of reading glasses subsidised through a government program, so she went back to cancel the order. The optometrist told her the glasses had already been made and she would have to pay the full account. She complained to HSC who negotiated the account to be waived. The optometrist agreed, in future, he would advise such patients of the existence of the government funded program.

A woman contacted HSC because she had not expected to pay the fee the doctor charged. She had been to the same doctor many times and considered there should be some notice that charges had been amended. The concerns were sent to the clinic which has now placed a notice of charges on the reception desk.

A man was referred to a specialist. He contacted HSC after his operation and said he had never been informed of all the charges involved with his operation. The concerns were sent to the doctor. The doctor now provides an information sheet that advises the item numbers, the amount he charges and the amount the patient will get back from Medicare. He also advises the names of the anesthetist and suggests patients contact them to confirm costs. Hospital charges are also outlined.

Table 14 shows the administration issues in complaints.

Table 14. Administration issues

Administration	2%
Management Practices	20
Failure to provide certificate	2
No/inadequate response	5
Other	17
Public health standards	13
Policy	1
Total Administration	**58**

There were 58 complaints in 2000/01 about administration issues in health services compared with 71 in 1999/2000. These complaints are about the ways in which services are run rather than the medical or health components of services. Complaints include public health standards.

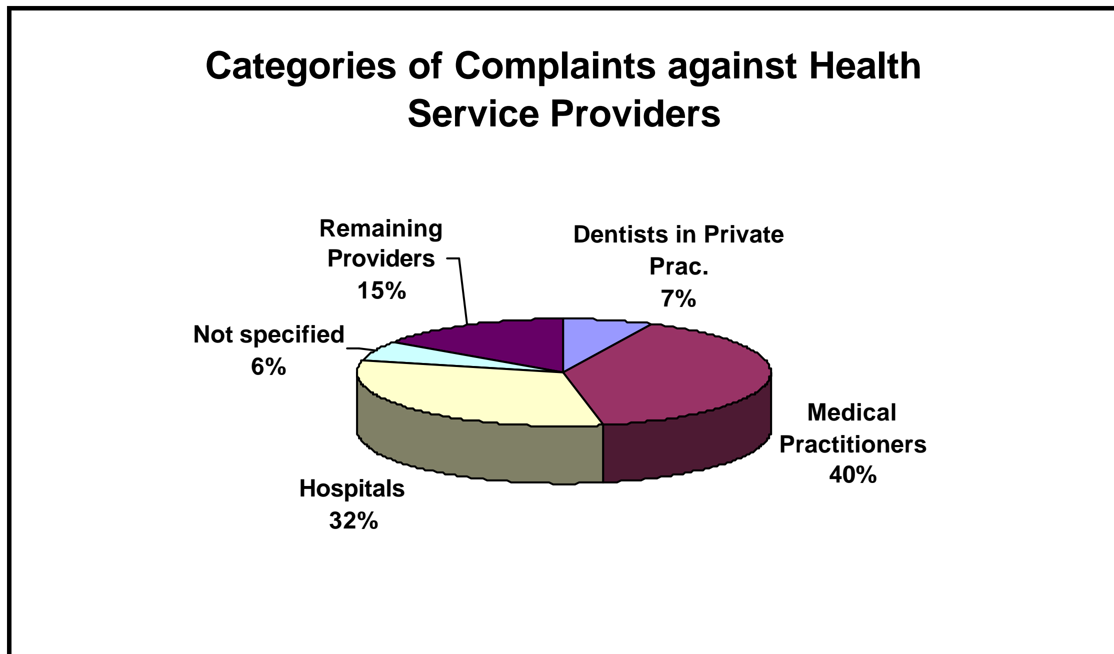
A young man from Fiji needed reports and x-rays to present to the Immigration Department. He had x-rays done at a private practice and paid $150. These were sent to the health service which did more tests which cost him $168.00. The health service assured the man the documents would be sent to the Immigration Department as he requested. The documents were never received and the staff said the documents were lost and all tests would need to be repeated and reports re-done. In response to a complaint to the HSC, the manager of the health service apologised in writing and forwarded a cheque to cover all additional expenses.

An inpatient at a private hospital experienced extreme cold and draughts when the heating malfunctioned on a very cold night. The man's brother contacted the hospital to speak to the CEO. The staff member who rang back was very off hand and uncaring about the incident. Although the problem was rectified, the patient later experienced draughts again and was moved to another room. After intervention by the HSC, the hospital responded directly to the complainant and explained that a fan at the top of the window was causing the problem and has since been removed.

CATEGORIES OF COMPLAINTS AGAINST HEALTH SERVICE PROVIDERS

Medical practitioners represented 40% of health service providers complained about followed by hospitals at 32%, dentists at 7% with the remainder representing 21%.

Figure 4. Categories of complaints against health service providers.



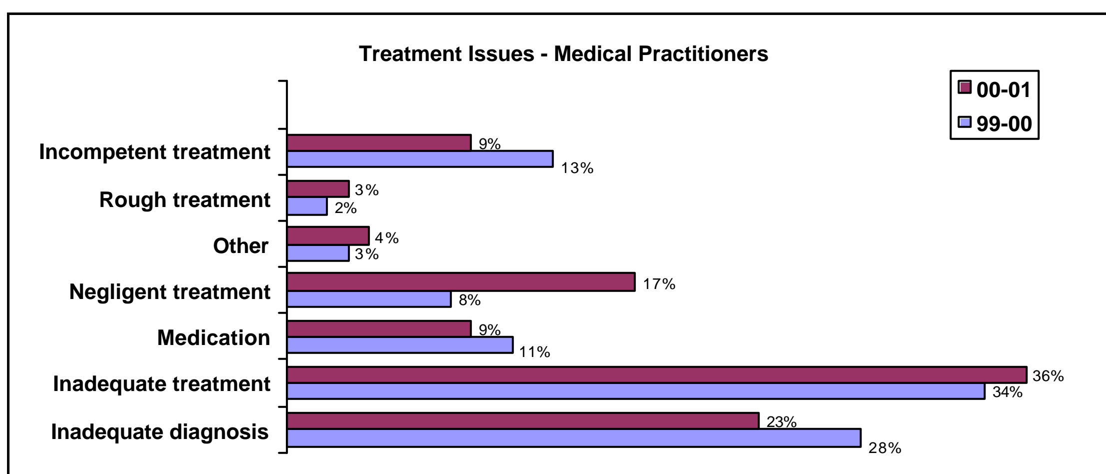
Private medical practitioners continue to be the subject of most complaints however they are, by far, the largest provider group. There was an increase in the number of complaints this year (1107) by comparison with last year, 994. The percentage of complaints about doctors remained at 40%. Public hospitals are the next largest category. Complaints about employees of public hospitals are always recorded as a complaint against the institution rather than the individual. Doctors working from private hospitals, however, are considered to be private practitioners. There is often confusion about responsibility, or shared responsibility, when a person complains about the treatment received in a private hospital.

MEDICAL PRACTITIONERS

The category "medical practitioners" includes all doctors whether in specialist service provision or general practice. The most common issues in these complaints related to treatment, but communication is nearly always an underlying issue.

Figure 5 below sets out the types of complaints about treatment made against medical practitioners over the past two years.

Figure 5. Treatment Issues – Medical Practitioners



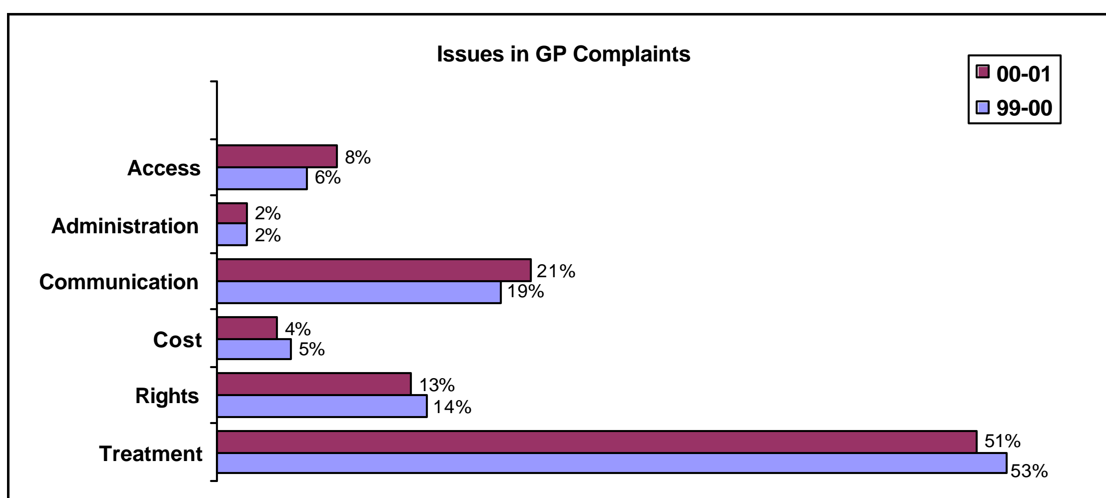
The largest group of doctors is the general practitioners (GPs). In 1999/2000 almost half (544) of all complaints against doctors were made about GPs. In 2000/2001 this decreased to 534. Figure 6 below shows the categories of complaints made against GPs for the past two years.

Appendix 2 lists the number of complaints about individual medical specialities

GENERAL PRACTITIONERS

Once again the most common issues in complaints about GPs relate to treatment issues, usually inadequate treatment and diagnosis, however attitudinal problems and poor communication occur far too often and have the potential to undermine public confidence in the medical profession.

Figure 6. Issues in GP Complaints



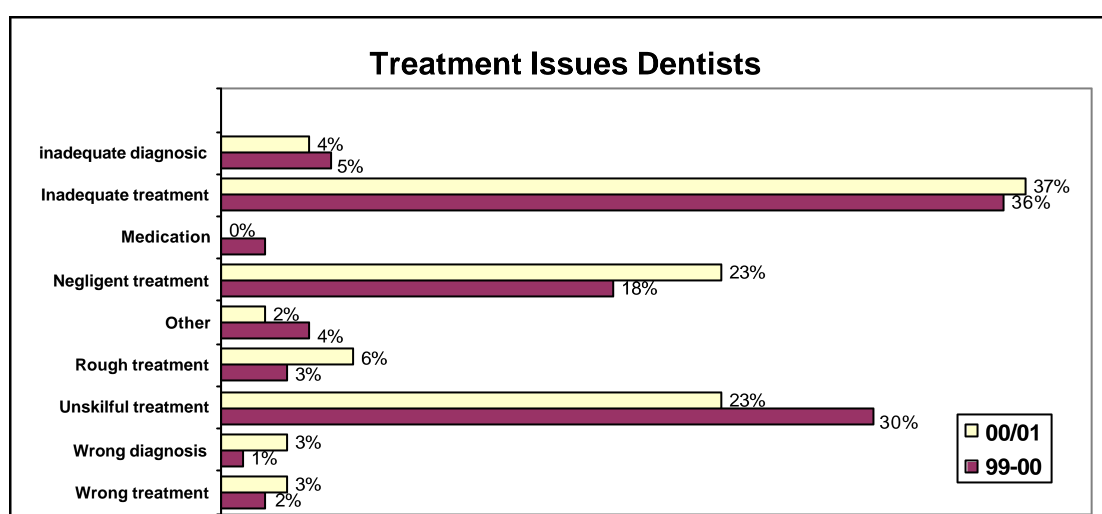
A woman and her sick child were kept waiting for two hours at a general practice clinic. The child became distressed and started to cry. The receptionist asked the woman to take the child outside because, she said, the crying was upsetting other patients. The woman demanded to see the doctor who was rushed. He said there was nothing wrong with the child and sent them away. That night the child required admission to the emergency unit of the hospital. The doctor steadfastly refused to apologise, so the HSC could not resolve the complaint and referred it to the Medical Practitioners Board of Victoria for investigation.

A doctor in a busy rural practice was over booked. A woman and her baby waited for two and a half hours to be seen. The examination was cursory and they were sent home. Subsequently, the baby was admitted to hospital with a serious infection. In response to the woman's complaint the doctor apologised and explained the changes he had made in appointment booking practices, so the problem should not occur again. The complainant was satisfied with the outcome and the file was closed.

DENTISTS

There were 195 complaints against dentists this year, 10 less than last year. As in previous years, most complaints were resolved at the enquiry stage. Seventy-four of these complaints were the subject of formal assessments by HSC. Treatment issues accounted for approximately 80% of the complaints with communication and cost cited in the remaining 20% of complaints.

Figure 7. Treatment Issues Dentists



Of the 74 complaints dealt with formally by HSC, 41 were closed during the report period.

Root canal therapy and cosmetic dentistry continue to account for a large number of complaints about dentists. The complexity of root canal treatment is not well understood and the treatment is usually lengthy and expensive. When problems occur communication needs to be particularly sensitive.

A man agreed to have root canal treatment to an upper molar. After six visits the pain persisted. The tooth was X-rayed and a fine fracture was detected. He then elected to have the tooth extracted but was given a large bill for the root canal work

Although there have been fewer complaints about dentures, they continue to be difficult to resolve. Functional problems cause the wearer great distress particularly when it is difficult to explain why a good fit is difficult to achieve.

A woman had her upper denture replaced. Despite several relines she is unable to wear the denture. She had lost weight and was unwilling to attend social functions where food was served.

The HSC is grateful for the assistance provided by the Dental Practitioners Board of Victoria and by the Australian Dental Association, Victorian Branch.

DENTAL TECHNICIANS

There were 22 complaints against dental technicians, 1 more than for the last report period.

All these complaints were about unsatisfactory dentures.

A man had an upper and lower denture made for him by a dental technician. Although the upper denture was functional, the lower denture was causing so much pain he could not eat while it was in place. A number of relines to the lower denture improved its function slightly. He was unhappy with the additional $250 bill for the reline.

Informed consent remains an issue in these complaints. If more time was taken to explain the procedures, the risks associated with them and the costs involved, many of the complaints would not occur.

HOSPITALS

Complaints made to the HSC about hospitals

Public hospitals attracted 86% (755) of total hospital complaints made to the HSC and private hospitals accounted for 14% (121). Hospitals, both public and private, made up 31% of the total complaints received by the HSC in the 2000/2001 period.

All public hospitals are required to have internal complaint handling systems. For this reason a large number of complaints are handled in-house and do not need to be referred to the HSC. Public hospitals are required to provide details of complaints to the Commissioner on a regular basis and these figures are reported in the section on the Health Complaints Information Program. The work of complaints liaison officers

or patient representatives at the hospital level in complaints resolution is most important. (See also Public Interest Issues, Complaints Liaison Officers on page 20 of this report.

Figure 8 shows the number of complaints made by inpatients and outpatients of public hospitals directly to the HSC.

Figure 8. Public/Private Hospital Comparisons

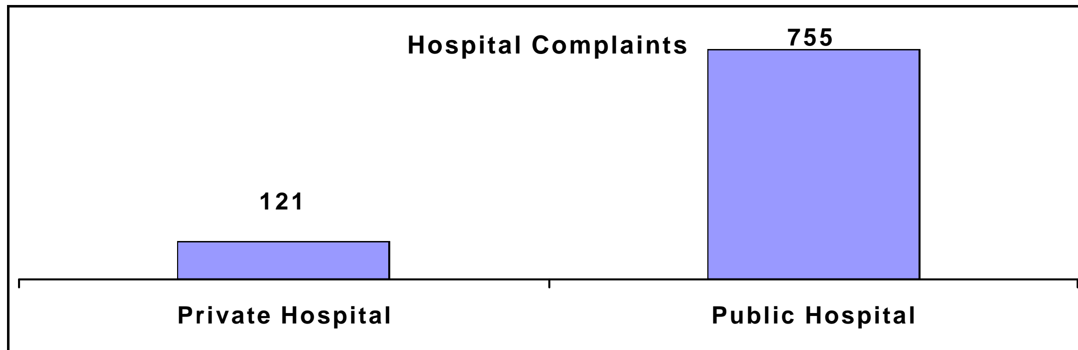
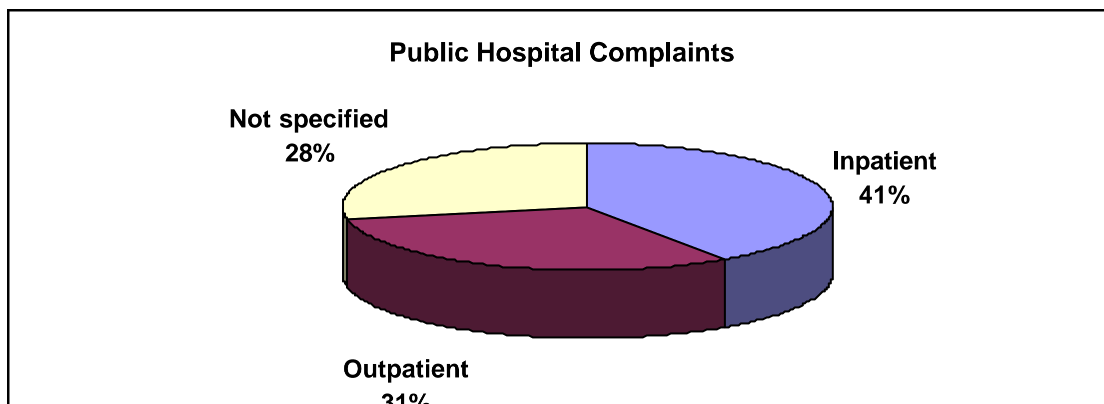


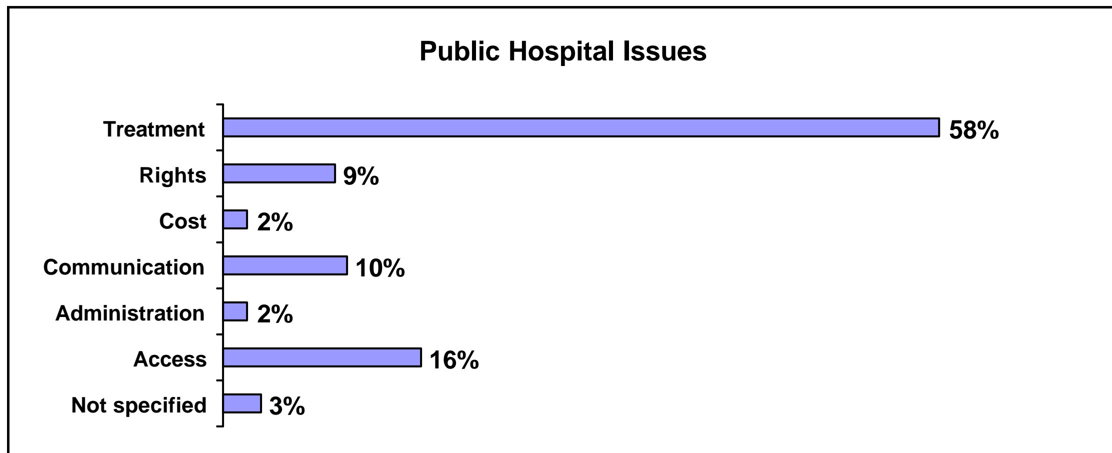
Figure 9. Public Hospital by Patient Type



PUBLIC HOSPITAL ISSUES

Figure 9 shows the issues that made up complaints to the HSC about public hospitals. The most frequent issue complained about is treatment (58%). Other issues are access (16%), communication (10%), rights (9%), administration (2%) and cost (2%).

Figure 10. Public Hospital Complaints



A man attended a diagnostic imaging service located in a hospital in a rural city. He was very angry to receive a bill for the x-rays taken, saying he was a public patient and he should not have to pay. His complaint was sent to the hospital CEO who explained the diagnostic imaging service was privately run from hospital premises and the complaint had been referred onto the manager of the service. The manger said, there were many signs in the rooms including a large one on the reception desk explaining fees would be charged and these were rebateable through Medicare. This was explained to the man who decided not to pursue his complaint further.

PRIVATE HOSPITALS

In 2000/01 there were 121 or 14% of hospital complaints made about private hospitals compared with 116 in 1999/2000. As with previous years treatment issues remain the most common. In the case of private hospitals the treatment issues relate to staff other than doctors because these hospitals do not employ their own doctors.

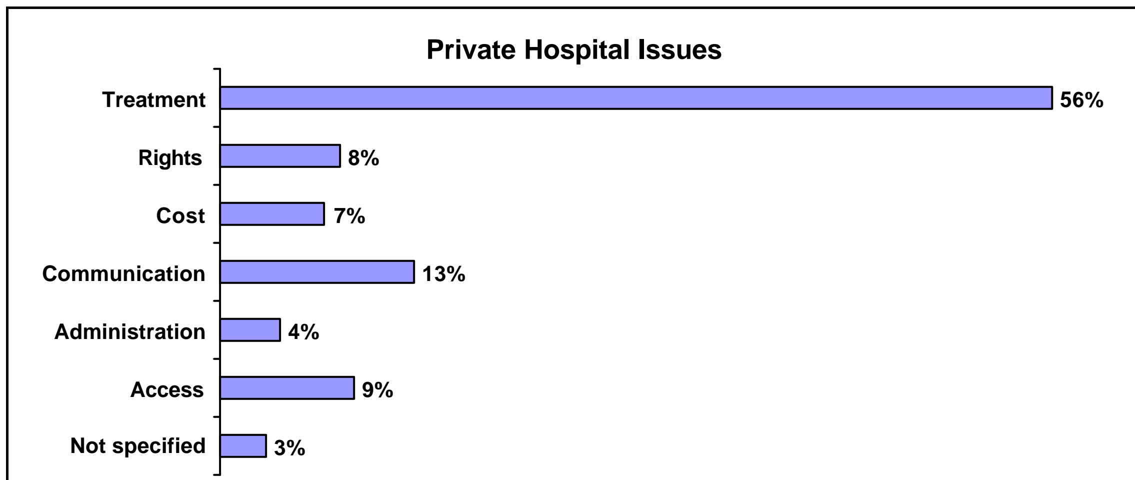
Figure 11 below shows the main issues in complaints against private hospitals. The most frequent issue complained about is treatment with 65 complaints. Other issues are cost 9, communication 16, administration 5, access 11 and rights 10.

A woman who was booked into a small private hospital for the birth of her first child had discussed with her doctor her wish to have an epidural for pain management. On the day of her admission the Hospital was unable to locate a suitable anaesthetist and she had to deliver her baby without the epidural. The Hospital explained they did not employ doctors but kept a list of on-call specialists. Unfortunately, no-one was available at the time of her admission as it had been a holiday weekend and two of the specialists had been at an overseas conference. The Hospital said it would expand its list of on-call doctors to avoid future problems.

A woman complained, on behalf of her frail elderly father, who was an in-patient in a private hospital awaiting placement in a nursing home. On two occasions he was taken for diagnostic tests - a chest x-ray and an ultrasound. Each time he queried the staff as to why he needed the tests. They ignored him but afterwards checked his arm band and realised that he was not the patient who needed these investigations. The man raised it with his physician but was ignored and made to feel as if it were his fault. His daughter complained to the HSC. The provider responded acknowledging their error. They assured the complainant that the matter had been discussed at all the relevant committees to highlight the complaint and to ensure that this type of incident did not reoccur. The complainant was satisfied with the response.

A woman underwent a diagnostic test in a private hospital. When she was getting down off the trolley she slipped and fell. As a result, she broke her toe and had to undergo extensive treatment. Following a complaint to the HSC, the hospital agreed to provide all necessary care including accommodation and crutches free of charge. They also agreed to the reimbursement of the cost of taxis to and from her treatment.

Figure 11 Private Hospital Issues



PSYCHIATRIC SERVICES

In the past year, there were 180 complaints lodged against a number of psychiatric services and against psychologists.

Figure 12. Psychiatric Services Complaints

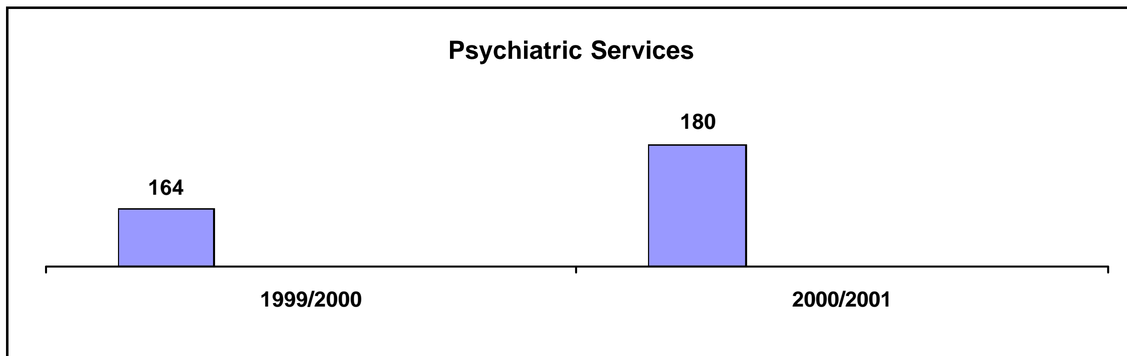
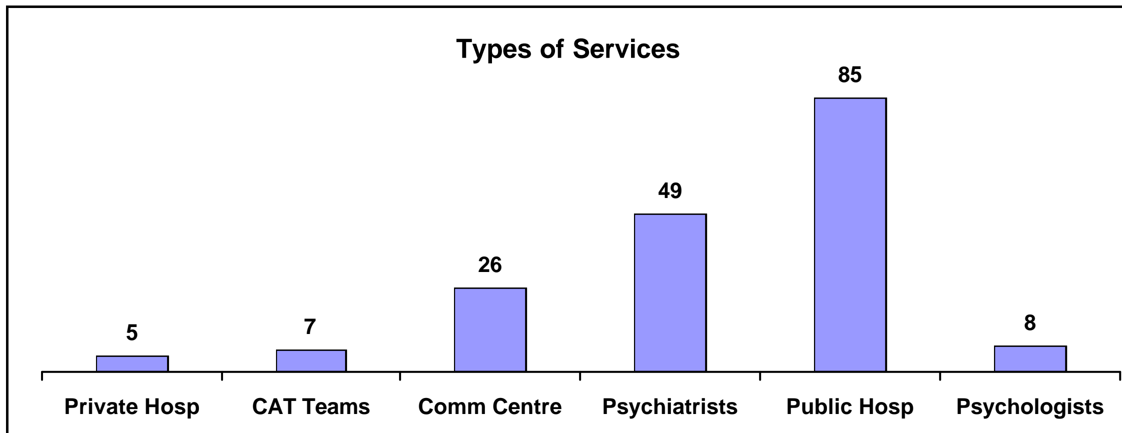


Figure 13 below shows the numbers of complaints made against each type of service.

Figure 13. Types of Service

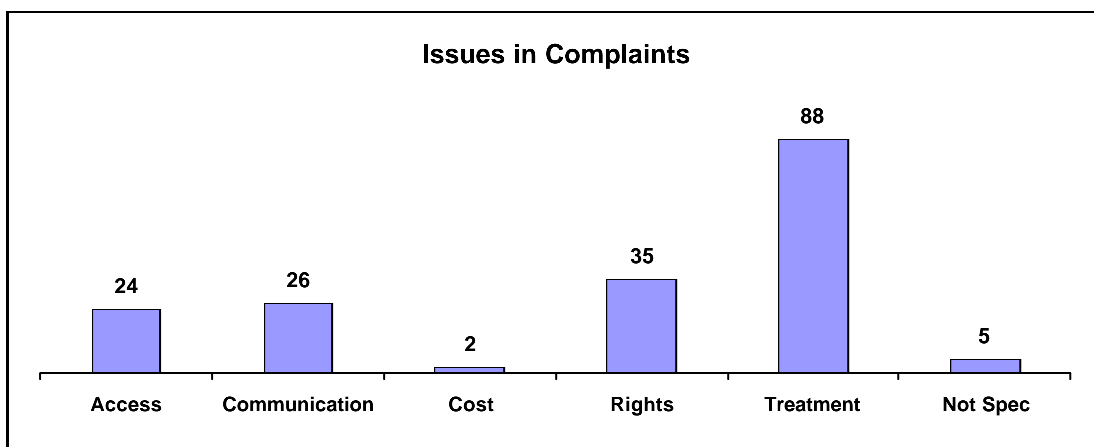


Complaints against CAT Teams (7) remained the same as the previous year. Complaints against psychiatric care in public hospitals increased from 73 in 1999/2000 to 85 for 2000/2001. Five complaints were made against private psychiatric hospitals, although such complaints would normally be made against the admitting doctor. There were 49 complaints lodged against psychiatrists, 2 more than were recorded in the previous year. Complaints against psychologists decreased from 12 in 1999/2000 to 8 in the period under review.

ISSUES IN PSYCHIATRIC SERVICE COMPLAINTS

Figure 14 below shows the primary issues identified in the 180 complaints received in the last year.

Figure 14. Issues in Psychiatric Complaints



The majority of complaints about psychiatric services are about issues of treatment and patient rights. Some complainants who have been admitted for psychiatric care in hospitals feel aggrieved they are required to take medication they feel causes upsetting side effects. Others do not believe that they require medical treatment. The HSC does not have jurisdiction to intervene in cases involving involuntary status. Complainants are advised of their right to appeal to the Mental Health Review Board.

A small number of people complain to the Commissioner about breaches of the human rights, including complaints about breaches of confidentiality, assault and unprofessional conduct by staff. These issues can be difficult to resolve, as there is often a difference in perception between the service staff and the complainant about what might constitute reasonable care and treatment.

People with mental illness have the same rights to quality health care as all other patients and this should never be diminished by the fact they are sometimes unable to consent to their treatment and care.

The HSC is often contacted by the families of people with mental illness who are concerned about the lack of information provided to them about Mental Health Review Board hearings and/or their son/daughters illness. If the person has sufficient capacity to make decisions for themselves then staff must respect patient confidentiality. In 1996, there was a concession made to carers with the amendment of the *Mental Health Act* 1926, section 120A. This section of the Act allows staff to provide some information about patients which would otherwise have been confidential to primary carers where the information is required for the ongoing care of the person.

HOSPITALS' COMPLAINT DATA

COMPLAINTS MADE AT PUBLIC HOSPITALS

Information contained in this section has been compiled from complaints lodged directly with the CLOs of public hospitals. They utilise the Health Complaints Information Program (HCIP) to record and monitor complaints handled locally within the hospital. These complaints are separate to those lodged with the HSC.

The following trends are taken from data provided by 37 public hospitals

WHO COMPLAINED AND HOW?

Fifty-nine percent of complainants were female and were 39% male. As expected public patients were the largest group (94%) and private patients (3%). The majority of complaints were made via letter or telephone call (35% each), 25% by personal visit and 5% by other means.

The age and gender profile of complainants is shown in Table 15 below

CONSUMER PROFILE

Table 15. HCIP - Age/Gender analysis

Age	Female	Male	Not Specified	Total
Under 1	6	14	4	24
1 – 4	19	23	0	42
5 – 14	14	27	9	50
15 – 24	116	66	2	184
25 – 34	237	86	0	323
35 – 44	306	166	0	472
45 – 54	260	181	0	441
55 – 64	241	155	1	397
65 – 74	121	104	4	229
75 – 84	144	85	1	230
85 – 94	21	42	0	63
95+	1	2	0	3
Not Specified	1623	1127	67	2817
Total	**3109**	**2078**	**88**	**5275**

Figure 15. HCIP - Gender

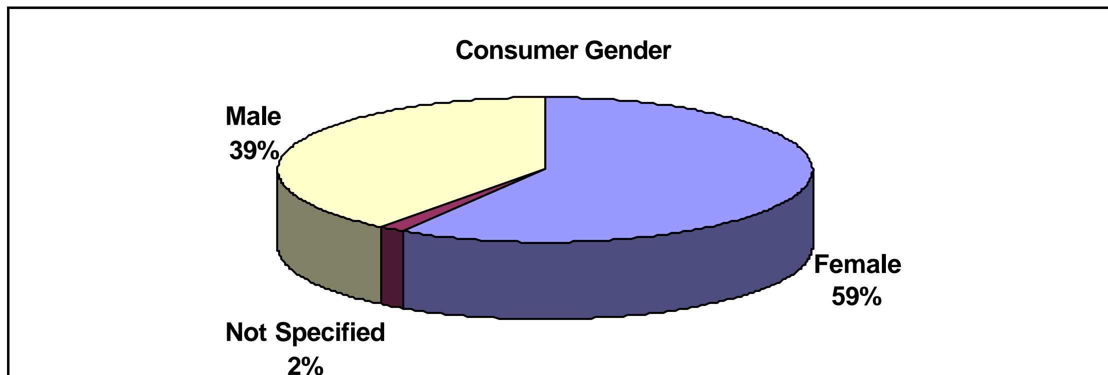
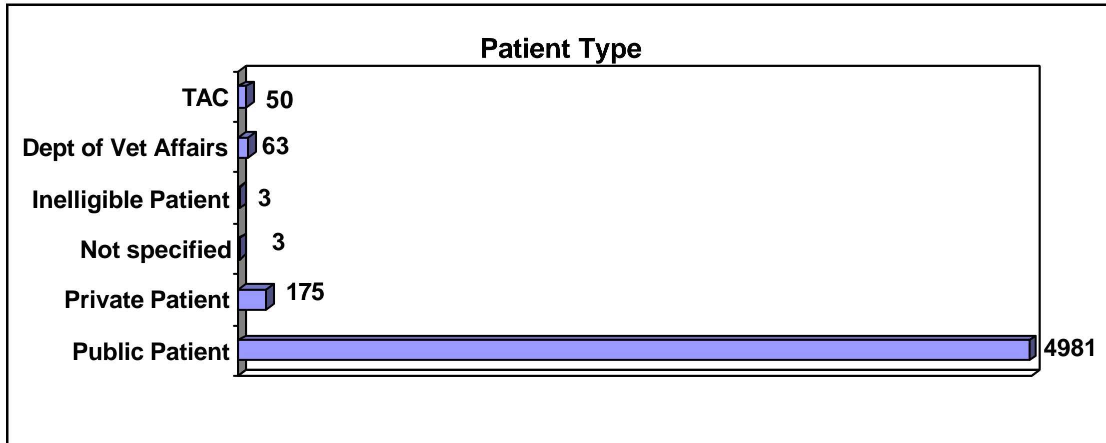


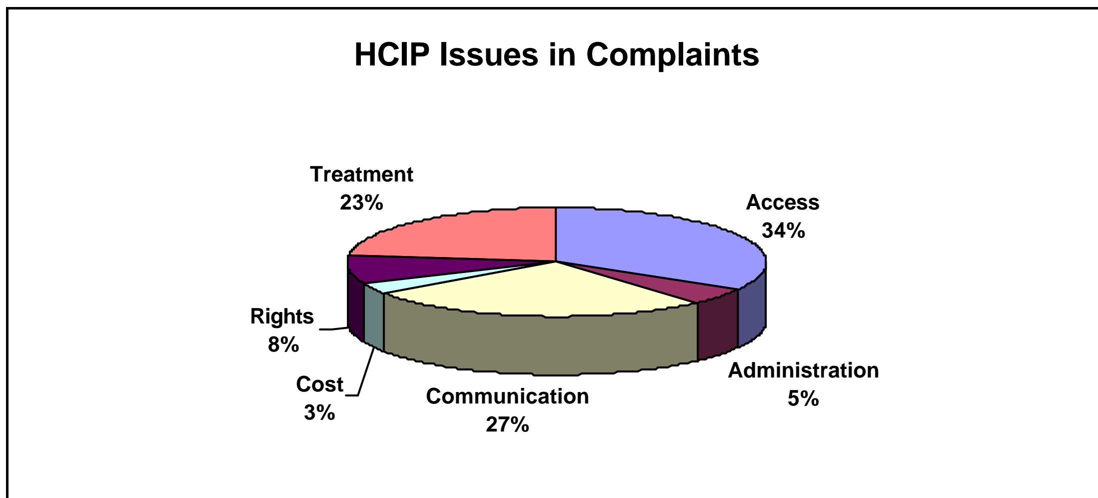
Figure 16. HCIP - Patient type



WHAT WAS THE COMPLAINT ABOUT?

During the period under review hospitals received, and dealt with, 5246 complaints concerning 13789 issues. That is, there were 2.6 issues per complaint received and addressed by the hospital complaints liaison officers (or patient representatives). A complaint may be multi-faceted and be concerned with not only poor communication but also inadequate treatment. The diagram below shows the issues in complaints. A more specific table of these issues appears as Appendix 3.

Figure 17. HCIP - Issues



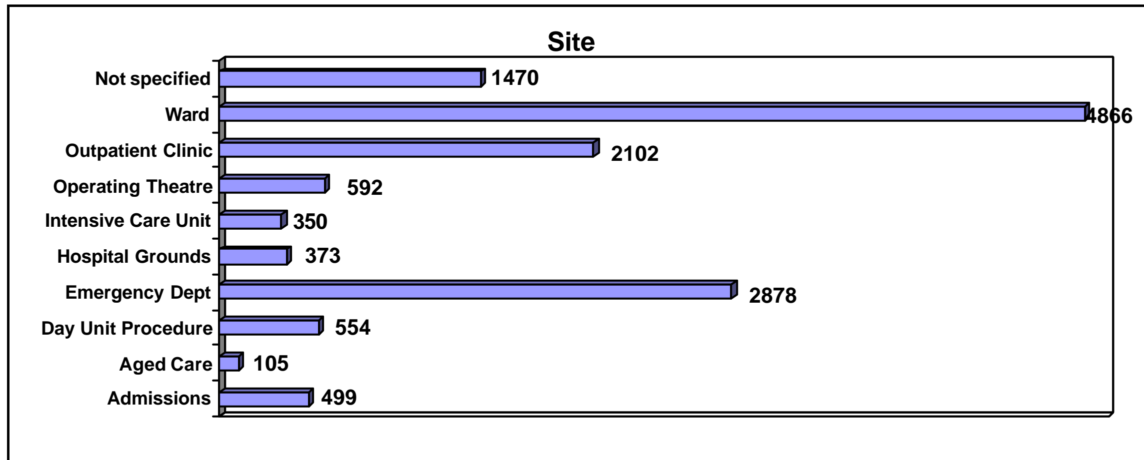
Access and communication were the two commonest issues in complaints, being 34% and 27% respectively, followed by treatment (23%).

At the end of the period, of 2325 issues, 2019 had been closed. The median days to closure were 12.

THE SITE AND SERVICE PROVIDED AT TIME OF THE COMPLAINT?

Thirty five percent of complaints occurred in the wards, 21% in the emergency department and 15% in outpatient clinics.

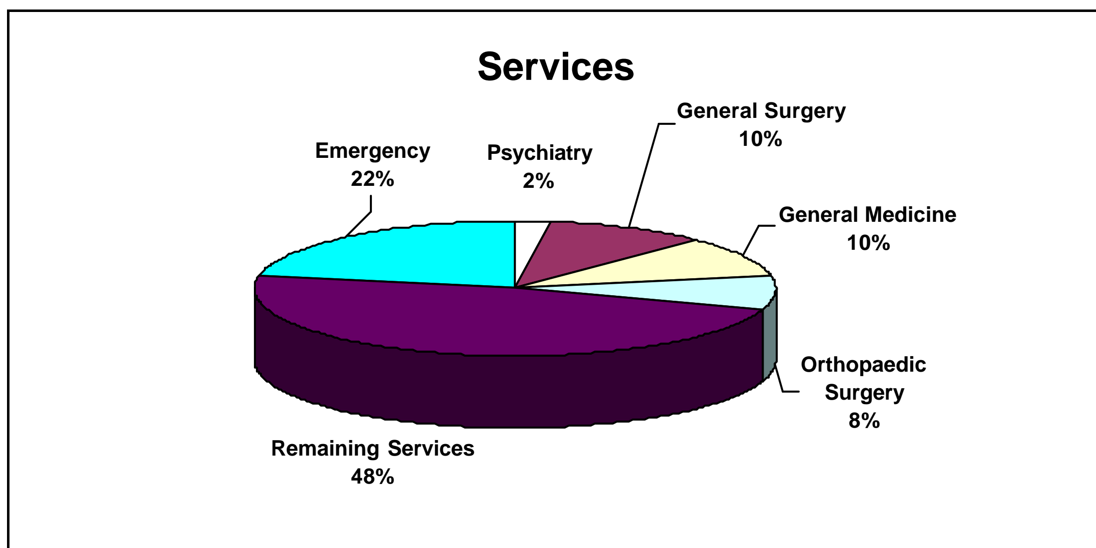
Figure 18. HCIP - Site



SERVICES

Six services received 37% of complaints. Twenty two percent (2359 complaints) were about emergency services, 6% (874 complaints) were regarding orthopaedic surgery, 7% concerned general medicine, 8% about general surgery and 2% psychiatry. Appendix 4 gives a complete service analysis.

Figure 19 HCIP - Services



HOW SERIOUS WERE THE COMPLAINTS?

Ten percent of complaints were categorised as serious or substantial and 63% as routine. The remainder were listed as either minor or trivial.

WHAT WERE THE OUTCOMES OF THE COMPLAINTS?

Outcomes, of the 13789 issues closed during the period, consisted of 10817 (78%) resolved, lapsed 1592 (12%), not upheld 653 (5%), referred 395 (3%), remedial 213 (2%) and change in policy 119 (1%).

Table 16. HCIP - Outcomes of complaints

Stage of Complaint Process	Number of Complaints
Resolved	10817
Lapsed	1592
Change in Policy	119
Remedial	213
Referred	395
Not Upheld	653
Total Number of Complaints	**13789**

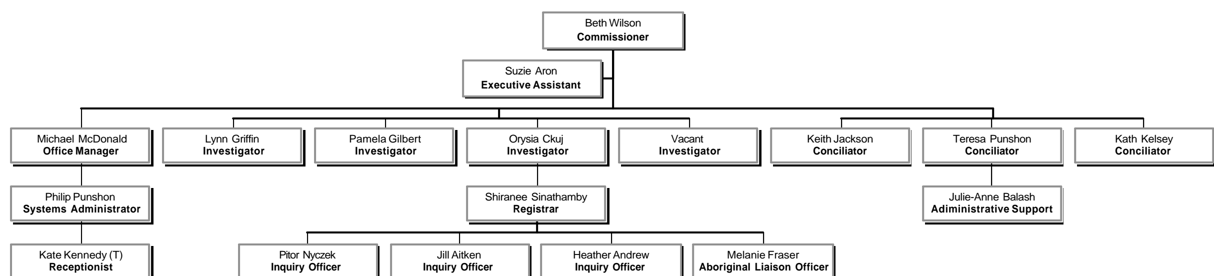
Of the resolved issues, the largest outcomes were apologies 5165 (48%),explanation offered 2618 (24%), users views acknowledged 912 (8%), information provided 697 (6%) and service/facility provided 520 (5%)
For a full account please refer to appendix 5.

OFFICE MANAGEMENT

HUMAN RESOURCES

Staff of the Commission

Organisational Structure



Merit and Equity Employment

The HSC supports specific initiatives of the Office of Public Employment Managing Diversity and Employment Equity goals. The office follows equal employment opportunity policies when recruiting.

The staff by gender for 2000/2001 was 13 women and 4 men.

INFORMATION TECHNOLOGY

Hardware Improvements

As the IT environment is constantly evolving it is necessary to continually review and improve the office equipment. Improvements made in 2000/2001 include:

- Purchase of new computers for all staff to meet Government standards
- Purchase of a laptop for use by office staff

Office Database

After rigorous compliance testing the HSC introduced a new complaints management system called RAEMOC in April 2001. It is an Access database that is also used in the Australian Capital Territory, Tasmania and Western Australia health complaints agencies and New South Wales is assessing whether it is suitable to meet their requirements. RAEMOC provides accurate periodical reporting and allows for in depth analysis of patterns and trends from the relevant complaints data.

FINANCE

Statement of Understanding

The HSC and the Director, Portfolio Services, DHS signed a "Statement of Understanding" which identifies the types and levels of services delivered by the office and the funding allocation necessary to deliver its statutory responsibilities and services. The document identifies service improvement initiatives, organisational and business management issues and statutory responsibilities and core business. The HSC reported how it met the targets in the 2000/01 document at the end of the financial year.

Evaluation Survey

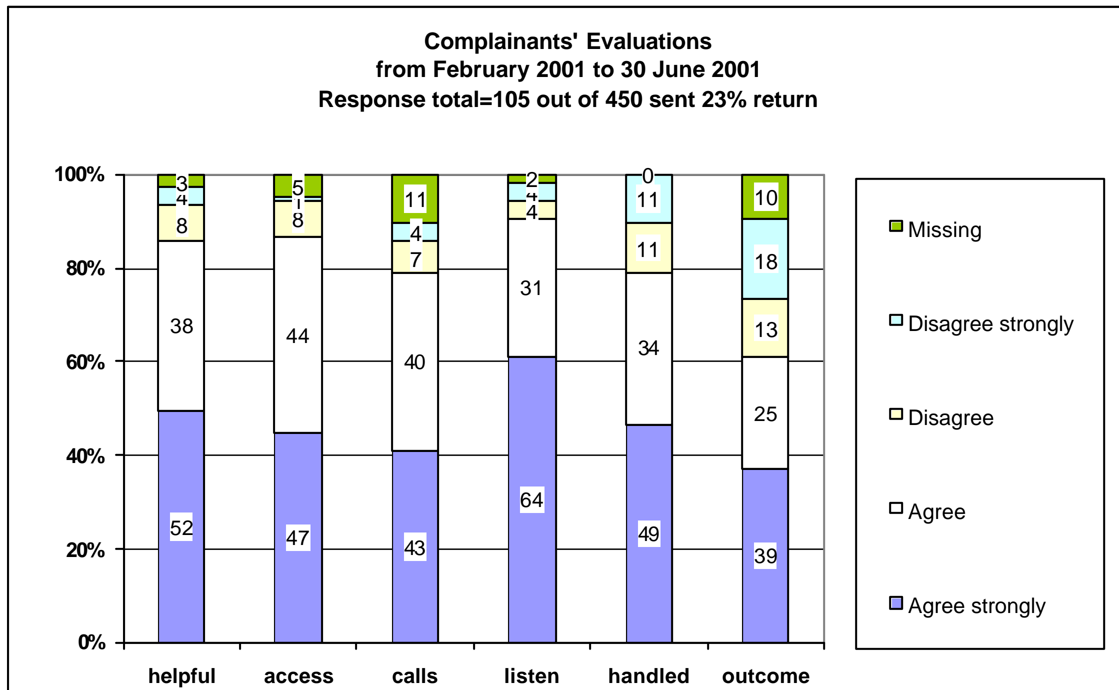
In February 2001 the HSC commenced sending evaluation survey forms to all complainants and providers at the conclusion of a complaint. These provide valuable feedback about our services, our manner and our efficiency. The forms list six questions:

1. HSC staff were helpful in explaining the complaints process
2. I was able to speak to HSC staff when I needed to
3. HSC Staff returned my calls within 24 hours
4. I felt HSC staff listened to what I had to say
5. I was satisfied with the way the complaint was handled
6. I was satisfied with the outcome of the complaint

and respondents were asked whether they Strongly Agreed, Agreed, Disagreed or Strongly Disagreed with the question. The responses received appear in the Table 17.

Complainants

Table 17. Complainants' Evaluations



Complainants who responded were very happy with the service provided by the HSC. Over 80% said the staff were helpful, they were able to access staff who listened to them and returned calls promptly. Seventy nine percent were satisfied with the way the complaint was handled and 61% were satisfied with the outcome of the complaint.

Some comments from complainants:

"I am very thankful and very grateful for the way my complaint was handled. The outcome of the complaint is what I wanted and I thank you for that."

"I was very impressed with the attention my complaint was given and also with the follow up to make sure I was happy with the outcome".

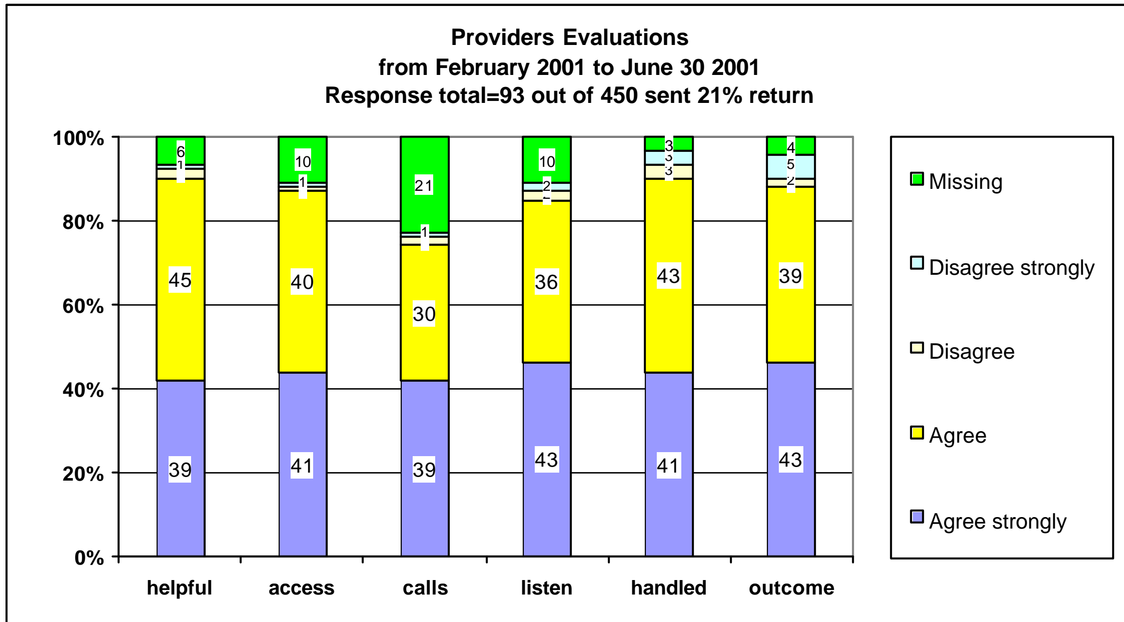
"Thank you very much for all your support throughout my difficult time. You were very helpful in informing me during this process."
"I would like to thank you once again for the way you listened to my complaint, it is a credit to your office the way you handled it."

"I could only speak very highly of your staff, the process and the healing it has bought to myself and my family."

"I appreciated your support at a time when I felt I was being treated unjustly – it is good to know support services are available to the public."

Providers

Table 18. Providers' Evaluations



Provider responses were also very positive. Eighty eight percent of providers who responded indicated they were satisfied with the outcome of the complaint. Over 84% of providers agreed the staff were helpful, they were able to access staff who listened to them and 74% agreed their calls were returned within 24 hours.

Here are some comments that indicate the level of satisfaction providers have:

"Thank you, its nice to have the HSC look after these issues; its becoming increasingly difficult to satisfy every patient and it seems complaints will become an ever present reality in medical practice and the HSC has dealt with my case well."

"I was impressed with the professionalism and the patience of the staff in a difficult and a time consuming process."

"As a health service provider I have no complaint with the current procedures of your office."

"I appreciate the chance for the complaint to be referred to me to enable an apology and for the complaint to be handled locally – which turned out to be satisfactory."

"I appreciated the opportunity to discuss the issue and the courtesy with which I was treated. I also appreciated the non-judgemental advice, likewise the feedback."

"Whilst form my point of view a satisfactory outcome was not achieved, your conduct of this matter was appreciated and approvingly managed."

While the period of evaluation was limited to 5 months the data indicate an overall satisfaction with the role of the office in complaint resolution. The evaluation process

continues and it will be interesting to review 12 months data in our next Annual Report.

BUDGET

For the 2000/2001 financial year the OHSC expended $1,042,244(excluding indirect expenses) being 97% of its total allocation of $1,078,124, resulting in a surplus of $35,880. This compared to expenditure of $1,040,569 in 1999/00.

Financial Statements

	Allocated	**Actual**
Operating Expenses	$142,893	$104,803
Salaries	$924,831	$910,442
Sub Total	$1,067,724	$1,015,224
Capital Expenditure	$10,400	$26,999
Total	$1,078,124	$1,042,244

Expenditure

Direct Expenses

Salaries		$910,442
Administrative stationery & operating supplies	$11,973	
Books/publications/subscriptions/memberships	$4,427	
Computer systems - maintenance	$625	
Furniture, fittings & equipment	$1,327	
Income	($17,053)	
Information technology costs	$7,909	
Interpreter Services	$890	
Legal Services	$2,416	
Medical reports	$15,353	
Meeting expenses	$1,436	
Miscellaneous	$6,135	
Postal /courier	$1,554	
Printing	$5,365	
Publicity & information	$917	
Staff development & seminars	$12,531	
Telephones	$24,727	
Travel-Airfares, Taxis, Personal Expenses	$13,752	
Vehicle	$226	
Workcover	$10,293	
Sub Total		$104,803
Capital Expenditure		$26,999
Total		$1,042,244

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APENDICES

APPENDIX 1 - Providers by Type

Provider		Total
Medical Practitioners		1107
Hospitals		876
Dentists in Private Practice		195
Remaining Providers		
Aboriginal Health Worker	2	
Acupuncturist	4	
Alcohol & drug service	4	
Alternative therapist	10	
Ambulance	21	
Appliances and Equipment	2	
Audiologist	2	
CAT Team	7	
Chiropodist/Podiatrist	5	
Chiropractor	9	
Community Health Centre	36	
Corrections Health	116	
Counselor	13	
Dental Technician	22	
Dept of Human Services	8	
Diagnostic Pathology	23	
Family Planning	3	
Health Insurance	3	
Hostel	8	
Infant Welfare Centre	1	
Masseur	6	
Naturopath	7	
Nurse	3	
Nursing Home	6	
Nursing Service	5	
Occupational therapist	1	
Optical Dispenser	5	
Optometrist	26	
Pharmacist	31	
Physiotherapist	6	
Psychiatric Health Centre	26	
Psychologist	8	
Radiographer	12	
Supported Residential Service	4	**420**
Not specified		**174**

	Total	2796

APPENDIX 2 - Medical Practitioner Specialities

Specialty	Total
Allergy	3
Anaesthetics	21
Cardiology	5
Dermatology	25
Ear, Nose and Throat	11
Emergency Medicine	1
General Surgery	49
General practice	544
Gastroenterology	7
Neurosurgery	5
Neurology	11
Obstetrics/Gynecology	52
Oncology	5
Ophthalmology	19
Orthopedic surgery	29
Pediatrics	4
Physical medicine	11
Plastic surgery	33
Psychiatry	49
Pathology	3
Reception/administration	7
Radiology	8
Rheumatology	4
Urology	13
Vascular surgery	2
Not specified	187
	1107

APPENDIX 3 - HCIP Issues

Access	33%	Treatment	23%
Absence of caring	701	Absence of caring	124
Delay in admission	297	Inadequate diagnosis	315
Delay in treatment	974	Inadequate treatment	730
Discharge arrangements	455	Inadequate nursing care	639
Discharge/transfer	211	Medication omission/error	173
No/inadequate service	940	Negligent treatment	125
Non attendance	26	Other	530
Other	467	Rough treatment	114
Refused admission	47	Unskillful/incompetent treatment	110
Refused to refer	21	Unexpected outcome	186
Service busy	128	Wrong diagnosis	64
Transport	71	Wrong treatment	46
Transfer unsuitable	19		
Waiting list	241		
Total Access	**4598**	**Total Treatment**	**3156**
Communication	**27%**	**Rights**	**8%**
Absence of caring	115	Accuracy of records	42
Conflicting information	270	Access to records	83
Communication breakdown	946	Assault	68
Failure to consult	147	Discrimination	160
Inadequate information	553	Failure to provide an interpreter	13
Other	400	No/insufficient consent	93
Poor attitude/discourtesy	1129	Other	174
Undignified service	82	Property	189
Wrong/misleading Information	91	Privacy/confidentiality	144
		Refusal to treat	26
		Unprofessional conduct	166
Total Communication	**3733**	**Total Rights**	**1158**
Cost	**3%**	**Administration**	**5%**
Amount charged	67	Failure to provide a certificate	11
Billing practice	84	Incorrect. Documentation	78
Information on cost	20	No/Inadequate response	93
Other	145	Other	169
Private health insurance	19	Policy	101
Public/private election	90	Public health standards	119
Unnecessary treatment	36	Treatment Cancelled	112
Total Cost	**461**	**Total Administration**	**683**
		Total	13789

APPENDIX 4 - HCIP Service Provided at time of Complaint

Services		Services	
Accommodation Services	192	Neurosurgery	359
Administrative Services	323	Nursing Home	34
Admissions	135	Nutrition	10
Aged Care	435	Obstetrics	174
Alcohol & drug Services	6	Obstetrics/Gynaecology	170
Anaesthetics	77	Occupational Therapy	23
Audiology	28	Oncology	229
Awaiting admission	52	Operating Theatre	99
Car Parking	184	Ophthalmology	174
Cardiac Surgery	96	Orthopaedic surgery	874
Cardiology	281	Outpatients clinic	479
Chiropody/Podiatry	8	Paediatrics	118
Colorectal	78	Pain services	17
Day procedure	159	Palliative care	27
Dentistry	91	Pathology	87
Dermatology	85	Patient Services	117
Ear, Nose & Throat	270	Pharmacy	28
Emergency	2107	Physiotherapy	55
Emergency Triage	252	Plastic surgery	191
Endocrinology	77	Podiatry	6
Environmental services	60	Prosthetics/Orthotics	17
Finance & Administration	81	Psychiatry	233
Food Services	49	Radiology	213
Gastroenterology	321	Reception/Administration	93
General medicine	1011	Rehabilitation medicine	75
General practice	71	Renal/Nephrology	218
General surgery	1081	Respiratory Medicine	153
Genrontology	42	Rheumatology	24
Gynaecology	22	Social work	73
Haematology	78	Speech therapy	10
Home Care	39	Specialist Medical	145
Hostel	43	Specialist Surgical	54
Infectious diseases	34	Spinal Injuries Unit	91
Intensive Care Unit	192	Telecommunications	31
Interpreter Services	7	Thalassemia	
Medical administration	18	Unknown	399
Medical technician	6	Urology	89
Neurology	344	Vascular surgery	165
		Total	**13789**

APPENDIX 5 - HCIP Outcomes

Resolved	78%	Change in Policy	1%
Agreement reached	260	Censure or reprimand	27
Apology	5165	Policy change	21
Compensation Paid	66	Procedural change	71
Explanation offered	2618		119
Fee waived or reduced	39		
Fee refunded	18	**Remedial**	**2%**
Frivolous/vexatious	26	Censure or Reprimand	27
Information Provided	697	Remedial action	142
Misunderstanding resolved	364	Caution or warning	44
No further action required	112		213
Service/facility provided	520		
Users view acknowledged	912	**Referred**	**3%**
Waiting Time Reduced	20	Outcome in Referral	395
	10817		395
Lapsed	**12%**	**Not Upheld**	
Insufficient detail	516	Complaint not upheld	317
Allowed to lapse by user	369	No action possible	336
Not confirmed	207		653
Unsubstantiated	382		
Withdrawn by user	118		
	1592	**Total**	**13789**