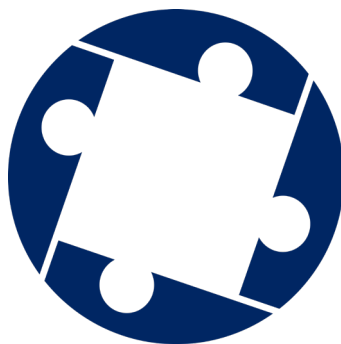


Annual Report

2020-2021



Health Complaints Commissioner
Tasmania



Health Complaints Commissioner

Annual Report 2020-2021

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Letter to Parliament

The Honourable President of the Legislative Council
The Speaker of the House of Assembly

Pursuant to section 12 of the *Health Complaints Act 1995*, I present to the Parliament the annual report of the Health Complaints Commissioner for 2020-2021.

Yours sincerely

Richard Connock
HEALTH COMPLAINTS COMMISSIONER

12 October 2021

About this Report

This report describes the functions and operations of the Health Complaints Commissioner Tasmania for the year ending 30 June 2021.

It is available in print or electronic viewing format to optimise accessibility and ease of navigation. It can also be made available in alternative formats to meet the needs of people with a disability. Requests should be directed to the Executive Officer at 1800 001 170 or Health.Complaints@ombudsman.tas.gov.au.

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From the Health Complaints Commissioner

This annual report is made pursuant to section 12 of the *Health Complaints Act 1995* (the Act), and details the work of my Office during the 2020-2021 reporting year.

INTRODUCTION

After almost four months of working from home due to the outbreak of COVID-19, we were very fortunate to be able to return to the workplace and resume more or less normal operations within the first few weeks of the commencement of the 2020/21 financial year.

Nevertheless, the 2020/2021 reporting year was another challenging year for the Office with low staffing levels and high case numbers. In addition to this, health service providers, particularly the public hospitals, continued to grapple with the impact of COVID-19 well into the year which necessarily impacted on their ability to respond to complaints and participate in conciliation meetings.

Notwithstanding this, at the end of the year there were only 80 active cases carried forward. My concern is that, with the pressure to respond to enquiries and assess complaints as quickly and informally as possible, the cases carried forward are the long standing complex cases that require a much greater level of information gathering, analysis and consultation which is challenging when staffing levels are low.

STAFFING

Steps were taken at the beginning of last year to address the historically low staffing levels in the Health Complaints team, with fixed term appointees to two positions being made permanent. This notionally brought the health team up to 4.4 full time equivalent (FTE) members of staff, however, due to circumstances largely out of our control, one of those positions remained vacant throughout the year and another was vacant for four months. This resulted once again in extensive periods when the team was reduced to just three FTEs.

RESOURCING

In May 2022 it will be 25 years since the Office of the Health Complaints Commissioner was established. Almost every annual report since then has testified to the importance of the role of this Office coupled with the inability to properly perform its functions due

to inadequate resourcing. I have reported in every annual report since my appointment in 2014 that this lack of resourcing has been particularly acute during the last seven years, when despite ever increasing complaint activity, staffing levels have been as low as two or three FTEs.

EFFICIENCIES

The requirement to work remotely during COVID-19, in some cases without access to office resources, meant that complaints and enquires were being addressed less formally than had previously been the case. In the spirit of the Act, which requires us to proceed with as little formality and technicality and with as much expedition as a proper consideration of the matter permits, we have continued to do this and now manage an increasing number of complaints without the need for the complainant to submit a signed and written complaint form and we engage in a lot more communication by way of email and informal dialogue with the parties.

The most significant change impacting on our level of efficiency this year has come about as the result of a review by the Australian Health Practitioner Regulation Agency (AHPRA) of the manner in which it handles notifications. This has resulted in a much faster and more efficient consultation process between our two organisations and - where I have for many years been reporting delays of up to several months in receiving responses from AHPRA to our recommendations regarding which entity is best equipped to manage a complaint/notification about a registered practitioner - these consultations are now occurring within less than a week.

CODE OF CONDUCT

In 2018 legislation was passed through the Tasmanian Parliament to amend the Health Complaints Act and to make provision for the implementation of a Code of Conduct for Health Care Workers. These amendments give me the power to investigate complaints about unregistered health care workers and, in cases where they are found to be in breach of the Code and representing a significant risk to the public, to issue prohibition orders preventing their continued practice

These amendments have not yet been proclaimed. As I have previously reported, any complaints related to the Code would mean an added strain on resources that are already stretched. If a significant number are received, existing resources will not be sufficient to deal with them. There will also need to be extensive modifications to our case management system to accommodate workflows related to the administration of the Code.

Discussion with my interstate colleagues indicates that the risk to the public in the States and Territories which do not yet operate under a Code of Conduct is extremely high.

While most health care workers do provide safe and ethical healthcare there is a small cohort, who, while they remain unregulated, pose a significant risk to public health and safety.

LEGISLATIVE AMENDMENTS

In the almost 25 years since the proclamation of the Health Complaints Act, although the intention was that it be reviewed on a regular basis, initially after three years then every five years thereafter, there has only been one review and that was undertaken in 2003.

Since then the National Registration and Accreditation Scheme for registered health practitioners has been introduced (in 2010) which resulted in some ad hoc amendments to the Act and, as mentioned previously, amendments have been passed to adopt the Code of Conduct. Apart from there being a number of anomalies in the Act, the existing provisions for the making, assessment, resolution and investigation of complaints is cumbersome and restrictive

Due to historically low staffing levels, as I have noted in previous reports, much of the work of the OHCC is performed within a protracted assessment process rather than within conciliation or investigation. I have previously foreshadowed that I would be seeking amendments to provide for other options following the assessment of a complaint. The impact of COVID-19 resulted in a loss of momentum in this regard and this has continued throughout this reporting year. I am currently considering whether, after 25 years of operation, it would be more appropriate to undertake a complete review of the Act.

CHARTER OF HEALTH RIGHTS

One of the main functions of the Commissioner under the Act is to develop and review a Charter of Health Rights. The Tasmanian Charter was developed in 1998 but has not been reviewed since. In 2008 the Australian Commission on Safety and Quality in Health Care (ACSQHC), in consultation with stakeholders across Australia, developed the Australian Charter of Health Care Rights, which largely reflects the matters set out in the Tasmanian Charter. In light of this, the Tasmanian Charter may no longer be necessary. A review process requires extensive consultation with stakeholders and I am hopeful we will be able to progress this before too long.

OUTREACH AND EDUCATION

Another major function under the Act is to provide information, education and advice in relation to the Charter, and to health rights and responsibilities. Although my OHCC staff continually provide information to both complainants and providers on how they

can make and respond to complaints most effectively we have not yet undertaken any formal training in this regard.

Earlier this year I was very pleased to participate in an information forum arranged on the initiative of Health Consumers Tasmania (HCT):

<https://www.AHPRA.gov.au/News/2021-03-31-Understanding-the-Tasmanian-Health-Complaints-System-sessions.aspx>

My Principal Officer provided an information session to Advocacy Tasmania (AT) on our role and how AT could support their clients in accessing our services. Both these presentations were well received and I will explore more outreach and training opportunities in the coming years.

WEBSITE UPGRADE AND PROMOTIONAL MATERIAL

Over the last two years we have worked towards upgrading the OHCC website and this “went live” in April 2021. Being such a small office with very limited resources we do not have staff with the requisite expertise in this regard, or funding to engage external support to assist with such projects. This work needs to be undertaken by complaint management staff in addition to the core functions set out in the legislation. I am particularly grateful to the two members of the health team and my Executive Officer who were instrumental in this project coming to fruition.

We also developed promotional material last year with the idea of distributing posters and postcards throughout a number of public offices, hospitals and health clinics. The theme was “It’s OK to Complain”. Given the extraordinary response by the health sector during the COVID-19 outbreak, and the ongoing challenges it has faced and overcome throughout the reporting year it seemed untimely to distribute this material. That will be done in the next reporting year.

CONCILIATION

I reported last year that inroads had been made into the backlog of matters that had been assessed as suitable for conciliation but were awaiting attention during the 2018/19 reporting year. Unfortunately, COVID-19 resulted in a cancellation of all face to face meetings and as such fewer matters progressed.

This continued to some extent as a result of the ongoing impact of COVID-19 on health service providers but also due to our own low staffing levels throughout this reporting year. The delay in being able to progress some of these matters within a reasonable timeframe resulted in a number of matters being brought to an end without resolution.

CASE MANAGEMENT SYSTEM

I have previously reported on the need to upgrade our case management system. This system, and the workflows attached, were introduced more than 12 years ago. This predates both the National Registration and Accreditation Scheme and other changes in our assessment process. As such the configurations, workflows, stages and closure reasons are not capturing the work of the OHCC as clearly or effectively as it could. We had planned to address this with an upgrade in early 2020 however we have postponed this project in so far as it relates to the health complaints jurisdiction, pending further developments with the implementation of the Code, and also in the hope the amendment to the legislation foreshadowed above will be passed in the near future.

CONCLUSION

Once again, I would like to thank my Health Complaints staff for the quality of their work, for their dedication and professionalism and for sustaining their remarkable levels of activity over yet another challenging year. I am looking forward to a new year, and hopefully the progression of a number of projects and initiatives which had been postponed.

Office of the Health Complaints Commissioner

The *Health Complaints Act 1995* established the Office of the Health Complaints Commissioner (OHCC) in 1997. The major functions of the Office are to:

- receive, assess and resolve complaints from health service users;
- assist health service providers in developing procedures to resolve complaints;
- encourage health service users to resolve complaints directly with health service providers; and
- identify and review issues arising out of complaints and suggest ways of improving health services.

The Commissioner is an independent statutory officer who does not represent the interests of, nor act as an advocate for, either party to a complaint. The functions of the Commissioner are performed independently, impartially and in the public interest. It is not the role of the Commissioner to attribute fault or blame, but to seek improvements in the delivery of health services in Tasmania and, where possible, resolve complaints between the parties through conciliation.

It has been the practice since the commencement of the Act for the appointments of Ombudsman and Health Complaints Commissioner to be held by the same person. The same Office, the Office of the Ombudsman and Health Complaints Commissioner, delivers the functions which go with these two separate appointments.

STAFF PROFILE

Table 1 - Staff profile as at 30 June 2021

Position	Male	Female	Total
Commissioner	0.2	0.0	0.2
Principal Officer (Band 8)	0.0	1.0	1.0
Senior Investigation Officer (Band 6)	0.0	1.6	1.6
Resolution Officer (Band 5)	0.0	0.0	0.0
Intake and Assessment Officer (Band 4)	0.0	1.0	1.0
Total	0.2	3.6	3.8

2020-2021 At a glance

SNAPSHOT

- 1065 approaches

Complaints opened

- 440 complaints opened
- 335 complaints assessed within 45 days
- 9 cases referred to conciliation

Complaints closed

- 487 complaints closed
- 381 complaints closed within three months
- 12 complaints closed in conciliation

Other achievements

- Updated website
- Development of promotional material
- Improved processes for consultations with AHPRA
- Systemic improvements and outcomes from cases closed in assessment and conciliation.

Staffing

Staffing level at 30 June 2021 was 3.8 FTE.

Complaint and enquiry activity

DATA COLLECTION

Data about our complaint activity is collected in our case management system. All cases received by the OHCC are initially recorded as enquiries. They then proceed through different workflows in the system, according to how they are managed, and data is collected at various points through those workflows. Cases are either closed as an enquiry or they progress to a complaint or notification.

For the purpose of the statistics which follow:

An **enquiry** is a case where a person or organisation is either seeking information from, or providing information to, the OHCC.

A **complaint** is a case where it is obvious that the person wants to make a complaint, rather than just seek or provide information, and where we undertake some form of assessment under the Act - even if that is only as to jurisdictional and threshold issues - or if we refer them to someone else.

A **notification** is a case where a person lodges a notification with AHPRA which, following consultation with this Office as to which is the preferred entity to deal with the matter, it is agreed that AHPRA should retain the matter.

COVID-19 IMPACT

As a result of COVID-19, staff were required to work from home for the last three months of the previous reporting year. Lack of technology and the inability to access the case management system by some staff, and the workflows through which cases move have created anomalies in last year's statistics. Many cases that would normally have been taken through the complaint workflow were recorded and managed as enquiries. The anomalies created last year impact on the comparative data set out in the tables below. Accordingly, as noted last year, overall case activity is the most reliable indicator of increased or decreased case loads.

OVERALL CASE ACTIVITY

As set out in Table 2, when compared with overall case numbers last year, there was a marked increase in both the number of cases received (8%) and the number of cases closed (12%) during this reporting year with a 39% reduction in the number of cases carried forward at the end of the year.

Table 2 – Overall case activity

Total cases	2019-20	2020-21	Variance
Cases carried forward	201	131	-35%
Cases received	982	1065	8%
Cases closed	997	1120	12%
Cases active	131	80	-39%

ENQUIRIES

Table 3 indicates a reduction in the number of enquiries received and carried forward at the end of the reporting year. This is attributable to a large number of cases remaining open as enquiries at the end of the last reporting year due to an inability to progress cases through our normal case management system while working from home during the COVID-19 pandemic.

Table 3 – Enquiry Activity

Enquiries	2019-20	2020-21	Variance
Enquiries received	616	573	-7%
Enquiries closed	564	580	3%
Enquiries active	60	18	-70%

COMPLAINTS

Table 4 indicates a very significant increase from last year in both the number of cases opened (36%) and the number of cases closed (31%) as complaints this reporting year. Again, the variation from last year's statistics is mostly attributable to cases remaining open as enquiries at the end of the last reporting year due to the inability to progress cases through our normal workflows, and being converted to, and closed as, complaints during the current reporting year.

Table 4 – Complaint Activity

Complaints*	2019-20	2020-21	Variance
Complaints carried forward	114	71	-38%
Complaints received	323	440	36%
Complaints closed	371	487	31%
Complaints active	71	62	-13%

*Excludes complaints that start as notifications from AHPRA

NOTIFICATIONS

The OHCC also receives notifications from AHPRA. As noted, there has been significant change in the manner in which AHPRA is managing the notifications it receives. This is discussed in more detail elsewhere in this report but it has resulted in a much more efficient turnaround in the management of notifications from AHPRA to OHCC.

Table 5 - Notification Activity

Notifications from AHPRA	2019-20	2020-21	Variance
Notifications carried forward	21	1	-95%
Notifications received	43	52	21%
Notifications closed	62	53	-15%
Notifications Active at 30/6	1	0	100%

Who and what did people complain about?

ISSUES RAISED

Consistent with previous reports the recurring issues raised in complaints relate to concerns about treatment, access to services, failure to prescribe medication and poor communication.

Figure 1 – Common issues



HEALTH SERVICE ORGANISATIONS

As in previous years, the main source of complaints about health organisations came from prisoners in the Tasmanian Prison Service (TPS) and related to Correctional Primary Health Services (CPHS). This was followed by complaints about public hospitals and then medical practices.

Figure 2 – Complaints about Health Organisations



Correctional Primary Health Services (CPHS)

As in previous years, inmates contacted this Office directly through the prison's secure telephone system at no cost to them.

During the reporting period there was an 11% increase (from 150 to 196) in the number of complaints received about the CPHS compared with last year. The reasons for this significant increase in complaints are unclear. One of the main issues raised by inmates, however, related to access to services, a situation that was heavily influenced by difficulties encountered by both staff and inmates in providing and accessing health services respectively during the numerous lockdowns occasioned by TPS staff shortages.

Access to medication was another common issue raised by inmates. These complaints may have been more prevalent as some policy changes were enforced which further regulated the prescribing of restricted medications.

Figure 3 - Issues arising from complaints about CPHS



Tasmanian Health Service (THS)

In line with previous years, public hospitals were the subject of the next highest number of complaints. There was a 74% increase in the number of complaints about public hospitals. This increase is a result of the unusually low number of complaints received about public hospitals last year (43) rather than there being an unusually high number of complaints this year (75). The number of complaints received this year was in line with previous reporting years – for example there were 61 in 2018/19. As in previous years, the main issues raised in relation to hospitals were treatment and communication. There was also an increase in the number of complaints received about mental health services from 10 to 18.

MEDICAL CLINICS

There was also an increase in the number of complaints (from 22 to 36) about medical clinics. Recurring themes were informed financial consent and billing practices. We also

received a number of complaints relating to the termination of the therapeutic relationship as a consequence of alleged patient aggression.

INDIVIDUAL PROVIDERS

We received 41 complaints about individual health service providers this year. This is in addition to 52 notifications received from AHPRA. This is not dissimilar from last year where we received 49 complaints and 43 notifications. The majority of complaints and notifications we receive about individual providers related to medical practitioners. As noted in previous reports, this is attributable to there being more doctors than other individual health providers who practice in their own right. Complaints about nurses for example are usually incorporated into complaints about hospitals. There was an increase in the number of complaints about medical practitioners received this year from 21 to 32.

How were complaints and notifications resolved?

Table 6 – Reason for closure of complaints and notifications

Reason closed	2019-20	2020-21
No further action following assessment	333	452
Referred to board pursuant to MoU ¹	24	22
Retained by board pursuant to MoU	62	53
Conciliation completed	14	12
Investigation (discontinued)	0	1
Total	433	540

ASSESSMENT

The majority of complaints received are closed following assessment. This was the case for 452 complaints closed this year. Table 8 at the end of this report provide more detail about the outcomes of assessment.

What is Assessment?

Assessment is the stage under the Act at which a determination must be made as to whether a complaint should be referred to another entity, referred to conciliation, referred to investigation, a combination of any of these, or dismissed. This determination is meant to occur within 45 days of the complaint being received, but this period can be extended to 90 days, or longer if the Commissioner is waiting for information. This is also the stage at which attempts are made at early resolution.

¹ The Memorandum of Understanding between AHPRA and the Health Complaints Entities, see Referral to Registration Boards on page 16

Preliminary Assessment

All complaints undergo a preliminary assessment to ascertain whether or not we have jurisdiction to deal with them. The Act sets out a number of criteria to be satisfied before we can accept a complaint. If these criteria are not met, or if there is another organisation or person better equipped to deal with the complaint, then it is either dismissed or referred to the other entity as required.

Cases dismissed following preliminary assessment represent approximately 27% of all cases closed this year (excluding enquiries). Of these, 103 were closed for failure to meet threshold issues or were withdrawn, and 45 were referred to another person or entity. In some cases these referrals involved a facilitated referral back to the health service provider.

Quick Resolution

Of the remaining cases, a further 250 were closed through our Quick Resolution pathway. These cases are managed as informally as possible and usually involve obtaining information from the provider, or other entity, and sharing this with the complainant. Alternatively they involve speaking with the parties and negotiating outcomes, such as a refund or waiver of fees or the provision of a service. Most cases about Correctional Primary Health Services fall into this category. These cases are recorded as having been closed in assessment on the basis that a reasonable explanation has been provided or that the complaint has been resolved.

Formal Assessment

All remaining complaints, including those ultimately referred to AHPRA or conciliation or investigation, undergo a more formal assessment process. This involves making preliminary enquiries, including: obtaining formal written responses from the provider; receiving and reviewing medical records; identifying and reviewing relevant clinical standards; and, where necessary, consulting with AHPRA in relation registered health practitioners involved in the episode of care.

Throughout this formal assessment process we continue to look for opportunities to resolve the complaint, and for possible improvements in the delivery of health services, without the need for referral to formal investigation or conciliation. In this reporting year, 55 complaints were closed following this formal assessment process on the basis that a reasonable explanation had been provided or that the complaint had been resolved (approximately 10%).

These cases tend to be the more complex ones, with multiple parties and multiple issues and they are rarely assessed within the statutory timeframe. This is in part due to the

time taken to receive responses from providers and other parties, but also because of a conscious decision made several years ago to retain matters in assessment to enable extensive enquiries and analysis to be undertaken, and resolution explored, without the need for referral to formal investigation or conciliation.

These cases are in effect “mini investigations” or informal conciliations and the closure reasons do not reflect the complexity or extent of the work undertaken. These cases represent a large percentage of the cases carried forward at the end of the reporting year.

REFERRAL TO REGISTRATION BOARDS

The relationship between this Office and the national boards and AHPRA is governed by the *Health Practitioner Regulation National Law Act 2009* (National Law). A Memorandum of Understanding (MoU) is in place between AHPRA and the various Health Complaints Entities, particularly with respect to the operation of s150 of the National Law.

When a complaint concerning a registered practitioner is made to the OHCC, we are required to advise and consult with AHPRA as to whether any aspects of the complaint should be referred to AHPRA. Unless the issues raised are so serious as to require urgent referral to AHPRA, then as described in the MoU, the OHCC obtains information and undertakes preliminary enquiries sufficient to enable us to make a recommendation to AHPRA.

Similarly, when a notification is received by AHPRA, if the subject matter of the notification could form the basis of a complaint to the OHCC, AHPRA is required to notify and consult with the OHCC as to which entity should handle the matter. More often than not these notifications are retained by AHPRA.

As discussed elsewhere in this report, the consultation process between this Office and AHPRA underwent significant change towards the end of the reporting year resulting in much more timely outcomes.

CONCILIATION

When there is an adverse outcome from an episode of care, most complainants want to understand what happened, and why it happened, and are often seeking an apology, ongoing care and/or compensation. They also want to know what can be done to prevent what happened to them happening to someone else. Conciliation under Part 5 of the Act is confidential and privileged, and provides a safe forum where the parties can have open and honest discussions about these issues.

In previous years, conciliation has been used extensively and with great success in resolving complaints, and as a vehicle for exploring and bringing about systemic change.

Low staffing levels and loss of momentum as a result of COVID-19 resulted in only twelve cases being finalised in conciliation in the reporting year. A further nine matters were referred to, and are currently awaiting, conciliation.

Outcomes from conciliation are set out in Table 10 in the appendix to this report. Of the twelve cases closed:

- two resulted in the actual payment of compensation;
- one was closed with the provider accepting liability to pay compensation and agreeing to obtain and pay for any reports necessary to enable quantum to be determined - delays in obtaining these reports resulted in the matter being finalised through legal proceedings in any event;
- two were resolved following face to face meetings at which the complainant had an opportunity to be heard, have their concerns acknowledged, and receive an apology and explanation;
- one was ended by the Commissioner as a result of the provider's refusal to participate in conciliation;
- a further five were ended by the Commissioner following extensive delays in being able to progress the conciliations; and
- five of the abovementioned cases resulted in significant quality improvements, including changes in policy or procedure.

In past years we have published case studies in relation to cases closed in conciliation. Due to the confidentiality provisions that attach to conciliation this has always been with the express permission of the parties involved. For a number of reasons this year case studies will not be published in this report.

INVESTIGATIONS

A decision was made some years ago that formal investigations would only be conducted into complaints which give rise to a matter of public interest, and that conciliation would be used more extensively. One of the reasons for this was that, in many cases, by the time the matter is brought to our attention, the provider has already engaged in a root cause analysis, and this has led to the identification and implementation of systemic changes necessary to prevent a recurrence of the subject incident. These outcomes are then shared with the complainant at conciliation.

The matters referred to investigation have tended to be those that affect vulnerable groups. One case was closed in investigation this reporting year having been discontinued.

Time taken to assess and finalise complaints

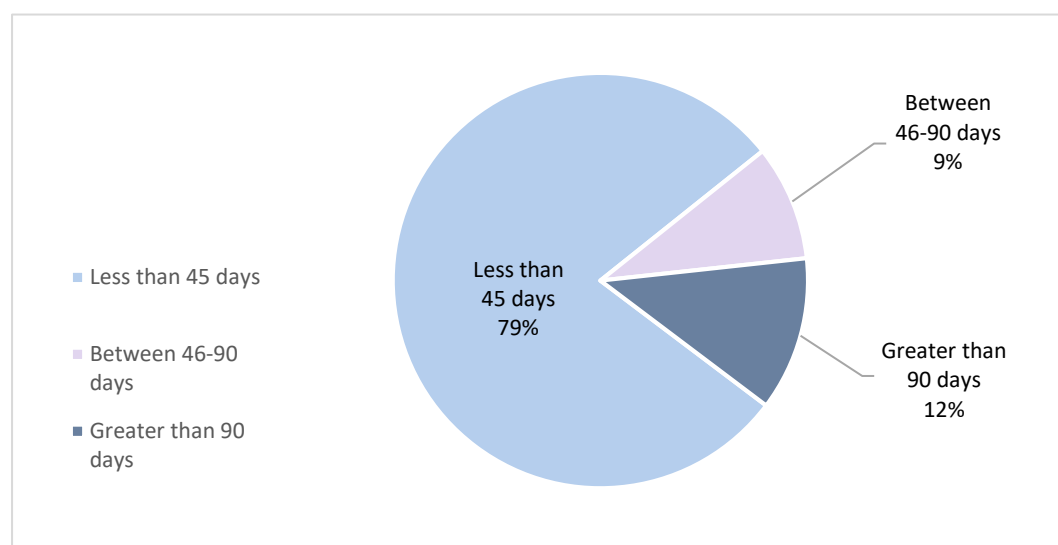
TIME TAKEN TO ASSESS COMPLAINTS

The Act requires that a complaint be assessed within 45 days. This can be extended to 90 days, and longer in some cases. There are a number of circumstances, described in past annual reports, and referred to earlier in this report, which are beyond our control and which have an impact on this Office's ability to meet these statutory periods.

As was the case last year, there were several instances in this reporting year of delays of more than six months in THS providing responses to complaints about public hospitals and other State funded services, and similar delays in receiving responses from AHPRA during the consultation process. Again, however, as a result of the changes AHPRA has made to the way notifications are managed, there is a much faster turnaround in relation to consultations with the OHCC.

As outlined earlier in this report, another reason for complaints not being assessed within the statutory timeframe is the decision made to retain matters in assessment to gather information and negotiate outcomes rather than refer matters to the more resource intensive investigation or, in the absence of a dedicated conciliator, to conciliation. Again although this decision delays the date of assessment it does not impact on the time taken to finalise the complaint.

Figure 4 – Time taken to assess complaints



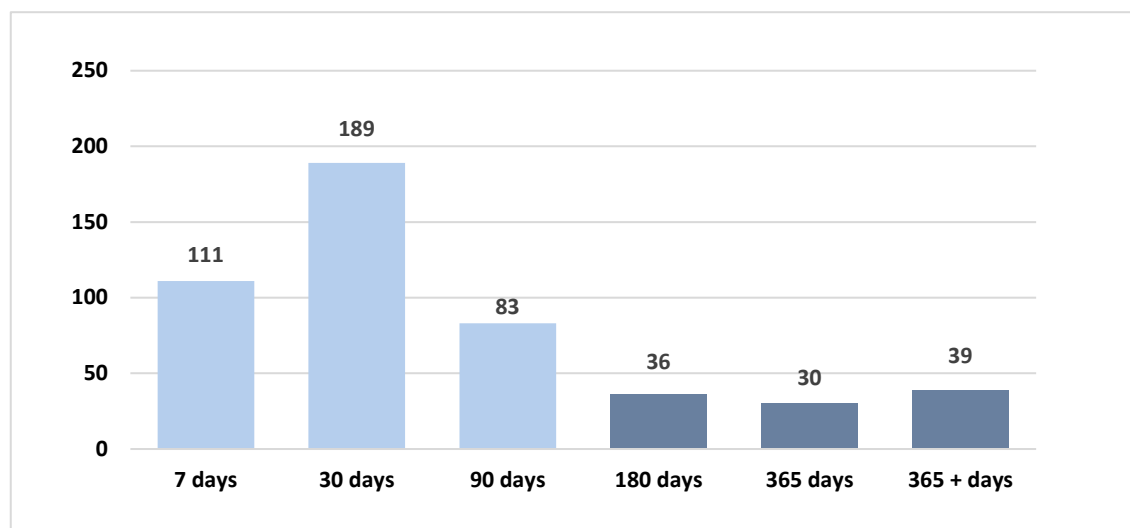
TIME TAKEN TO FINALISE COMPLAINTS

Figure 5 below illustrates the time it takes to finalise complaints. As previously noted, the less complex complaints were generally resolved within three months and made up around 78% of all complaints received. The remaining 22% tended to be more complex.

The statistics for this year showed a decrease in the percentage of complaints taking more than 12 months to finalise. Although this looks encouraging, it appears to be attributable to the large number of old cases being carried forward at the end of the reporting year rather than cases being resolved more quickly. As noted earlier in this report we once again experienced challenges during the reporting year with staff absences on top of already low staffing levels.

Of the 60 complaints carried forward the average age was already 402 days with 26 cases more than 300 days old.

Figure 5 – Time taken to finalise complaints



Outcome from complaints

QUALITY IMPROVEMENTS FROM COMPLAINTS

General Practice

- Staff education in relation to patient identification checks prior to procedures.
- Staff education in de-escalation skills in relation to improving outcomes for patients presenting whilst suffering a mental health emergency.
- Improvements in internal communication systems to prevent risks to patients not receiving important notifications and referrals.
- Improvements in the content of automated messages relaying results of investigations such as breast scans in order to reduce the risk of psychological trauma to the patient.

Pharmacy

- Refresher training to pharmacists in relation to Webster packs.
- New protocol to ensure contents of Webster packs correspond with the patient's medical summary.

Private Hospital

- Patient orientation booklet updated and improved.
- Rectification of problem identified with online patient feedback system.
- Staff education in relation to wounds, specifically in relation to pressure injury and skin integrity.
- Improved wound policy documents.
- Staff training regarding administration of Heparin.
- Improved storage system in relation to emergency department patients' valuables.

Public Hospital

- Implementation of Children's Early Warning Tool (CEWT) for use in a regional health care facility.
- Training in Paediatric management including intubation, fluid assessment and fluid retention in a regional health care facility.
- New protocols developed and implemented to improve the care and treatment for patients experiencing 'ambulance ramping' and/or access block (that is

patients who arrive by ambulance who are unable to be admitted to the Emergency Department due to a lack of beds/staff).

- Confidentiality breaches in a public hospital waiting room were addressed and amended promptly.

Specialist Service

- Amended policy in relation to suitable vein site selection for intravenous cannulation by Registered Nurses.
- New consent form for iron infusions was implemented by a service who previously did not have a consent form.
- Consent form amendments to reflect more specific details of the operations performed on patients.

Mental Health Services

- Education to clinical and nursing staff regarding better communication with carers and persons responsible.
- Development of a new guideline by the Chief Psychiatrist in relation to “off label prescribing”.

Case Summaries

The following case summaries have been de-identified to protect the identity and privacy of the parties, and demonstrate the variety of matters we deal with.

COMPLAINTS RESOLVED IN ASSESSMENT

Improvements to health services during 'ambulance offload delay' (ramping)

'Access block'², emergency department (ED) overcrowding, and ambulance offload delay (ramping³) have been common occurrences in Tasmania's four public hospitals⁴.

Following on from a serious complaint submitted by a patient who felt she was going to die in an ambulance before she could be transported to the ED, the Tasmanian Health Service (THS) developed and implemented two new protocols in 2020 aimed at improving the emergency care provided to patients affected by ramping.

At the time of the complainant's ambulance presentation, there were no specific THS protocols regarding the management of patients affected by ramping.

Enquiries on behalf of the complainant by the OHCC contributed to the development and implementation of these important systemic improvements in the way that ramping is managed in Tasmanian Hospitals.

The THS provided a lengthy explanation for the delays experienced by the patient and also apologised for the delay that occurred between the time she arrived in the ambulance and her admission to the ED.

² The Australasian College of Emergency Medicine (ACEM) defines access block as the situation where patients who have been admitted and need a hospital bed are delayed from leaving the Emergency Department (ED) because of lack of inpatient bed capacity.

³ Ambulance ramping is when a transported patient has a prolonged wait within the ambulance on arrival at a hospital because there are no vacant care areas or beds available in the hospital's emergency department (ED), is a problem of increasing importance in Australia.

⁴ The Australasian College of Emergency Medicine.

Legal fees reimbursed and the patient reinstated into a remote general practice

A patient complained that he and his family had been barred from his regular general practice following a dispute with a staff member outside the practice. The patient had commenced legal proceedings against the practice in this regard.

The OHCC obtained a range of responses from medical and administrative staff members of the practice and held a number of discussions with the practice management team in an effort to obtain an explanation, an apology and compensation for the complainant.

Ultimately, the practice management provided a sincere apology to the complainant, reimbursed his legal fees and paved the way for him and his family to return to the practice.

Patient care reinstated at a rural practice and training for staff undertaken

The complainant was excluded from a rural general practice following an emotional outburst at reception staff. He complained that the reception staff had failed to assist him when he had been suffering a 'medication induced' psychological emergency. He also claimed that the staff had focused on their own reactions to his outburst, rather than assisting him to obtain an appointment with a GP in order to be treated for his episodic trauma.

He wished to be repatriated into the practice. He also sought an apology for the exclusion and skills training for staff in emergency mental health care so that this situation would not occur again for him or other patients.

This complaint was managed by our 'direct facilitation' process which necessitated lengthy telephone conversations and emails with both parties.

The medical practice was invited to consider the complaint as a reason to foster more understanding of and skills for dealing with patients experiencing mental health issues. We suggested that the practice adopted a broader, more patient focussed perspective on what may be causing a patient to raise their voice. We have recommended to the general practice that, should such an event occur again, it would be beneficial for reception staff (if possible) to consult with a medical practitioner about their concerns about a patient before making a decision as to how to manage a situation.

The practice also offered a verbal apology to the complainant and agreed to allow him to return to the practice, subject to a 'behaviour contract'.

Concerns about confidentiality breach during COVID-19

Following a presentation to an emergency department, a patient raised concerns about potential privacy breaches created by the volume of the speaker system in the emergency department (ED) at the hospital.

He complained to the OHCC that his personal details had been broadcast around the ED waiting room.

Hospital staff took these concerns seriously and undertook the following improvements to address the privacy issue:

- the microphone speaker volume at the reception window of the ED was lowered; and
- the ED clerks were reminded to ask patients of their details in a way that protects their privacy.

The patient later visited the ED and was satisfied that the issue had been resolved.

Improvements to internal communication systems at a general practice results in safer health care for patient

A complainant felt her health had been compromised when her GP failed to make an important referral for her in a timely manner. Reception staff committed to escalating her concerns about the delays, but failed to do so.

Following initial inquiries with the Practice it became apparent that the complaint was underpinned by a communication breakdown between administrative and medical staff members. Additionally, the practice had developed a culture of 'key-person dependence' such that when a manager went on leave, staff failed to action important requests from patients.

As a result of this complaint, the OHCC made recommendations for improvements to the Practice's internal communication systems and processes in order to reduce the risks of such an event reoccurring.

Following internal meetings to discuss the complaint and the recommendations, several systemic improvements relating to internal communications were adopted by doctors at the Practice.

Complaint about the HotDoc automated messaging system⁵

A patient complained that she had received some very disturbing information via the HotDoc automated messaging system regarding the results of her mammogram scan. The message was phrased such that the patient felt she had received a positive result, but she was not able to obtain an appointment with a GP for almost three days after receiving the message.

The OHCC held conversations with the Practice Manager about the issue, who acknowledged and understood that the wording of the automated text message following a mammogram was both very distressing and misleading. Specifically, the words *extremely important* in the text message naturally created a frightening suspicion that the patient may have had a positive result from the mammogram.

The practice apologised to the complainant, advising that they were ‘sincerely sorry’.

The practice amended the wording of the automated message to convey a more appropriate meaning to recipients about the urgency, or otherwise, of consulting with their practitioner about the results of their mammograms. This amendment will hopefully prevent such a difficult and distressing situation occurring again.

Updated Vaccination Policy

This Office received a complaint from a mother concerned about the administration of incorrect vaccinations to her children. The general practitioner had administered vaccinations without checking the identity of each child prior to administration. The children had not suffered any ill effects but the mother wanted to register her concern.

During our assessment process we identified shortcomings in the practice policy relating to the administration of vaccines as a result of which the practice implemented changes to the policy to reduce the risk of this error occurring again.

As a result vaccinations will no longer be drawn up before a patient attends, rather they will be checked by two people at the time of drawing up, and with the most recent vaccination guidelines, and the patients in the room. This is a more robust procedure to ensure this error does not occur again. A copy of the updated policy was forwarded to this Office.

⁵ A totally automated service that allows practices to send SMS health reminders and results messages to patients.

New process for checking identity prior to administration of medication

A complaint was received from an inmate concerned that they had been administered an injection they should not have received. They claimed that they were not asked for their date of birth, name or offender number prior to the administration of the medication.

The response confirmed the wrong inmate had been given medication and advised that they had been given an antidote within an hour of the original injection and monitored for adverse effects. None were noted.

We notified, and consulted with, AHPRA as to whether there were aspects of the complaint that required regulatory action. AHPRA is primarily concerned with ongoing risk to the public, and determined on this occasion that the performance of the practitioner did not indicate an ongoing risk which required action from them.

It was identified that medication processes had contributed to the incident. A new policy was developed and implemented whereby all inmates receive a paper printout of their identification prior to receiving any medication. This will reduce the chance of this error occurring again and ensure that the correct patient is presenting for the correct medication.

Implementation of new process to check Webster packs at a pharmacy

We received a complaint about medication being missed out of a Webster pack. The Webster pack was packaged interstate before being sent to the local pharmacy in Tasmania. The complainant claimed that this had occurred previously. They were seeking a change of policy/procedure as they were concerned this may be occurring undetected in other Webster packs.

We obtained a response to the complaint which indicated that the error had occurred due to a systemic failure, and appropriate measures were subsequently implemented to mitigate this risk.

Having become aware of the two incidents, refresher training was provided to all pharmacists in the pharmacy and all Webster packs are now checked when received from the service where they are packaged to ensure they correspond with the patient's medical summary.

Appendix I – Statistics

Table 7 - Reasons for Closure

Reason	2019-20	2020-21
Dismiss - Section 25 (5) (a) Complainant not a person entitled under s22	10	6
Dismiss - Section 25 (5) (b) Complaint does not disclose a subject matter referred to in s23	8	13
Dismiss - Section 25 (5) (c) Complainant became aware of the circumstance more than 2 years ago	2	9
Dismiss - Section 25 (5) (d) Complainant has not attempted direct resolution	23	61
Dismiss - Section 25 (5) (e) Issues adjudicated by court or tribunal	1	0
Dismiss - Section 25 (5) (h) The complaint lacks substance	7	0
Dismiss - Section 25 (5) (i) The complaint is frivolous, vexatious or not made in good faith	2	5
Section 30 (1) The complaint has been withdrawn in writing	7	8
Other	3	2
Dismiss - Section 25 (5) (g) Complainant has been given reasonable explanation and information	176	259
Dismiss - Section 25 (5) (j) Complaint has been resolved	62	44
Out of Jurisdiction	2	0
Section 25 (1) (a) Complaint referred to the Ombudsman or another person	29	45
Referred to AHPRA pursuant to MoU*	24	22
Retained by AHPRA pursuant to MoU*	62	53
Closed in Conciliation*	14	12
Closed in Investigation (investigation discontinued)	0	1
Total	432	540

Note: From 2020-2021 Referred to AHPRA, Retained by AHPRA and Closed in conciliation have been included as closure reasons.

Outcomes achieved through the assessment process are set out in Table 8. These included apologies, provision of services, refunds of costs, and recommendations for, and the implementation of, quality improvements such as changes in policy or procedure. It should be noted that more than one outcome may result from one complaint. Examples of cases finalised in assessment appear in the case studies earlier in this report and are published on our website.

Table 8 - Outcomes from cases closed in Assessment Stage

Outcomes	2019-20	2020-21
Apology Given	38	38
Change in Policy	11	10
Change in Procedure	15	14
Compensation Received	2	0
Concern Registered	82	149
Declined/Referred	0	6
Dismissed (no other outcome)	0	14
Explanation Given	102	177
Fees/Costs - Refunded, waived or reduced	17	7
Information obtained	184	257
Quality Improvement	17	14
Service Obtained	59	85
Total	527	771

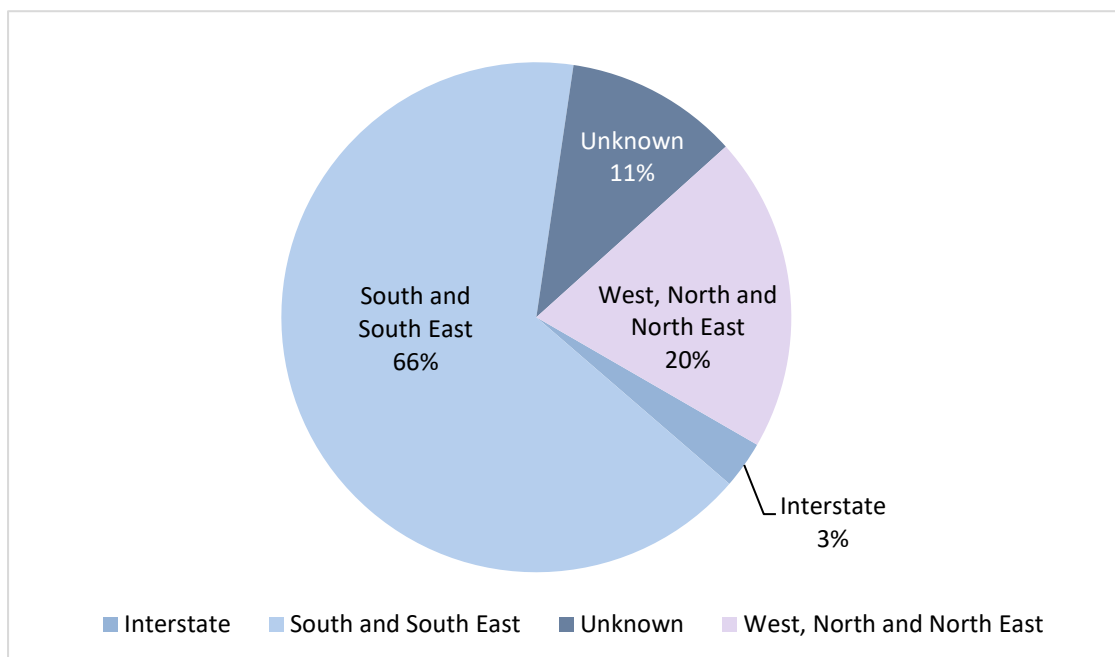
Note: From 2020-2021 S25(1)(a) is no longer categorised as an outcome in assessment.

Outcomes achieved from cases closed in conciliation are set out in Table 9. A number of matters closed in conciliation did not proceed. Some of the outcomes recorded in Table 9 were achieved during the assessment stage. It should be noted that more than one outcome may result from one complaint.

Table 9 - Outcomes from cases closed in Conciliation

Outcomes	2019-20	2020-21
Apology Given	7	9
Change in Policy	3	2
Change in Procedure	3	1
Compensation Received or agreed	3	4
Concern Registered	10	8
Declined/Referred	0	1
Explanation Given	14	10
Fees/Costs refunded, waived or reduced	0	1
Information obtained	11	2
Quality improvement	5	5
Service obtained	5	0
Total	61	43

Figure 6 - Geographical location of complainants



WHAT DID THEY COMPLAIN ABOUT?

Issues by category

Table 10 - Summary of issues by category

Issue	2019-20	2020-21
Access	110	166
Communication and information	90	124
Consent	16	19
Discharge and transfer arrangements	8	10
Environment / Management of facilities	5	31
Fees and costs	21	20
Grievance processes	16	21
Inquiry service	29	17
Medical records	6	8
Medication	132	172

Issue	2019-20	2020-21
Professional conduct	24	27
Reports / certificates	16	20
Treatment	188	214
Total	661	849

A breakdown of the issues arising from complaints closed in the reporting year is set out in Tables 11 to 23. It should be noted that a significant number of complaints contain more than one issue.

Table 11 - Access

Issue	2019-20	2020-21
Access to facility	1	2
Access to subsidies	1	3
Refusal to admit or treat	5	18
Remoteness of service	0	2
Service availability	101	122
Waiting lists	2	19
Total	110	166

Table 12 - Communication and Information

Issue	2019-20	2020-21
Attitude/manner	46	66
Inadequate information provided	27	25
Incorrect/misleading information provided	13	26
Special needs not accommodated	4	7
Total	90	124

Table 13 – Consent

Issue	2019-20	2020-21
Consent not obtained or inadequate	8	8
Involuntary admission or treatment	3	10
Uninformed consent	5	1
Total	16	19

Table 14 – Discharge and Transfer Arrangements

Issue	2019-20	2020-21
Delay	1	1
Inadequate discharge	6	7
Mode of transport	1	0
Patient not reviewed	0	2
Total	8	10

Table 15 – Environment / Management of Facilities

Issue	2019-20	2020-21
Administrative processes	4	20
Cleanliness/hygiene of facility	1	1
Physical environment of facility	0	7
Staffing and rostering	0	2
Statutory obligations/accreditation standards not met	0	1
Total	5	31

Table 16 – Fees and Costs

Issue	2019-20	2020-21
Billing practices	12	12
Cost of treatment	3	1
Financial consent	6	7
Total	21	20

Table 17 – Grievance Processes

Issue	2019-20	2020-21
Inadequate/no response to complaint	14	18
Information about complaints procedures not provided	0	3
Reprisal/retaliation as a result of complaint lodged	2	0
Total	16	21

Table 18 – Inquiry Service

Issue	2019-20	2020-21
Request for information - Health Service	5	4
Request for information - Other	3	4
Request for Information - Commission	1	0
Request for information - Complaint mechanisms	20	9
Total	29	17

Table 19 – Medical Records

Issue	2019-20	2020-21
Access to/transfer of records	4	5
Record keeping	2	2
Records management	0	1
Total	6	8

Table 20 – Medication

Issue	2019-20	2020-21
Administering medication	8	4
Dispensing medication	8	3
Prescribing medication	116	164
Supply/security/storage of medication	0	1
Total	132	172

Table 21 – Professional Conduct

Issue	2019-20	2020-21
Assault	1	2
Boundary violation	0	1
Competence	14	9
Discriminatory conduct	1	0
Emergency treatment not provided	0	1
Financial fraud	0	3
Illegal practice	0	3
Inappropriate disclosure of information	6	8
Sexual misconduct	2	0
Total	24	27

Table 22 – Reports/Certificates

Issue	2019-20	2020-21
Accuracy of report/certificate	6	7
Cost of report/certificate	1	1
Refusal to provide report/certificate	5	9
Report written with inadequate or no consultation	1	2
Timeliness of report/certificate	3	1
Total	16	20

Table 23 – Treatment

Issue	2019-20	2020-21
Coordination of treatment	18	26
Delay in treatment	15	34
Diagnosis	32	24
Excessive treatment	2	2
Experimental treatment	0	1
Inadequate care	28	32
Inadequate consultation	2	9
Inadequate prosthetic equipment	4	4
Inadequate treatment	24	22
Infection control	1	1
No/inappropriate referral	7	7
Rough and painful treatment	9	6
Unexpected treatment outcome/complications	41	36
Withdrawal of treatment	1	2
Wrong/inappropriate treatment	4	8
Total	188	214

WHO DID THEY COMPLAIN ABOUT?

Table 24 – Complaints received about Health Organisations

Health Organisation	2019-20	2020-21
Aged Care	0	1
Ambulance	3	2
Community Health	0	4
Correctional Health	150	196
Dental Practices/Clinics	6	4
Department of Health (previously DHHS)	8	14
Diagnostic Services	1	2
Disability Services	2	0
Medical Practices/Clinics	22	36
Mental Health Services	10	18
Optometrist	2	2
Oral Health Services	2	0
Other	8	11
Pathology	2	2
Pharmacies	5	5
Private Hospitals	7	8
Public Hospitals	43	75
Total	274	380

Table 25 – Issues Relating to Correctional Primary Health Service

Issue	2019-20	2020-21
Access	80	116
Communication & information	9	13
Consent	0	1
Discharge and transfer arrangements	0	1
Environment/management of facilities	1	5
Inquiry Service only	3	2
Medical records	2	0
Medication	100	131
Professional conduct	1	0
Reports/certificates	3	5
Treatment	15	49
Total	214	323

Hospitals

Table 26 – Issues Relating to Private Hospitals

Issue	2019-20	2020-21
Access	2	0
Communication & information	1	8
Consent	0	1
Discharge and transfer arrangements	1	1
Environment/management of facilities	0	5
Fees & costs	1	1
Grievance processes	1	4

Medication	1	3
Professional conduct	1	2
Treatment	7	13
Total	17	38

Table 27 – Issues Relating to Public Hospitals

Issue	2019-20	2020-21
Access	11	23
Communication & information	24	30
Consent	9	5
Discharge & transfer arrangements	4	4
Environment/management of facilities	0	7
Fees and costs	1	5
Grievance processes	3	3
Inquiry service only	5	4
Medical records	0	0
Medication	5	9
Professional conduct	4	1
Reports/certificates	2	1
Treatment	63	44
Total	131	136

Individual Providers

Table 28 - Complaints about Individual Providers

Provider	2019-20	2020-21
Dental	9	5
Exempt	0	1
Medical practitioner	21	32
Nurse	1	2
Optometrist	1	0
Other/unknown	12	0
Pharmacist	3	0
Psychologist	2	1
Total	49	41