

# Complaints to HDC involving Te Whatu Ora

Report and Analysis for period 1 January to 30 June 2022



Health and Disability Commissioner  
*Te Toihau Hauora, Hauātanga*

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# Commissioner's Foreword

Tēnā koutou

I am pleased to present my Office's first complaint trend report for complaints made about Te Whatu Ora districts. This report outlines the trends in complaints received by HDC about districts between 1 January and 30 June 2022 and replaces previous reporting about DHB complaints. We are continuing to work on ensuring these reports support quality and safety in the new system, and would welcome any feedback you have.

HDC received 566 complaints about Te Whatu Ora districts in January to June 2022. This represents a 22% increase on the average number of complaints received, but is the same number of complaints as was received in the previous six month period.

The general trends in this report are consistent with past trends. Surgery, mental health & addictions, medicine and emergency department services remain the most commonly complained about services. Missed/delayed diagnosis continues to be the most common primary complaint issue raised by complainants.

HDC continued to receive a high number of COVID-19 related complaints in the first six months of 2022, and the profile of these complaints changed significantly with the advent of the Omicron outbreak and the significant pressure this placed on the health system. Complaints changed from being primarily related to the vaccine roll-out to being about the impact of COVID-19 on the health system. Almost 40% of district complaints related to COVID-19 were about reduced access and/or significant delays in care, as well as the impact reduced staffing had on consumers' experience of services. A number of complaints also related to COVID-19 related policies and protocols, most commonly concerns related to visitor restrictions.

I hope these reports assist in understanding the consumer experience and people's concerns. I know 2022 has been a particularly challenging year for the health and disability workforce. Ngā mihi for remaining committed to quality and safety and improving the consumer experience.

Morag McDowell  
**Health and Disability Commissioner**

# National data for Te Whatu Ora | Health New Zealand

## 1. Complaints received about Te Whatu Ora

### 1.1 Number of complaints received

In the period Jan–Jun 2022, HDC received 566<sup>1</sup> complaints about care provided by Te Whatu Ora | Health New Zealand (previously District Health Boards). This is the same number of complaints as was received in the previous six-month period, but is a 16% increase on the average number of complaints received over the past four six-month periods.

**Table 1.** Number of complaints received in the last five years

	Jul– Dec 17	Jan– Jun 18	Jul– Dec 18	Jan– Jun 19	Jul– Dec 19	Jan– Jun 20	Jul– Dec 20	Jan– Jun 21	Jul– Dec 21	Average of last four periods	Jan– Jun 22
<b>Number of complaints</b>	439	450	442	427	471	392	464	532	566	<b>489</b>	<b>566</b>

### 1.2 Rate of complaints received

When numbers of complaints to HDC are expressed as a rate per 100,000 discharges, comparisons can be made between and within regions over time, enabling any trends to be observed.

Complaint rate calculations are made using discharge data provided by Manatū Hauora | Ministry of Health. This data is provisional as at the date of extraction (20 October 2022) and may be incomplete. It should be noted that this discharge data excludes short-stay emergency department discharges and patients attending outpatient clinics.

**Table 2.** Rate of complaints received per 100,000 discharges

<b>Number of complaints received</b>	<b>Total number of discharges</b>	<b>Rate per 100,000 discharges</b>
566	453,671	124.76

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jan–Jun 2022 and previous six-month periods.

<sup>1</sup> Provisional as of date of extraction (1 September 2022).

**Table 3.** Rate of complaints received in the last five years

	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Jan–Jun 20	Jul–Dec 20	Jan–Jun 21	Jul–Dec 21	Average of last 4 periods	Jan–Jun 22
<b>Rate per 100,000 discharges</b>	93.80	88.47	87.97	92.92	90.35	92.00	106.77	117.33	<b>101.61</b>	<b>124.76</b>

The rate of complaints received during Jan–Jun 2022 (124.76) is 23% higher than the average rate of complaints received for the previous four periods, and is the highest rate of complaints ever received in a six-month period.

The number and rate of complaints received in Jan–Jun 2022 and previous six-month periods is displayed below in Figure 1.

**Figure 1.** Number of complaints received over the last five years

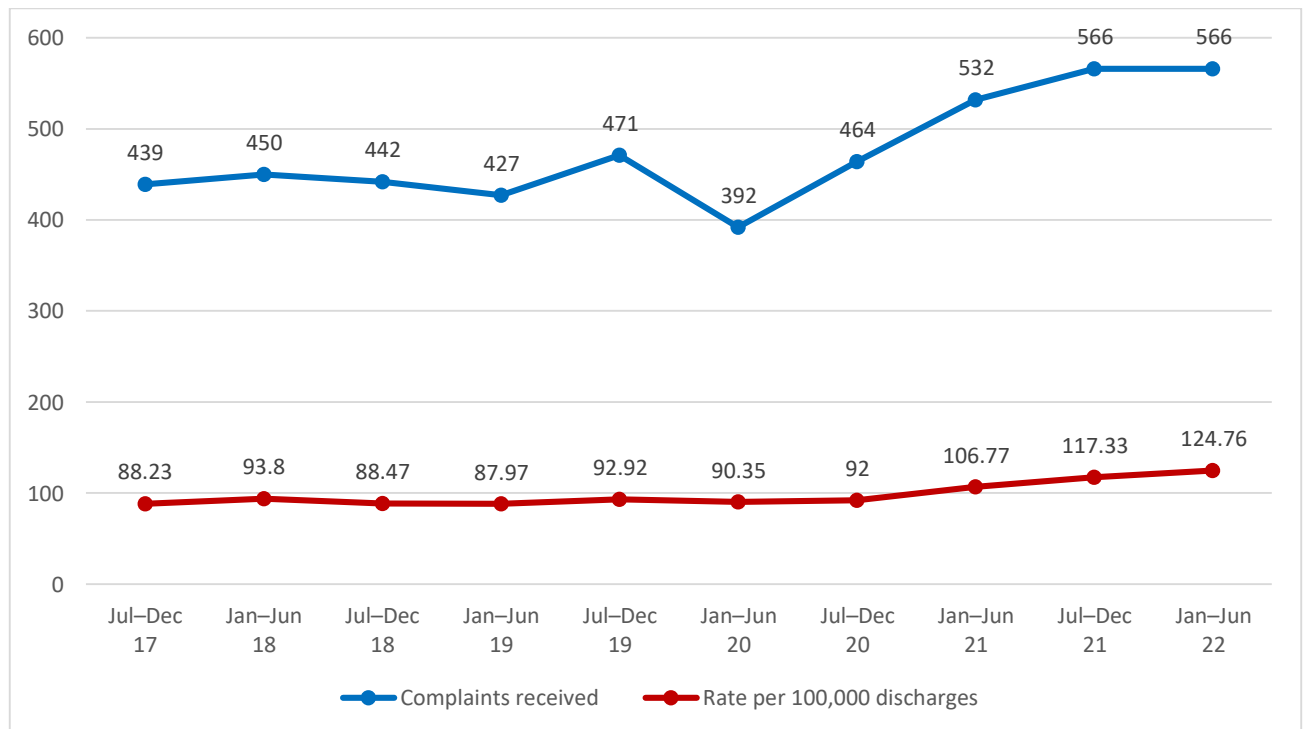


Table 4 shows the number and rate of complaints received by HDC for each Te Whatu Ora region and district.

**Table 4.** Number and rate of complaints received for each Te Whatu Ora region and district in Jan–Jun 2022

Region and district	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
<b>Northern North Island</b>	<b>183</b>	<b>170,471</b>	<b>107.35</b>
Te Tai Tokerau	21	21,051	99.76
Waitematā	56	51,262	109.24
Te Toka Tumai Auckland	59	57,296	102.97
Counties Manukau	47	40,862	115.02
<b>Te Manawa Taki</b>	<b>110</b>	<b>100,919</b>	<b>108.99</b>
Waikato	51	45,524	112.03
Lakes	17	11,423	148.82
Hauora a Toi Bay of Plenty	23	26,466	86.90
Tairāwhiti	9	4,837	186.07
Taranaki	10	12,669	78.93
<b>Central North Island</b>	<b>128</b>	<b>84,193</b>	<b>152.03</b>
Te Pae Hauora o Ruahine o Tararua MidCentral	23	13,970	164.64
Whanganui	11	6,627	165.99
Capital, Coast and Hutt Valley	67	42,531	157.53
Te Matau a Māui Hawke's Bay	19	17,110	111.05
Wairarapa	8	3,955	202.28
<b>Te Waipounamu</b>	<b>145</b>	<b>98,090</b>	<b>147.82</b>
Waitaha Canterbury	64	53,802	118.95
Te Tai o Poutini West Coast	7	2,727	256.69
Nelson Marlborough	20	11,537	173.36
South Canterbury	9	5,797	155.25
Southern	45	24,227	185.74

### Notes on region/district complaint number and rate of complaints

It should be noted that a district's number and rate of complaints can vary considerably from one six-month period to the next. Therefore, care should be taken before drawing conclusions on the basis of one six-month period. Further, for smaller districts, a very small absolute increase or decrease in the number of complaints received can dramatically affect the rate of complaints. Accordingly, much of the value in this data lies in how it changes over time, as such analysis allows trends to emerge that may point to areas that require further attention.

It is also important to note that the number of complaints received by HDC is not always a good proxy for quality of care provided, and can be impacted by a number of factors (e.g., features of the services provided by a particular district/region). Additionally, complaints received within a single six-month period will sometimes relate to care provided within quite a different time period. From time to time, some districts may also be the subject of a number of complaints from a single complainant within one reporting period. This is important context that is taken into account by regions when considering their own complaint patterns.

## 2. Who complained?

This section outlines the demographics of consumers in complaints to HDC about Te Whatu Ora services. The demographics of consumers is very similar to what was seen in the previous period.

### 2.1 Consumer gender

The gender of consumers in complaints to HDC about Te Whatu Ora services in Jan–Jun 2022 is detailed below.

**Table 5.** Consumer gender

Consumer gender	Number of complaints	Proportion of complaints
Female	343	61%
Male	215	38%
Unknown/did not wish to answer	8	1%



## 2.2 Consumer age

The age of consumers in complaints to HDC about Te Whatu Ora services in Jan–Jun 2022 is detailed below.

**Table 6.** Consumer age

Consumer age	Number of complaints	Proportion of complaints
0 to 17 years	43	8%
18 to 24 years	35	6%
25 to 34 years	89	16%
35 to 49 years	97	17%
50 to 64 years	108	19%
65+ years	132	23%
Unknown/did not wish to answer	62	11%

## 2.3 Consumer ethnicity

The ethnicity of consumers in complaints to HDC about Te Whatu Ora services in Jan–Jun 2022 is detailed below.

**Table 7.** Consumer ethnicity

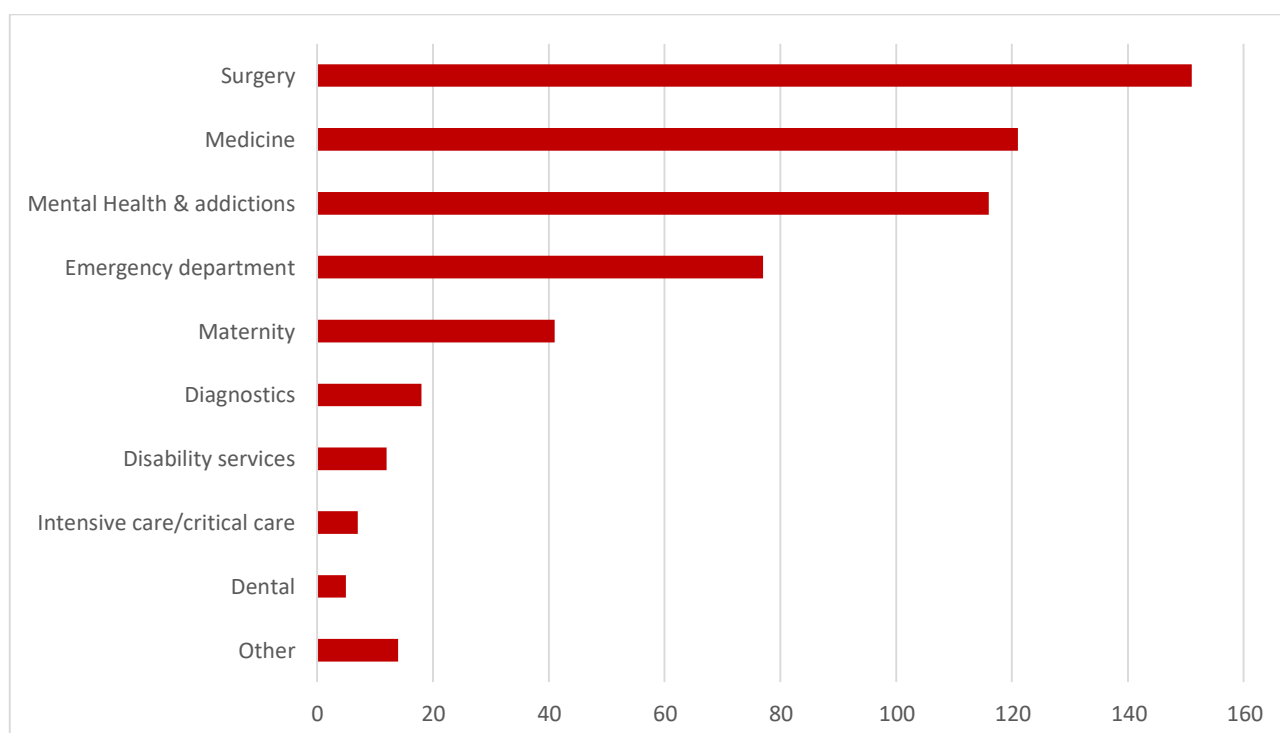
Consumer ethnicity	Number of complaints	Proportion of complaints
Māori	95	17%
Pacific	20	4%
Middle Eastern/African/Latin American	12	2%
Asian	31	5%
Other European	22	4%
New Zealand European	275	49%
Unknown/did not wish to answer	111	20%

### 3. Which Te Whatu Ora services were complained about?

#### 3.1 Te Whatu Ora service types complained about

Please note that some complaints involve more than one Te Whatu Ora district and/or more than one service or hospital; therefore, although there were 566 complaints about Te Whatu Ora, 578 services were complained about. Figure 2 below shows the most commonly complained about service types in Jan–Jun 2022. A more nuanced picture of service types complained about, including individual surgery and medicine services, is provided in Table 8.

**Figure 2.** Service types complained about



Surgery (26%) received the greatest number of complaints in Jan–Jun 2022, with orthopaedics (6%) being the surgical specialty most commonly complained about.

Other commonly complained about services included medicine (21%), mental health and addictions (20%), and emergency department (13%) services.

**Table 8.** Service types complained about

<b>Service type</b>	<b>Number of complaints</b>	<b>Percentage</b>
<b>Assisted dying</b>	<b>3</b>	<b>Less than 1%</b>
<b>Dental</b>	<b>5</b>	<b>Less than 1%</b>
<b>Diagnostics</b>	<b>18</b>	<b>3%</b>
<b>Disability services</b>	<b>12</b>	<b>2%</b>
<b>District nursing</b>	<b>3</b>	<b>Less than 1%</b>
<b>Emergency department</b>	<b>77</b>	<b>13%</b>
<b>Intensive care/critical care</b>	<b>7</b>	<b>1%</b>
<b>Maternity</b>	<b>41</b>	<b>7%</b>
<b>Medicine</b>	<b>121</b>	<b>21%</b>
General medicine	15	3%
Cardiology	17	3%
Endocrinology	6	1%
Gastroenterology	8	1%
Geriatric medicine	11	2%
Neurology	14	2%
Oncology	13	2%
Palliative care	4	Less than 1%
Renal/nephrology	8	1%
Respiratory	4	Less than 1%
Rheumatology	4	Less than 1%
Other/unspecified	17	3%
<b>Mental health and addiction</b>	<b>116</b>	<b>20%</b>
<b>Paediatrics (not surgical)</b>	<b>4</b>	<b>Less than 1%</b>
<b>Surgery</b>	<b>151</b>	<b>26%</b>
Cardiothoracic	2	Less than 1%
General	41	7%
Gynaecology	30	5%
Neurosurgery	8	1%
Ophthalmology	9	2%
Orthopaedics	37	6%
Otolaryngology	7	1%
Plastic and reconstructive	2	Less than 1%
Paediatric	6	1%
Urology	7	1%
Other/unknown	2	Less than 1%
<b>Other/unknown health service</b>	<b>20</b>	<b>2%</b>
<b>TOTAL</b>	<b>578</b>	

Table 9 below shows a comparison of the proportion of complaints received over time for the most commonly complained about service types.

**Table 9.** Comparison of the proportion of complaints received about the most commonly complained about service types

Service type	Jul–Dec 2019	Jan–Jun 2020	Jul–Dec 2020	Jan–Jun 2021	Jul–Dec 2021	Jan–Jun 2022
<b>Surgery</b>	31%	31%	23%	26%	22%	26%
<b>Mental health and addictions</b>	25%	22%	24%	23%	20%	20%
<b>Medicine</b>	16%	18%	19%	16%	21%	21%
<b>Emergency department</b>	11%	11%	15%	12%	16%	13%
<b>Maternity</b>	5%	7%	5%	5%	5%	7%

## 4. What did people complain about?

### 4.1 Primary issues identified in complaints

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received in Jan–Jun 2022 are listed below in Table 10. It should be noted that the issues included are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, they provide a valuable insight into consumers’ experience of services provided and the issues they care about most.

The most common primary issue categories were:

- Care/treatment (53%)
- Access/funding (14%)
- Consent/information (11%)
- Communication (9%)

The most common specific primary issues complained about were:

- Missed/incorrect/delayed diagnosis (12%)
- Inadequate/inappropriate treatment (9%)
- Unexpected treatment outcome (8%)
- Lack of access to services (7%)
- Waiting list/prioritisation issue (6%)

**Table 10.** Primary issues complained about

<b>Primary issue in complaints</b>	<b>Number of complaints</b>	<b>Percentage</b>
<b>Access/Funding</b>	<b>76</b>	<b>13%</b>
Lack of access to services	39	7%
Lack of access to subsidies/funding	4	Less than 1%
Waiting list/prioritisation issue	33	6%
<b>Boundary violation</b>	<b>5</b>	<b>Less than 1%</b>
<b>Care/Treatment</b>	<b>296</b>	<b>52%</b>
Delay in treatment	24	4%
Delayed/inadequate/inappropriate referral	3	Less than 1%
Inadequate coordination of care/treatment	7	1%
Inadequate/inappropriate clinical treatment	53	9%
Inadequate/inappropriate examination/assessment	15	3%
Inadequate/inappropriate follow-up	13	2%
Inadequate/inappropriate monitoring	16	3%
Inadequate/inappropriate non-clinical care	9	2%
Inadequate/inappropriate testing	1	Less than 1%
Inappropriate admission/failure to admit	2	Less than 1%
Inappropriate/delayed discharge/transfer	20	4%
Inappropriate withdrawal of treatment	3	Less than 1%
Missed/incorrect/delayed diagnosis	67	12%
Refusal to assist/attend	2	Less than 1%
Refusal to treat	13	2%
Rough/painful care or treatment	3	Less than 1%
Unexpected treatment outcome	45	8%
<b>Communication</b>	<b>48</b>	<b>8%</b>
Disrespectful manner/attitude	28	5%
Failure to accommodate cultural/language needs	1	Less than 1%
Failure to communicate openly/honestly/effectively with consumer	11	2%
Failure to communicate openly/honestly/effectively with family/whānau	8	1%
<b>Complaints process</b>	<b>3</b>	<b>Less than 1%</b>
<b>Consent/Information</b>	<b>60</b>	<b>11%</b>
Consent not obtained/adequate	24	4%
Inadequate information provided regarding treatment	5	Less than 1%
Incorrect/misleading information provided	7	1%
Issues with involuntary admission/treatment	24	4%
<b>Documentation</b>	<b>8</b>	<b>1%</b>
<b>Facility issues</b>	<b>31</b>	<b>5%</b>
General safety issue for consumer in facility	11	2%
Inadequate/inappropriate policies/procedures	18	3%
Other	2	Less than 1%
<b>Medication</b>	<b>23</b>	<b>4%</b>
Inappropriate prescribing	15	2%
Refusal to prescribe/dispense/supply	5	Less than 1%

Other medication issue	3	Less than 1%
<b>Professional conduct issues</b>	<b>8</b>	<b>1%</b>
Disrespectful behaviour	4	Less than 1%
Inappropriate collection/use/disclosure of information	4	Less than 1%
<b>Other issues</b>	<b>8</b>	<b>1%</b>
<b>TOTAL</b>	<b>566</b>	

Table 11 shows a comparison over time for the most common primary issues complained about.

**Table 11.** Top five primary issues in complaints received over the last four six-month periods

Top five primary issues in all complaints (%)							
Jul–Dec 20 n=464		Jan–Jun 21 n=532		Jul–Dec 21 n=566		Jan–Jun 22 n=566	
Misdiagnosis	12%	Misdiagnosis	13%	Misdiagnosis	11%	Misdiagnosis	12%
Lack of access to services	10%	Unexpected treatment outcome	8%	Inadequate treatment	8%	Inadequate treatment	9%
Unexpected treatment outcome	8%	Lack of access to services	7%	Lack of access to services	8%	Unexpected treatment outcome	8%
Waiting list/prioritisation	7%	Waiting list/prioritisation	7%	Delay in treatment	6%	Lack of access to services	7%
Inadequate treatment	5%	Inadequate treatment	6%	Inadequate treatment	6%	Waiting list/Prioritisation	5%

The most common primary issues complained about in regard to care provided to Māori consumers were:

- Inadequate/inappropriate clinical treatment — 14%
- Unexpected treatment outcome — 12%
- Missed/incorrect/delayed diagnosis — 10%
- Disrespectful manner/attitude — 7%

Māori raised issues around “inadequate treatment”, and “unexpected treatment outcome” and “disrespectful manner/communication” at a slightly higher rate than was seen across all population groups.

### Complaints related to COVID-19

HDC received 129 complaints about COVID-19-related issues at districts in Jan–Jun 2022. This represents 23% of all complaints about COVID-19 received by HDC during this time period, and is an increase on the 72 COVID-19-related complaints received about districts in Jul–Dec 2021.

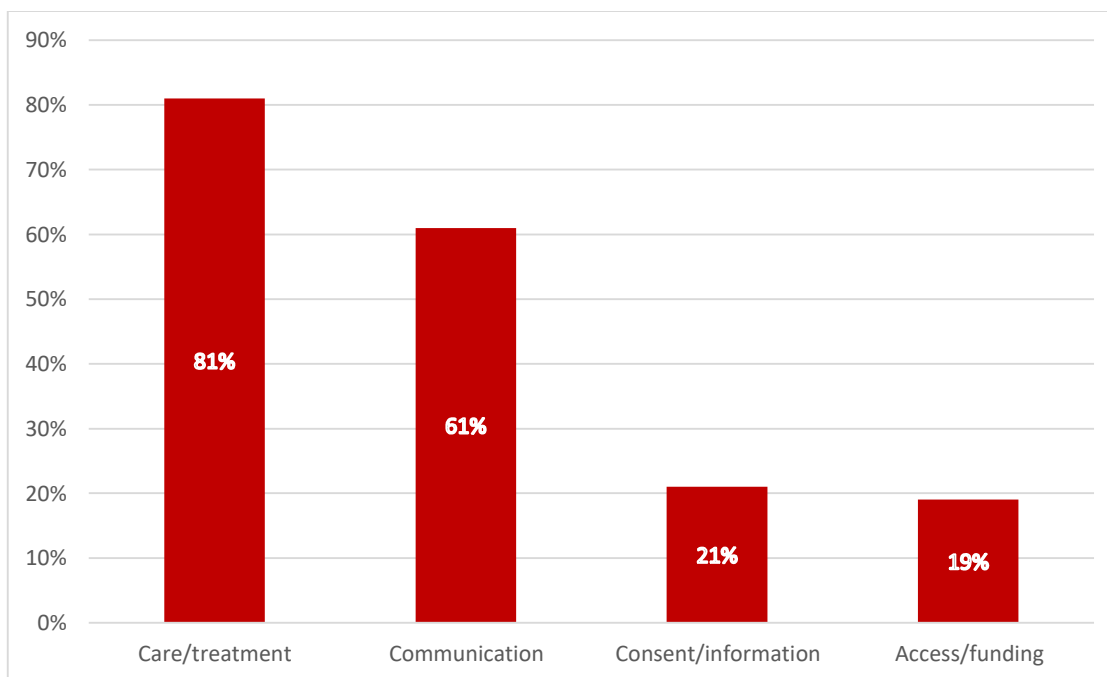
Complaints related to:

- Impact of COVID-19 on the health care system (e.g., delayed care, reduced staffing, etc.) — 39%
- COVID-19-related policies/procedures (primarily visitor restrictions, but also included concerns about mask requirements, vaccine mandates and other infection control policies) — 35%
- Vaccine-related issues (e.g., consent, adverse effects, administration procedure, etc.) — 12%
- Treatment of COVID-19 — 8%
- Testing-related issues (e.g., access to testing, delays in receiving results, etc.) — 5%

## 4.2 All issues identified in complaints

As well as the primary complaint issue, up to six additional complaint issues are identified for each complaint received by HDC. Figure 3 below shows the most common complaint issues when these additional complaint issues and primary complaint issues are considered. This is broadly similar to what has been seen in previous periods.

**Figure 3.** Most common complaint issues



### 4.3 Primary issues by service type

Table 12 shows the top three primary issues in complaints concerning the most commonly complained about service types.

This is broadly similar to what was seen in previous periods. However, compared to the previous period there has been an increase in complaints about “unexpected treatment outcome” for surgical services.

**Table 12.** Three most common primary issues in complaints by service type

Surgery		Mental health & additions		Medicine		Emergency department	
Unexpected treatment outcome	25%	Issues with involuntary admission/treatment	18%	Missed/incorrect/delayed diagnosis	14%	Missed/incorrect/delayed diagnosis	28%
Waiting list/prioritisation issue	14%	Lack of access to services	9%	Inadequate/inappropriate treatment	10%	Inadequate/inappropriate treatment	13%
Lack of access to services	11%	Inadequate/inappropriate treatment	7%	Lack of access to services	8%	Delay in treatment	11%

## 5. What were the outcomes of the complaints closed?

HDC is focused on fair and early resolution of complaints. Each complaint received by HDC is assessed carefully and resolved in the most appropriate manner, bearing in mind the issues raised and the evidence available. The assessment process can involve a number of steps, including



obtaining a response from the provider/s, seeking clinical advice, and asking for information from the consumer or other people.

A number of options are available to the Commissioner for the resolution of complaints. HDC may refer a complaint back to the provider or to the Advocacy Service to resolve directly with the consumer. In line with their responsibilities under the Code, providers have increasingly developed good systems to address complaints in a timely and appropriate way. Where complaints are assessed as suitable for resolution between the parties, it is often appropriate for HDC to refer a complaint to Te Whatu Ora to resolve with a requirement that it report back to HDC on the outcome of its handling of the complaint.

The Commissioner also has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider’s actions were reasonable in the circumstances; a more appropriate outcome can be achieved in a more flexible and timely way than by means of investigation; or the matters that are the subject of the complaint have been, are being, or will be, addressed appropriately by other means. A decision to take no further action can be accompanied by an educational comment or recommendations designed to assist the provider to improve services in future.

Where appropriate, the Commissioner may investigate a complaint, which may result in Te Whatu Ora being found in breach of the Code. Notification of investigation generally indicates more serious issues.

## 5.1 Number of complaints closed

In the period Jan–Jun 2022, HDC closed 505<sup>2</sup> complaints involving Te Whatu Ora districts. Table 13 shows the number of complaints closed in previous six-month periods.

**Table 13.** Number of complaints closed about districts in the last five years

	Jul– Dec 17	Jan– Jun 18	Jul– Dec 18	Jan– Jun 19	Jul– Dec 19	Jan– Jun 20	Jul– Dec 20	Jan– Jun 21	Jul– Dec 21	Average of last 4 periods	Jan– Jun 22
<b>Number of complaints closed</b>	383	476	449	444	423	428	390	478	330	<b>407</b>	<b>505</b>

## 5.2 Outcomes of complaints closed

The manner of resolution and outcomes of all complaints closed about Te Whatu Ora districts in Jan–Jun 2022 is shown in Table 14.

<sup>2</sup> Note that complaints may be received in one six-month period and closed in another six-month period — therefore, the number of complaints received will not correlate with the number of complaints closed.

**Table 14.** Outcome for districts of complaints closed by complaint type<sup>3</sup>

<b>Outcome for Te Whatu Ora districts</b>	<b>Number of complaints closed</b>
<b><i>Investigation</i></b>	<b>40</b>
Breach finding — referred to Director of Proceedings	3
Breach finding	18
No breach finding with adverse comment and recommendations	9
No breach finding with recommendations	5
No breach finding	3
Withdrawn	2
<b><i>Other resolution following assessment</i></b>	<b>465</b>
No further action with recommendations or educational comment	59
Referred to District Inspector	18
Referred to other agency	4
Referred to Te Whatu Ora	92
Referred to Advocacy	129
No further action	162
Withdrawn	1
<b>TOTAL</b>	<b>505</b>

### 5.3 Recommendations

Regardless of whether or not a complaint has been investigated, the Commissioner may make recommendations to Te Whatu Ora. HDC then follows up with Te Whatu Ora to ensure that these recommendations have been acted upon.

Table 15 shows the recommendations made to Te Whatu Ora for complaints closed in Jan–Jun 2022. Please note that more than one recommendation may be made in relation to a single complaint.

**Table 15.** Recommendations made to districts following a complaint

<b>Recommendation</b>	<b>Number of recommendations made</b>
Apology	27
Audit	19
Presentation/discussion of complaint and improvements with others	18
Provision of evidence of change to HDC/evaluation of change	24
Review/implementation of policies/procedures	33
Training/professional development	32
<b>TOTAL</b>	<b>153</b>

<sup>3</sup> Note that outcomes are displayed in descending order. If there is more than one outcome for a Te Whatu Ora region upon resolution of a complaint, then only the outcome that is listed highest in the table is included.

The most common recommendations made in Jan–Jun 2022 were that the Te Whatu Ora district involved review/implement policies/procedures (33 recommendations) or that it provide further training to its staff (32 recommendations). Training was most often in relation to clinical issues, followed by communication and new policies/procedures. HDC also often suggests that an anonymised version of the complaint be presented to staff for educative purposes.

## 6. Learning from complaints

### 6.1 Informed consent to involvement of medical students<sup>4</sup>

**This case highlights the expectation that the presence or involvement of students in sensitive examinations or procedures can take place only with unequivocal informed consent.**

#### *Background*

A woman with a mild intellectual disability was accompanied by her mother to an appointment with an obstetrician & gynaecologist (the doctor). The doctor outlined the range of available contraceptive options, including a Mirena IUD. The woman's preference was for the Mirena to be inserted under a general anaesthetic.

The woman and her mother were clear that she did not consent to the presence of medical students, and that she had completed a form at the pre-assessment clinic refusing the presence of medical students. No such form could be found on her file. When the woman saw the doctor in the pre-assessment clinic, the subject of student involvement was not raised, and the "consent to students" section of the surgical consent form was not completed.

Prior to the procedure being undertaken, the doctor recognised that she had omitted to complete the checkbox on the consent form related to student involvement. The doctor therefore noted on the consent form that the presence of students needed "to be checked on admission", and that consent was to be confirmed. However, there is no evidence that anyone, including the doctor, acted on this alert or sought the woman's consent to student involvement.

The operation note states that the Mirena was inserted by a fifth-year medical student. There were also other medical students in the room as observers.

#### *Findings*

The Commissioner acknowledged the importance of medical education, but emphasised that there is a clear expectation that the presence or involvement of students in sensitive examinations or procedures can take place only with unequivocal informed consent, given the vulnerability of the person being examined. It is at the heart of patient-centred care.

The Commissioner considered that the woman was entitled to be notified about medical students' participation in her procedure, and concluded that the woman had earlier expressly refused it. While acknowledging that the woman's refusal appears not to have been known to the clinical team on the day of the procedure, consent was not otherwise obtained from her regarding the presence of medical students. The Commissioner found that by providing services involving teaching to the woman without first notifying her and obtaining her consent, the district breached Right 6(1)(d) and Right 7(1) of the Code.

The Commissioner also considered that the district's systems for obtaining consent were demonstrably lacking in that there were multiple forms at different stages of the process, and the "Time Out" processes were inadequate. Accordingly, the Commissioner found that the district failed to provide the woman with services with reasonable care and skill, in breach of Right 4(1) of the Code.

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<sup>4</sup> Decision 20HDC01693

### *Recommendations*

The Commissioner recommended that the district:

- Conduct an audit of cases within Obstetrics & Gynaecology in which students have observed or performed sensitive procedures, to check whether consent was given and recorded;
- Provide training to staff within Obstetrics & Gynaecology on informed consent, capacity, communication between clinicians, and the requirement to review clinical records; and
- Apologise to the woman in writing.

The Commissioner acknowledged that earlier this year a study was published in the *New Zealand Medical Journal* that showed serious lapses in obtaining informed consent for the involvement of medical students in sensitive examinations. Following the publication of the study in May 2022, the Commissioner wrote to all DHBs, medical schools and Te Whatu Ora to reinforce the message that informed consent must be sought for student involvement in sensitive examinations.

## **6.2 Assessment and action taken by an Emergency Department<sup>5</sup>**

**This case highlights the importance of critically assessing patients when they present to hospital on multiple occasions with the same symptoms within a relatively short period of time, particularly with little improvement. It also highlights the importance of communication, objectivity, and critically reflecting on biases when providing health services.**

### *Background*

A man in his thirties, of Māori descent, was diagnosed with otitis media (an infection of the middle ear) by a community health centre.

The man presented to the Emergency Department (ED) of a public hospital with a bacterial skin infection on his left foot, and was reviewed by the Senior House Officer (SHO). An incidental finding of discharge in his right ear, which had been present for two weeks, was noted. Following discussion with the Senior Medical Officer (SMO), the man was discharged with a referral to the Ear, Nose and Throat (ENT) service for follow-up. This referral was declined as it did not contain any clinical information indicating any degree of urgency.

A few weeks later, the man presented to ED with a four-week history of right ear pain, neck swelling and fever. He was seen by an SHO. The SHO noted that in the past the man had taken methamphetamine and cannabis, but had not taken those substances for six months. The man's blood tests indicated a significant infection. The SMO then reviewed the man and initiated the sepsis pathway. Antibiotics were commenced and a CT scan of his neck was undertaken, which showed an infection in the external ear. However, the middle ear could not be viewed on the scan and no further imaging was undertaken.

The man was then reviewed by an ENT specialist. The specialist understood that he was being asked to review a patient with a possible neck abscess, rather than for sepsis or a complicated ear infection. The specialist told HDC that the man was "in a state of great activity and euphoria" and was vague in responding to questions. The specialist documented his opinion that the man had otitis media/otitis externa, and recommended he be discharged with ear drops, antibiotics and a follow-up ENT

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<sup>5</sup> Decision 19HDC01783

appointment. The specialist stated that he saw no signs of sepsis, and no comments were made to him about possibly admitting the man.

The specialist reported that, based on the man's behaviour, he believed the man was experiencing acute methamphetamine intoxication. However, he did not discuss this with the man or his whānau. The specialist told HDC that he discussed the man's possible substance use with ED staff, but this is not documented. The man's family state that he was not intoxicated, and there is no documentation from ED staff that he was observed to be intoxicated.

The man was discharged from the ED and another ENT referral made. Later that evening (a Sunday), the ED Medical Director received a call from the laboratory, which advised that the man's blood cultures were positive for the bacteria *Streptococcus pyogenes* — a pathogen that can cause a variety of acute life-threatening infections. The discharge summary suggests that there was a delay of a few days before action was taken on these results.

The man re-presented to ED after being alerted to the abnormal results. The SMO noted that he was clinically well, and given his improvement he was discharged home with more intensive antibiotic treatment. The ED did not inform ENT of his positive blood cultures.

Around a month later, the man returned to ED with pain and discharge in his right ear, which had started the previous day. He was reviewed by an SHO and pus was noted in his right ear canal, and his eardrum was later confirmed to be perforated. The man's vital signs were abnormal. He was diagnosed with recurring otitis media, and discharged with antibiotics and an urgent ENT referral. At the time of the man's presentation there was no direct SMO supervision or experienced registrars in the ED, although there was an SMO on call. There is no record of the SHO discussing the man's presentation with an SMO.

A few weeks later, the man attended an outpatient appointment with the ENT specialist. The specialist found the man sleeping in the waiting room. The specialist believed the man's behaviour was a result of substance use. The specialist examined the man's ears. It was documented that the specialist reinforced to the man the importance of care of the ear and follow-up, and ear drops were prescribed and a CT scan arranged. The specialist recorded: "[T]he patient has obviously had very poor follow up with a significant history of substance abuse and methamphetamine use." There is no evidence that the specialist asked the man about his drug use or whether he had taken any substances.

The man's father had arranged to pick him up from the appointment, and the father told HDC that insensitive remarks were made by the ENT SMO about his son and drug use. The specialist stated that although he spoke about the man's drug use, he did not do so in the manner described by the father. The specialist said that he asked the man's father whether the family were aware that the man was using methamphetamine and doing very poorly.

The man collapsed at home three days later and was taken to ED by ambulance. CT imaging showed an abscess in the man's brain, arising from the temporal bone with associated fluid around the brain. Sadly, the man's condition continued to deteriorate despite intervention, and he died three days after his collapse at home.

### *Findings*

Over the course of about two months, the man presented to the ED on four occasions with a recurring ear infection. There were a number of missed opportunities to investigate whether the man was experiencing complications. The clinicians involved failed to appreciate the significance of the man's repeated presentations and poorly resolving symptoms.

The Deputy Commissioner found that the district failed to provide care to the man with appropriate care and skill, in breach of Right 4(1) of the Code for the following reasons:

- CT head scans, including adequate views of the temporal and mastoid areas, were not undertaken.
- The follow-up of abnormal results policy for patients discharged from ED was insufficient in that it did not explicitly state timeframes and responsibilities, and there was poor follow-up of the man's positive blood cultures.
- There was an inadequate system for overnight SMO supervision in the ED — with the ability to call the SMO being limited to a small list of conditions, giving a strong impression that contacting SMOs is for urgent issues only and not for consultation. This resulted in a lack of SMO input into the man's care during one presentation to ED, and therefore a poor assessment being undertaken.

The Deputy Commissioner was critical of the ENT specialist for his communication with the man's father and for discussing his assumption that the man was using methamphetamine without clarifying his suspicion with the man himself, or seeking to understand the interplay of the man's overall presentation.

In relation to speaking with whānau, the Deputy Commissioner reminded the ENT specialist of the Medical Council's statement on cultural safety, which stipulates that doctors should formulate treatment plans in partnership with patients that fit their cultural contexts and are balanced with the need to follow the best clinical pathway, and include the patient's whānau in their healthcare when appropriate.

#### *Recommendations*

The Deputy Commissioner recommended that the district:

- Provide a written apology to the man's whānau;
- Provide evidence of its amendment of ED SMO on-call policy and its review of the process for recalling patients to ED if they have positive blood cultures;
- Amend its ED follow-up policy for patients discharged from the ED with abnormal diagnostic results, to include timeframes in which the actions should occur;
- Develop clear guidelines for investigating and managing chronic otitis media, including details of when a CT head scan should be undertaken;
- Devise a protocol for managing suspected drug use; and provide training to all medical staff regarding expectations if drug use is suspected, including the provider's expectations in relation to documentation of conversations about suspected drug use between clinicians;
- Undertake an audit of positive blood cultures received by the ED in the last six months to identify whether timely follow-up occurred; and
- Provide evidence to HDC of the changes made as recommended in the critical systems analysis.

The Deputy Commissioner also recommended that the ENT specialist provide a written apology to the man's whānau; undertake self-directed learning on bias in healthcare; and reflect on his care in this case relating to his suspicion of drug use and the appropriate course of action, and his lack of documentation of discussions and observations, and provide HDC with his reflections and the changes made to his practice as a result.

## 6.3 Sharing clear information and risks about medication vital for informed choice and consent<sup>6</sup>

**This case concerns a woman who became pregnant whilst taking Epilim (sodium valproate), which places the fetus at high risk of developing serious birth defects and can affect the way in which the child develops. The case reinforces the significance of the informed consent process, and highlights the importance of prescribing clinicians sharing with women clear information about the risks of taking Epilim with regard to pregnancy.**

### *Background*

A woman was referred to the District's mental health service by her GP. She was seen by a locum psychiatrist, who recorded her diagnosis as borderline personality disorder with a secondary differential diagnosis of Bipolar Affective Disorder Type 2. The psychiatrist commenced the woman on 200mg of Epilim in the morning and 500mg at night.

The psychiatrist's clinic letter addressed to the woman's GP contained no reference to any discussion with the woman regarding contraception or pregnancy planning in relation to Epilim. The psychiatrist told HDC that the woman agreed to a trial of Epilim after a full discussion of the risks and benefits of treatment, as well as alternative options. The psychiatrist could not recall whether she provided the woman with a medication safety information sheet about Epilim, but noted that it was her usual practice, and also that it was routine within the service for key workers to pass on this information.

The psychiatrist reviewed the woman again a few months later and noted that she was finding Epilim effective at regulating her emotions. The psychiatrist increased the dose to 900mg at night. There is no reference to discussion regarding contraception or pregnancy planning in relation to Epilim in the clinic letter to the GP from this appointment.

A second psychiatrist then reviewed the woman and increased her dose to 1000mg and then 1200mg at night. Again there is no reference in the clinic letters to discussions around contraception or pregnancy. The second psychiatrist told HDC that it was her routine practice to discuss the side effects of Epilim in pregnancy and that she had this discussion with the woman.

The woman told HDC that none of the psychiatrists gave her written information about Epilim and pregnancy. She recalls being told that there were some risks regarding Epilim and pregnancy, but not what these were. She also recalled being provided with a pregnancy test by the second psychiatrist. The woman stated that there were no discussions about alternatives to Epilim.

Nearly 18 months following the initial consultation, the woman tested positive on a pregnancy test. The woman's GP reduced her Epilim dose to 1000mg at night, and sent an urgent referral to the District's obstetric service. A third psychiatrist reviewed the woman and advised slow weaning off Epilim to find the lowest effective dose — as the risk for congenital abnormality is dose dependent. The psychiatrist also increased the woman's folic acid dose. She recorded that the woman agreed with the plan and was aware of the risks and benefits. The woman was eventually weaned off Epilim completely during the pregnancy.

The woman attended an appointment with an obstetrician. The woman raised concerns with HDC that the obstetrician gave her incorrect information, telling her that there was a small increased risk of neural tube defects when taking Epilim, but no risk of cognitive or developmental delays. In a clinic

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<sup>6</sup> Decision 19HDC00773



letter to the woman's midwife, the obstetrician wrote, "Epilim thought not to cause any cognitive issues". The obstetrician later apologised to the woman for this statement.

### *Findings*

The Deputy Commissioner was not satisfied that the first psychiatrist who prescribed the woman Epilim provided her with information that a reasonable consumer in the woman's circumstances would expect to receive, including an explanation of the woman's options and the specific risks of Epilim in relation to pregnancy. The first psychiatrist was therefore found in breach of Right 6(1)(b) of the Code and Right 7(1) of the Code.

The Deputy Commissioner noted that the woman was of childbearing age, and this was the first occasion on which Epilim was being prescribed. As such, given the significant risks to the woman's child if she were to become pregnant, it was imperative that this information be discussed and a record made of the information provided.

The Deputy Commissioner was also critical of the obstetrician for providing incorrect information about the risks of Epilim, but noted that the primary responsibility for discussing the risks and benefits of Epilim lay with the prescribers — the mental health team.

An overarching factor that made it difficult to assess whether the standard of information provided to the woman about the risks of Epilim and pregnancy was adequate was the practice at the district of using the clinic letter from the psychiatrists to the GP as the record of assessment and treatment, rather than more fulsome clinical notes. The Deputy Commissioner was critical that this was the accepted practice at the District at the time.

The Deputy Commissioner was also critical that the District did not have a policy in place at the time relating to the prescribing of Epilim to women of childbearing age. She noted that in the absence of a clear set of guidelines for clinicians to follow consistently, particularly those who were working as locums, the District must bear some responsibility for the inadequacy of information given.

### *Recommendations*

The significant effort invested by multiple organisations, including the District, to strengthen information sharing to ensure that information about Epilim and its risks in pregnancy are well known to prescribers and consumers was acknowledged.

The Deputy Commissioner made recommendations to improve the accessibility of information about Epilim, including recommending that:

- Relevant professional colleges circulate the Medsafe safety alert for Epilim to all their New Zealand members;
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP) consider whether its Clinical Practice Guidelines for Mood Disorders (2020) are consistent with the 2019 Medsafe safety alert;
- Medsafe, ACC and HQSC work together to consider reproducing the current information book *Medicines for epilepsy, mental health, and pain can harm your unborn baby* in plain English, and in other languages, with a view to making this information as accessible as possible; and
- Relevant professional colleges communicate with their members HDC's recommendation that clinicians in New Zealand who prescribe Epilim to women of childbearing potential will do the following before commencing the medication:

- i. Provide written information to their patients about the risks of Epilim and pregnancy;
- ii. Discuss the risks and benefits of the medication, and the necessary precautions to mitigate the risks, and confirm that the patient has understood these; and
- iii. Document in the clinical records that they have done i) and ii).

The Deputy Commissioner also recommended that the District share HDC's commentary about sparse note-keeping with its psychiatrists and report back to HDC on whether it has now developed and implemented a guidance document regarding the use of anti-seizure medications in women of childbearing age.

## **6.4 Robust systems vital to ensure patients are informed of the need for follow-up appointments<sup>7</sup>**

**This case concerns the delayed treatment of muscle-invasive bladder cancer. The complaint highlights the importance of robust administrative systems to ensure that important follow-up appointments are actioned.**

### *Background*

A man aged in his sixties presented to his GP regarding blood in his urine and other urinary symptoms. The GP referred the man to the District's urology service and arranged further testing. Cytology results showed a high-grade non-invasive tumour on the man's bladder. The GP updated the urology service referral with the cytology results, noting that there was now a high suspicion of cancer.

Three weeks later, the man saw a urologist to discuss the results and create a management plan. The urologist discussed with the man that a tumour had been identified on the right-hand lateral bladder wall that was thought likely to be carcinoma in situ. A further tumour was identified on the right-hand side of the bladder. The man signed a consent form for transurethral resection of the bladder tumour (TURBT).

The next month, the urologist performed the TURBT on the man in the day stay unit. Samples of the tumours were sent for analysis (histology). The urologist recorded that there would be a follow-up appointment in 2–3 weeks to discuss the histology report with the man.

The plan for a follow-up appointment was recorded by a registrar both in the handwritten clinical notes of the operation and in a dictated note on the day of the surgery. However, the dictated note was not typed and uploaded to the electronic record until a week later. The District stated that at the time, the day stay unit did not complete discharge summaries for patients who were discharged on the same day.

The man told HDC that he was advised that he would be followed up by the hospital within a few weeks, but he did not receive a discharge summary or information about the surgery following the operation. A registrar spoke with the man prior to his discharge, but he cannot recall the specific details of the conversation.

The District told HDC that despite the clear plan set out in the man's operation note following the surgery, the follow-up appointment with the urologist was never arranged. This was due to an error in the booking process for outpatient appointments. At the time of events, the urology secretary

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<sup>7</sup> Decision 20HDC01960

usually did a second check of the documentation prior to discharging the patient from the system. However, in the man's case, the operation note had yet to be added to the system, and there was no discharge summary from the day stay unit.

The man returned to the hospital two days after his procedure for a trial removal of his catheter. There is no record in the clinical notes of any discussion about a follow-up appointment in two to three weeks' time.

The man's histology was reported three days later, and indicated that his bladder tumours were cancerous and were likely to grow rapidly and spread. The man's histology results were to be discussed at the follow-up appointment, but this did not occur. The man told HDC that he assumed that he would be contacted if necessary and would receive an appointment card as he had done in the past.

The following year, the man presented to a medical centre with noticeable blood in his urine, and was later diagnosed with high-grade muscle-invasive bladder cancer for which he underwent chemotherapy.

### *Findings*

The Deputy Commissioner was concerned that the District's outpatient booking system was not sufficiently robust to ensure that the man received a follow-up appointment within two to three weeks of his surgery. The follow-up plan was recorded contemporaneously by handwritten clinical note, but the District's system was unable to identify this information. In addition, had the urology service been in the practice of issuing discharge summaries at the time of these events, it is likely that the failure to book a follow-up appointment would not have occurred.

The Deputy Commissioner considered that by failing to arrange a follow-up appointment, the district failed to provide the man services with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner was also critical that the man was not notified about his histology results, which contained serious findings of fast-spreading cancerous tumors, and considered this to be a systems failure. Had the follow-up appointment been booked by administrative staff, the man would have been informed of the results. The results of tumour biopsies was information that a reasonable consumer in the man's circumstances would expect to receive, and, accordingly, the district was found in breach of Right 6(1) of the Code.

### *Recommendations*

The Deputy Commissioner recommended that the District:

- Provide a written apology to the man for the failings identified in the report;
- Outline the progress made in implementing discharge summaries for all day-stay patients;
- Monitor the new system implemented and automated in relation to referrals created in the electronic system, and consider further changes to ensure that patients are informed of the need for a follow-up appointment; and
- Consider what further improvements could be made to its systems to ensure that patients are informed and understand that they will need to return for a follow-up appointment when this is the case.

The Deputy Commissioner also asked Manatū Hauora to seek confirmation from Te Whatu Ora | Health New Zealand of the activities and expected outcomes under Te Pae Tata | New Zealand Health Plan that will improve electronic booking systems and administrative processes to improve patient outcome by reducing multiple handling of information.

# Data for Te Whatu Ora — Northern North Island

Please note that data reported captures only those complaints in which districts within the Te Whatu Ora — Northern North Island region were identified as a provider by the complainant or subsequently were identified by HDC as a party. Where a complaint is made about an individual practitioner and a Te Whatu Ora district is not identified, the complaint may not be included in these reports.

## 7. Complaints received about Northern North Island

### 7.1 Number of complaints received

In the period Jan–Jun 2022, HDC received a total of 183<sup>8</sup> complaints about care provided by districts within the Northern North Island region of Te Whatu Ora.

### 7.2 Rate of complaints received

Table 16 shows the rate of complaints to HDC per total discharges for districts within the Northern North Island region of Te Whatu Ora (170,471) compared to the rate of complaints per total discharges nationally (453,671).

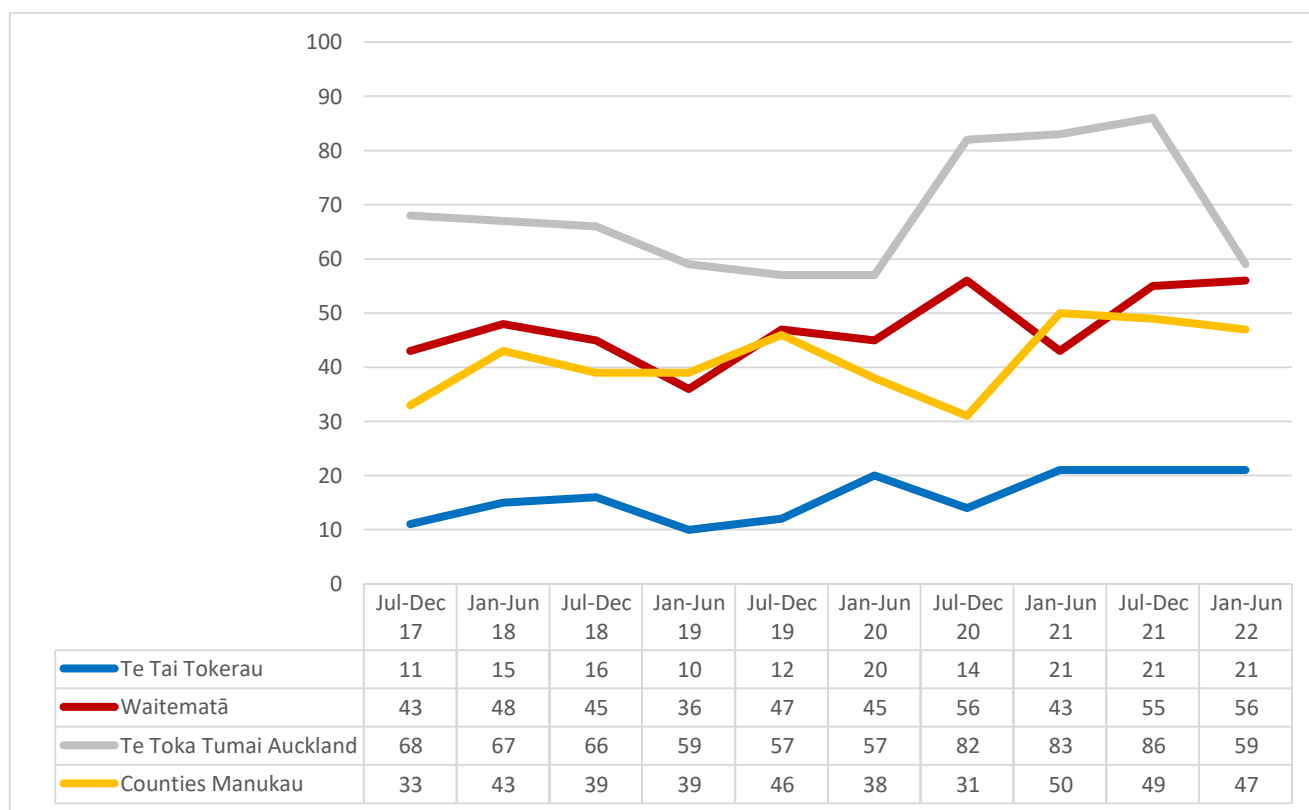
The number of total discharges excludes short-stay discharges from emergency departments, and patients attending outpatient clinics.

**Table 16.** Number and rate of complaints per total discharges

	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
<b>Northern North Island</b>	<b>183</b>	<b>170,471</b>	<b>107.35</b>
Te Tai Tokerau	21	21,051	99.76
Waitematā	56	51,262	109.24
Te Toka Tumai Auckland	59	57,296	102.97
Counties Manukau	47	40,862	115.02
<b>National (all districts)</b>	<b>566</b>	<b>453,671</b>	<b>124.76</b>

<sup>8</sup> Provisional as of date of extraction (1 September 2022).

**Figure 4.** Number of complaints about districts over the last five years



## 8. Who complained?

### 8.1 Consumer gender

The gender of consumers in complaints to HDC about districts within the Northern North Island region in Jan–Jun 2022 is detailed below.

**Table 17.** Consumer gender

Consumer gender	Number of complaints	Proportion of complaints
Female	111	61%
Male	70	38%
Another gender	1	1%
Unknown/did not wish to answer	1	1%

### 8.2 Consumer age

The age of consumers in complaints to HDC about districts within the Northern North Island region in Jan–Jun 2022 is detailed below.

**Table 18.** Consumer age

Consumer age	Number of complaints	Proportion of complaints
0 to 17 years	11	6%
18 to 24 years	10	5%
25 to 34 years	30	16%
35 to 49 years	41	22%
50 to 64 years	40	22%
65+ years	36	20%
Unknown/did not wish to answer	15	9%

### 8.3 Consumer ethnicity

The ethnicity of consumers in complaints to HDC about districts within the Northern North Island region in Jan–Jun 2022 is detailed below.

**Table 19.** Consumer ethnicity

Consumer ethnicity	Number of complaints	Proportion of complaints
Māori	32	17%
Pacific	14	8%
Middle Eastern/African/Latin American	8	4%
Asian	19	10%
Other European	6	3%
New Zealand European	77	42%
Unknown/did not wish to answer	27	15%

## 9. Services complained about for the Northern North Island region

For the complaints received, the services concerned and the numbers of complaints about these services are shown in Table 20. Please note that some complaints involve more than one district/hospital, and therefore, although there were 183 complaints about Northern North Island, 188 services were complained about.

**Table 20.** Service types complained about

Service type	Number of complaints	Percentage
<b>Anaesthetics/pain medicine</b>	<b>1</b>	<b>Less than 1%</b>
<b>Dental</b>	<b>1</b>	<b>Less than 1%</b>
<b>Diagnostics</b>	<b>3</b>	<b>2%</b>
<b>Disability services</b>	<b>2</b>	<b>1%</b>
<b>District nursing</b>	<b>1</b>	<b>Less than 1%</b>
<b>Emergency department</b>	<b>22</b>	<b>12%</b>
<b>Intensive care/critical care</b>	<b>4</b>	<b>2%</b>
<b>Medicine</b>	<b>45</b>	<b>24%</b>
Cardiology	2	1%
Endocrinology	3	2%
Gastroenterology	1	Less than 1%
Geriatric medicine	3	2%
General medicine	8	4%
Haematology	1	Less than 1%
Immunology	1	Less than 1%
Neurology	7	4%
Oncology	7	4%
Palliative care	2	1%
Renal/nephrology	2	1%
Rheumatology	1	Less than 1%
Other/unspecified	7	4%
<b>Maternity</b>	<b>12</b>	<b>6%</b>
<b>Mental Health and Addictions</b>	<b>38</b>	<b>20%</b>
<b>Paediatrics (not surgery)</b>	<b>1</b>	<b>Less than 1%</b>
<b>Rehabilitation</b>	<b>2</b>	<b>1%</b>
<b>Sexual health</b>	<b>1</b>	<b>Less than 1%</b>
<b>Surgery</b>	<b>51</b>	<b>27%</b>
Cardiothoracic	1	Less than 1%
General	12	6%
Gynaecology	14	7%
Neurosurgery	1	Less than 1%
Ophthalmology	2	1%
Orthopaedics	12	6%
Otolaryngology	3	2%
Paediatric	3	2%
Urology	2	1%
Other/unspecified	1	Less than 1%
<b>Other/unknown health service</b>	<b>4</b>	<b>2%</b>
<b>TOTAL</b>	<b>188</b>	

Similar to national trends, surgery (27%) and medicine (24%) were the most commonly complained about service types for districts within the Northern North Island region in Jan–Jun 2022.

Table 21 shows the number and proportion of complaints about the most commonly complained about service types for each district.

**Table 21.** Commonly complained about service types for each district

Service type	Te Tai Tokerau	Waitematā	Te Toka Tumai Auckland	Counties Manukau
Emergency department	1 (5%)	9 (16%)	4 (7%)	8 (17%)
Maternity	2 (9%)	1 (2%)	4 (7%)	5 (10%)
Medicine	6 (29%)	13 (23%)	18 (31%)	8 (17%)
Mental health & addictions	6 (29%)	13 (23%)	10 (17%)	9 (19%)
Surgery	7 (33%)	13 (23%)	18 (31%)	13 (28%)

Orthopaedics was the most commonly complained about surgical service for **Te Tai Tokerau** (4 complaints), and general medicine (6 complaints) was the most commonly complained about medical specialty.

Gynaecology (5 complaints) and general surgery (5 complaints) were the most commonly complained about surgical specialties for **Waitematā**. Compared to the last period, Waitematā saw a small increase in complaints about gynaecology services in Jan–Jun 2022.

Gynaecology (5 complaints) was the most commonly complained about surgical specialty for **Te Toka Tumai Auckland**, and neurology (5 complaints) and oncology (6 complaints) were the most commonly complained about medical specialities. Compared to the last period, Te Toka Tumai saw an increase in complaints about neurology services, and a decrease in complaints about emergency department services in Jan–Jun 2022.

General surgery (5 complaints) was the most commonly complained about surgical specialty for **Counties Manukau**. Compared to the previous periods, Counties Manukau saw an increase in the proportion of complaints about mental health and addiction services, and a decrease in complaints about medicine services in Jan–Jun 2022.



## 10. Issues complained about for the Northern North Island region

### 10.1 Primary issues

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received about districts within the Northern North Island region are listed in Table 22.

**Table 22.** Primary issues complained about

Primary issue in complaints — Northern North Island	Number of complaints	Percentage
<b>Access/funding</b>	<b>14</b>	<b>8%</b>
Lack of access to services	10	5%
Waiting list/prioritisation issue	4	2%
<b>Boundary violation</b>	<b>1</b>	<b>Less than 1%</b>
<b>Care/treatment</b>	<b>102</b>	<b>56%</b>
Delay in treatment	9	5%
Delayed/inadequate/inappropriate referral	2	1%
Inadequate coordination of care or treatment	3	2%
Inadequate/inappropriate non-clinical care	5	3%
Inadequate/inappropriate examination/assessment	6	3%
Inadequate/inappropriate follow-up	6	3%
Inadequate/inappropriate monitoring	5	3%
Inadequate/inappropriate clinical treatment	16	9%
Inappropriate withdrawal of treatment	1	Less than 1%
Inappropriate/delayed discharge/transfer	11	6%
Missed/incorrect/delayed diagnosis	21	11%
Refusal to assist/attend	1	Less than 1%
Refusal to treat	2	1%
Unexpected treatment outcome	14	8%
<b>Communication</b>	<b>20</b>	<b>11%</b>
Disrespectful manner/attitude	11	6%
Failure to communicate openly/honestly/effectively with consumer	5	3%
Failure to communicate openly/honestly/effectively with whānau/family	4	2%
<b>Consent/information</b>	<b>27</b>	<b>15%</b>
Consent not obtained/adequate	12	7%
Incorrect/misleading information provided	3	2%
Inadequate information provided regarding treatment	2	1%
Issue with involuntary admission/treatment	10	5%
<b>Documentation</b>	<b>2</b>	<b>1%</b>
<b>Facility issues</b>	<b>6</b>	<b>3%</b>
Inadequate/inappropriate policies/procedures	5	3%

General safety issue for consumer in facility	1	Less than 1%
<b>Medication</b>	<b>9</b>	<b>5%</b>
Administration error	1	Less than 1%
Inappropriate dispensing	1	Less than 1%
Inappropriate prescribing	7	4%
<b>Other issues</b>	<b>2</b>	<b>1%</b>
<b>TOTAL</b>	<b>183</b>	

Similar to national trends, the most common primary complaint issues for districts within the Northern North Island region were “missed/incorrect/delayed diagnosis” (11%), “inadequate/inappropriate clinical treatment” (9%), and “unexpected treatment outcome” (8%).

Table 23 shows the most common primary issues complained about for each district.

**Table 23.** Most common primary issues complained about by district

Te Tai Tokerau		Waitematā		Te Toka Tumai Auckland		Counties Manukau	
Unexpected treatment outcome	24%	Missed/delayed diagnosis	18%	Consent not obtained/adequate	21%	Missed/delayed diagnosis	32%
Inadequate treatment	18%	Disrespectful manner/attitude	16%	Missed/delayed diagnosis	11%	Inadequate treatment	14%
Inappropriate/delayed discharge	12%	Lack of access to services	7%	Inadequate treatment	11%	Unexpected treatment outcome	14%

Compared to the previous period:

- **Te Tai Tokerau** saw a higher proportion of complaints primarily about “unexpected treatment outcome”
- **Waitematā** saw a higher proportion of complaints primarily about disrespectful manner/attitude than has been seen in previous periods for this district.
- **Te Toka Tumai Auckland** saw a higher proportion of complaints primarily about consent processes than has been seen in previous periods
- **Counties Manukau** saw a higher proportion of complaints about “inappropriate discharge/transfer”

### Complaints related to COVID-19

HDC received 47 complaints about COVID-19-related issues for the Northern North Island region in Jan–Jun 2022. Complaints by district were as follows:

- **Te Tai Tokerau** — 4 complaints
- **Waitematā** — 23 complaints
- **Te Toka Tumai Auckland** — 12 complaints
- **Counties Manukau** — 8 complaints

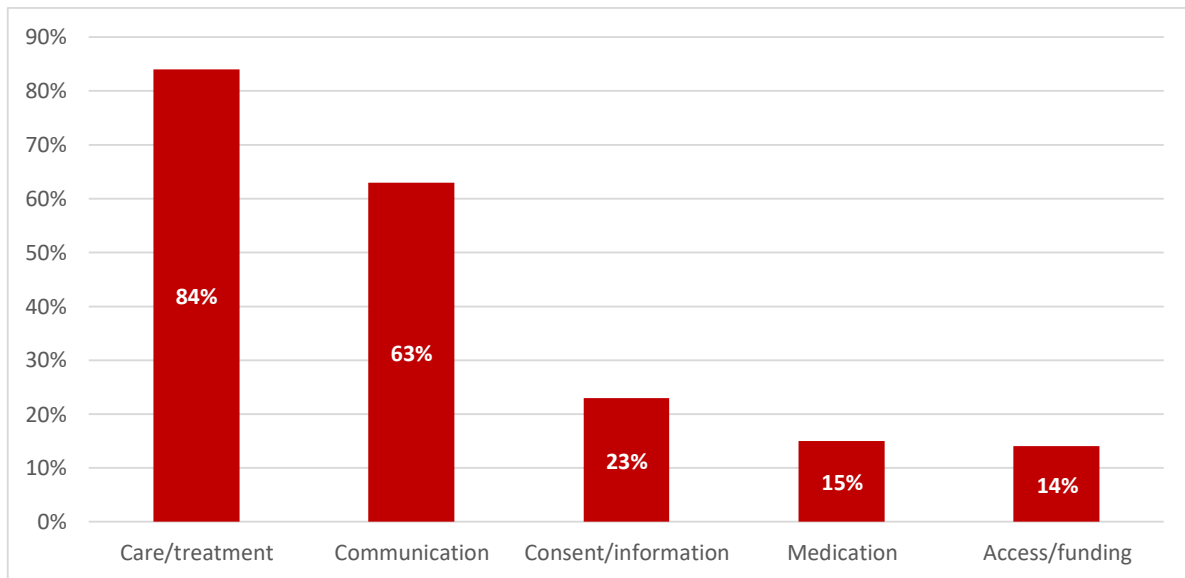
Complaints related to:

- Impact of COVID-19 on the healthcare system (e.g., delayed care, reduced staffing, etc.) — 38%
- COVID-19-related policies/procedures (primarily visitor restrictions, but also included concerns about mask requirements, vaccine mandates and other infection control policies) — 32%
- Vaccine-related issues (e.g., consent, adverse effects, administration procedure, etc.) — 15%
- Treatment of COVID-19 — 11%
- Testing-related issues (e.g., access to testing, delays in receiving results, etc.) — 4%

## 10.2 All issues identified in complaints

As well as the primary complaint issue, up to six additional other complaint issues are identified for each complaint received by HDC. Figure 5 below shows the most common complaint issue categories for the Northern North Island region when both these additional complaint issues and primary complaint issues are considered.

**Figure 5.** Most common complaint issue categories



### **10.3 Primary issues complained about by service type**

The primary issues complained about in relation to each service are set out below.

**Table 24.** Primary issues complained about for each service

<b>Te Whatu Ora — Northern North Island</b>							
<b>Surgery</b>		<b>Medicine</b>		<b>Mental health</b>		<b>Emergency department</b>	
Unexpected treatment outcome	29%	Missed/delayed diagnosis	18%	Involuntary admission/Treatment	21%	Missed/delayed diagnosis	32%
Consent not adequate	18%	Inadequate treatment	16%	Lack of access to services	11%	Communication with consumer	14%
Lack of access to services	12%	Inadequate monitoring	7%	Inadequate follow-up	11%	Inadequate examination/assessment	14%
<b>Te Tai Tokerau</b>							
Unexpected treatment outcome	71%	Inadequate treatment	50%	Involuntary admission/treatment	33%	Inadequate examination/assessment	100%
Missed/delayed diagnosis	14%	Inappropriate/delayed discharge	17%	Inappropriate/delayed discharge	33%	N/A	
Lack of access to services	14%	Disrespectful manner/attitude	17%	Safety issue for consumer in facility	17%	N/A	
<b>Waitematā</b>							
Lack of access to services	31%	Inappropriate/delayed discharge	15%	Involuntary admission/treatment	23%	Missed/delayed diagnosis	33%
Consent not adequate	23%	Missed/delayed diagnosis	15%	Lack of access to services	15%	Communication with consumer	22%
Disrespectful manner/attitude	15%	Inadequate/inappropriate treatment	8%	Inadequate follow-up	15%	Disrespectful manner/attitude	22%
<b>Te Toka Tumai Auckland</b>							
Consent not adequate	28%	Missed/delayed diagnosis	22%	Involuntary admission/treatment	30%	Communication with consumer	25%
Unexpected treatment outcome	22%	Inadequate treatment	17%	Lack of access to services	20%	Missed/delayed diagnosis	25%
Waiting list/prioritisation issue	11%	Consent not adequate	11%	Missed/delayed diagnosis	10%	Delay in treatment	25%
<b>Counties Manukau</b>							
Unexpected treatment outcome	38%	Delay in treatment	25%	Disrespectful manner/attitude	22%	Missed/delayed diagnosis	38%
Inappropriate/delayed discharge/	23%	Missed/delayed diagnosis	25%	Inappropriate dispensing	22%	Inadequate treatment	25%
Consent not adequate	8%	Inadequate information provided re: treatment	13%	Involuntary admission/treatment	11%	Communication with whānau	13%

## 11. Complaints closed about Te Whatu Ora — Northern North Island

### 11.1 Outcomes of complaints closed

The outcomes of all complaints closed about districts within the Northern North Island region in Jan–Jun 2022 are shown in Table 25.

**Table 25.** Outcomes of complaints closed about districts within the Northern North Island region<sup>9</sup>

Outcome for district	Te Tai Tokerau	Waitematā	Te Toka Tumai Auckland	Counties Manukau
<b>Investigation</b>	<b>0</b>	<b>1</b>	<b>7</b>	<b>5</b>
Breach finding	-	1	2	4
No breach finding with adverse comment and recommendations	-	-	2	-
No breach finding with recommendations	-	-	2	1
No breach finding	-	-	1	-
<b>Other resolution following assessment</b>	<b>21</b>	<b>47</b>	<b>61</b>	<b>42</b>
No further action with recommendations or educational comment	3	5	9	3
Referred to District Inspector	1	2	1	2
Referred to District	5	14	13	7
Referred to Advocacy	3	10	11	10
No further action	9	16	27	20
<b>TOTAL</b>	<b>21</b>	<b>48</b>	<b>68</b>	<b>47</b>

<sup>9</sup> Note that outcomes are displayed in descending order. If there is more than one outcome for a Te Whatu Ora region upon resolution of a complaint then only the outcome listed highest up in the table is included.

# Data for Te Whatu Ora — Te Manawa Taki

Please note that data reported captures only those complaints in which districts within Te Whatu Ora — Te Manawa Taki were identified as a provider by the complainant or subsequently were identified by HDC as a party. Where a complaint is made about an individual practitioner and a Te Whatu Ora district is not identified as a provider, the complaint may not be included in these reports.

## 12. Complaints received about Te Manawa Taki

### 12.1 Number of complaints received

In the period Jan–Jun 2022, HDC received a total of 110<sup>10</sup> complaints about care provided by districts within the Te Manawa Taki region of Te Whatu Ora.

### 12.2 Rate of complaints received

Table 26 shows the rate of complaints to HDC per total discharges for districts within the Te Manawa Taki (100,919) region of Te Whatu Ora compared to the rate of complaints per total discharges nationally (453,671).

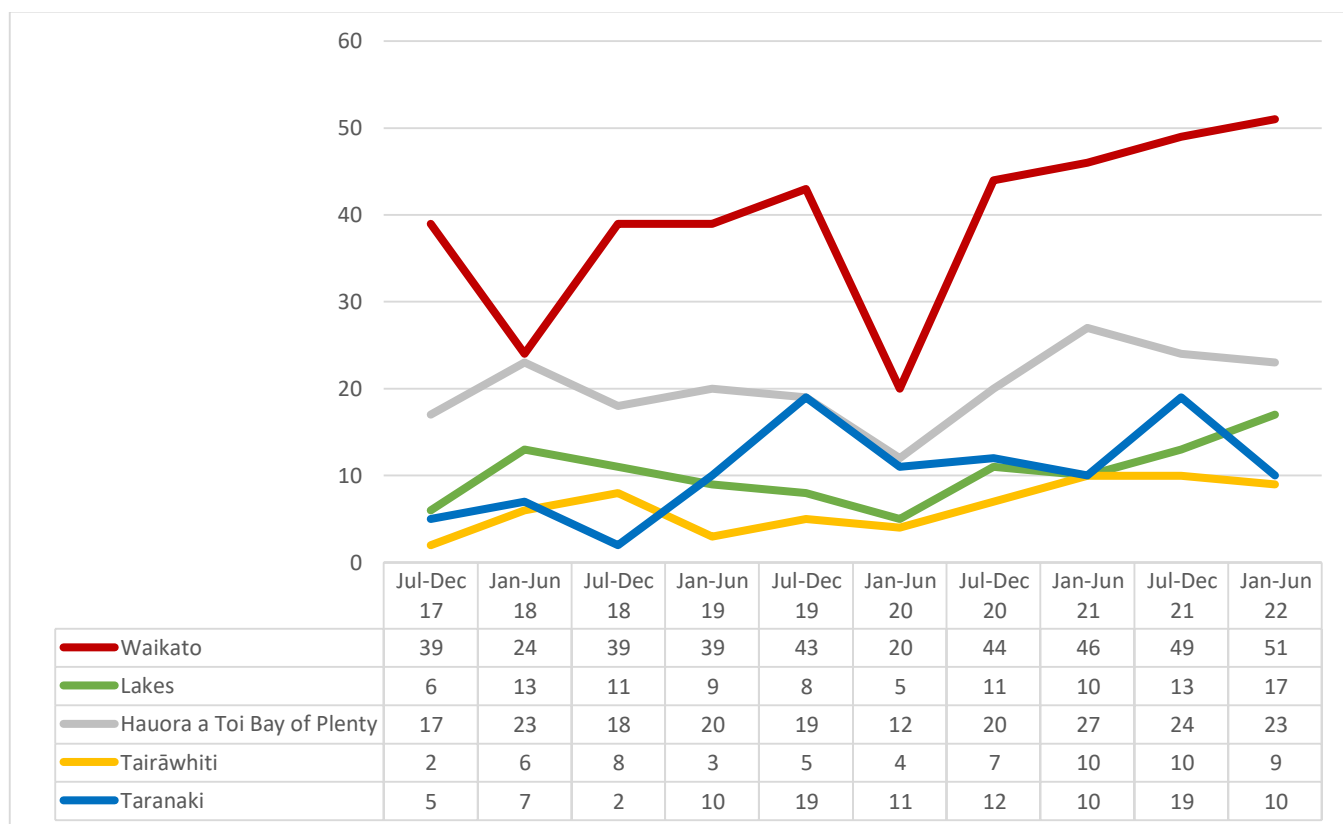
The number of total discharges excludes short-stay discharges from emergency departments, and patients attending outpatient clinics.

**Table 26.** Number and rate of complaints per total discharges

	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
<b>Te Manawa Taki</b>	<b>110</b>	<b>100,919</b>	<b>108.99</b>
Waikato	51	45,524	112.03
Lakes	17	11,423	148.82
Hauora a Toi Bay of Plenty	23	26,466	86.90
Tairāwhiti	9	4,837	186.07
Taranaki	10	12,669	78.93
<b>National (all districts)</b>	<b>566</b>	<b>453,671</b>	<b>124.76</b>

<sup>10</sup> Provisional as of date of extraction (1 September 2022).

**Figure 6.** Number of complaints for each district over the last five years



## 13. Who complained?

### 13.1 Consumer gender

The gender of consumers in complaints to HDC about districts within the Te Manawa Taki region in Jan–Jun 2022 is detailed below.

**Table 27.** Consumer gender

Consumer gender	Number of complaints	Proportion of complaints
Female	68	62%
Male	42	38%



## 13.2 Consumer age

The age of consumers in complaints to HDC about districts within the Te Manawa Taki region in Jan–Jun 2022 is detailed below.

**Table 28.** Consumer age

Consumer age	Number of complaints	Proportion of complaints
0 to 17 years	9	8%
18 to 24 years	6	5%
25 to 34 years	14	13%
35 to 49 years	23	21%
50 to 64 years	19	17%
65+ years	29	26%
Unknown/did not wish to answer	10	9%

## 13.3 Consumer ethnicity

The ethnicity of consumers in complaints to HDC about districts within the Te Manawa Taki region in Jan–Jun 2022 is detailed below.

**Table 29.** Consumer ethnicity

Consumer ethnicity	Number of complaints	Proportion of complaints
Māori	25	23%
Middle Eastern/African/Latin American	1	1%
Asian	2	2%
Other European	3	3%
New Zealand European	58	53%
Unknown/did not wish to answer	21	19%

## 14. Service types complained about for Te Manawa Taki

For the complaints received, the services concerned and the numbers of complaints about these services are shown in Table 30. Please note that some complaints involve more than one district/hospital, and therefore, although there were 110 complaints about districts within the Te Manawa Taki region, 112 services were complained about.

**Table 30.** Service types complained about

Service type	Number of complaints	Percentage
<b>Disability services</b>	<b>2</b>	<b>2%</b>
<b>Assisted Dying</b>	<b>1</b>	<b>Less than 1%</b>
<b>Diagnostics</b>	<b>5</b>	<b>4%</b>
<b>District nursing</b>	<b>1</b>	<b>Less than 1%</b>
<b>Emergency department</b>	<b>17</b>	<b>15%</b>
<b>Intensive care/critical care</b>	<b>1</b>	<b>Less than 1%</b>
<b>Medicine</b>	<b>28</b>	<b>25%</b>
Cardiology	5	4%
Endocrinology	1	Less than 1%
Gastroenterology	2	2%
General medicine	3	3%
Geriatric medicine	3	3%
Neurology	2	2%
Oncology	1	Less than 1%
Renal/nephrology	6	5%
Respiratory	1	Less than 1%
Rheumatology	1	Less than 1%
Other/unspecified	3	3%
<b>Maternity</b>	<b>7</b>	<b>6%</b>
<b>Mental health and addictions</b>	<b>19</b>	<b>17%</b>
<b>Paediatrics (not surgical)</b>	<b>1</b>	<b>Less than 1%</b>
<b>Surgery</b>	<b>25</b>	<b>22%</b>
General	8	7%
Gynaecology	4	4%
Neurosurgery	2	2%
Ophthalmology	1	Less than 1%
Orthopaedics	6	5%
Plastic and reconstructive	2	2%
Urology	2	2%
<b>Other/unknown health service</b>	<b>5</b>	<b>3%</b>
<b>TOTAL</b>	<b>112</b>	

Similar to national trends, medicine (25%), surgery (22%), mental health and addictions (17%), and emergency department (15%) services were the most commonly complained about service types for districts in the Te Whatu Ora — Te Manawa Taki region in Jan–Jun 2022.

Table 31 shows the number and proportion of complaints about the most commonly complained about service types for each district.

**Table 31.** Most common service types complained about by district

Service type	Waikato	Lakes	Hauora a Toi Bay of Plenty	Tairāwhiti	Taranaki
<b>Emergency department</b>	7 (14%)	2 (12%)	4 (16%)	4 (40%)	0
<b>Maternity</b>	2 (4%)	2 (12%)	5 (20%)	0	0
<b>Medicine</b>	17 (33%)	4 (24%)	2 (8%)	1 (10%)	4 (44%)
<b>Mental health &amp; addictions</b>	9 (18%)	2 (12%)	5 (20%)	1 (10%)	2 (22%)
<b>Surgery</b>	11 (22%)	5 (29%)	7 (28%)	2 (20%)	0

Cardiology (5 complaints) was the most commonly complained about medical speciality, and general surgery (5 complaints) was the most commonly complained about surgical speciality for **Waikato**. Compared to the previous period, complaints about medicine services slightly increased for Waikato in Jan–Jun 22 (from 24% to 33%).

## 15. Issues complained about for Te Manawa Taki

### 15.1 Primary issues

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received about Te Manawa Taki are listed in Table 32.

**Table 32.** Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
<b>Access/funding</b>	<b>11</b>	<b>10%</b>
Lack of access to services	6	5%
Waiting list/prioritisation issue	5	5%
<b>Boundary violation</b>	<b>1</b>	<b>Less than 1%</b>
<b>Care/treatment</b>	<b>57</b>	<b>52%</b>
Delay in treatment	3	3%
Delayed/inadequate/inappropriate referral	1	Less than 1%
Inadequate/inappropriate examination/assessment	2	2%
Inadequate/inappropriate follow-up	4	4%
Inadequate/inappropriate monitoring	5	5%
Inadequate/inappropriate testing	1	Less than 1%
Inadequate/inappropriate clinical treatment	9	8%
Inappropriate withdrawal of treatment	1	Less than 1%
Inappropriate/delayed discharge/transfer	3	3%
Missed/incorrect/delayed diagnosis	16	15%
Refusal to treat	4	4%
Unexpected treatment outcome	8	7%
<b>Communication</b>	<b>12</b>	<b>11%</b>
Disrespectful manner/attitude	8	7%
Failure to accommodate cultural/language needs	1	Less than 1%
Failure to communicate openly/honestly/effectively with consumer	3	3%
<b>Complaints process</b>	<b>1</b>	<b>Less than 1%</b>
<b>Consent/information</b>	<b>9</b>	<b>8%</b>
Consent not obtained/adequate	2	2%
Incorrect/misleading information provided	2	2%
Issues with involuntary admission/treatment	3	3%
Other consent/information issues	2	2%
<b>Documentation</b>	<b>3</b>	<b>3%</b>
<b>Facility issues</b>	<b>6</b>	<b>5%</b>
General safety issue for consumer in facility	2	2%
Inadequate/inappropriate policies/procedures	4	4%
<b>Medication</b>	<b>7</b>	<b>6%</b>
Inappropriate/unlawful prescribing	6	5%
Refusal to prescribe/dispense/supply	1	Less than 1%
<b>Other issues</b>	<b>3</b>	<b>3%</b>
<b>TOTAL</b>	<b>110</b>	

Similar to national trends, the most common primary issue complained about for districts within the Te Manawa Taki region was “missed/incorrect/delayed diagnosis” (15%).

Table 33 shows the most common primary issues complained about for each district.

**Table 33.** Most common primary issues complained about for each district

Waikato		Lakes		Hauora a Toi Bay of Plenty		Tairāwhiti		Taranaki	
Missed/delayed diagnosis	18%	Inadequate examination/assessment	12%	Missed/delayed diagnosis	17%	Missed/delayed diagnosis	13%	Disrespectful manner/attitude	20%
Inadequate clinical treatment	12%	Disrespectful manner/attitude	12%	Inadequate/inappropriate follow-up	13%	Refusal to treat	13%	Missed/delayed diagnosis	20%
Waiting list/prioritisation issue	8%	Inappropriate/delayed discharge	12%	Lack of access to services	13%	Delay in treatment	13%	Lack of access to services	20%

Compared to the previous period:

- **Waikato** saw a small increase in complaints primarily about waiting list/prioritisation issues;
- **Hauora a Toi Bay of Plenty** saw an increase in complaints about missed/delayed diagnosis and access to services; and
- **Taranaki** saw an increase in complaints about disrespectful manner/attitude and lack of access to services.

#### Complaints related to COVID-19

HDC received 23 complaints about COVID-19-related issues for districts within the Te Manawa Taki region in Jan–Jun 2022. Complaints by district were as follows:

- **Waikato** — 12 complaints
- **Lakes** — 2 complaints
- **Hauora a Toi Bay of Plenty** — 7 complaints
- **Tairāwhiti** — 1 complaint
- **Taranaki** — 1 complaint

Complaints related to:

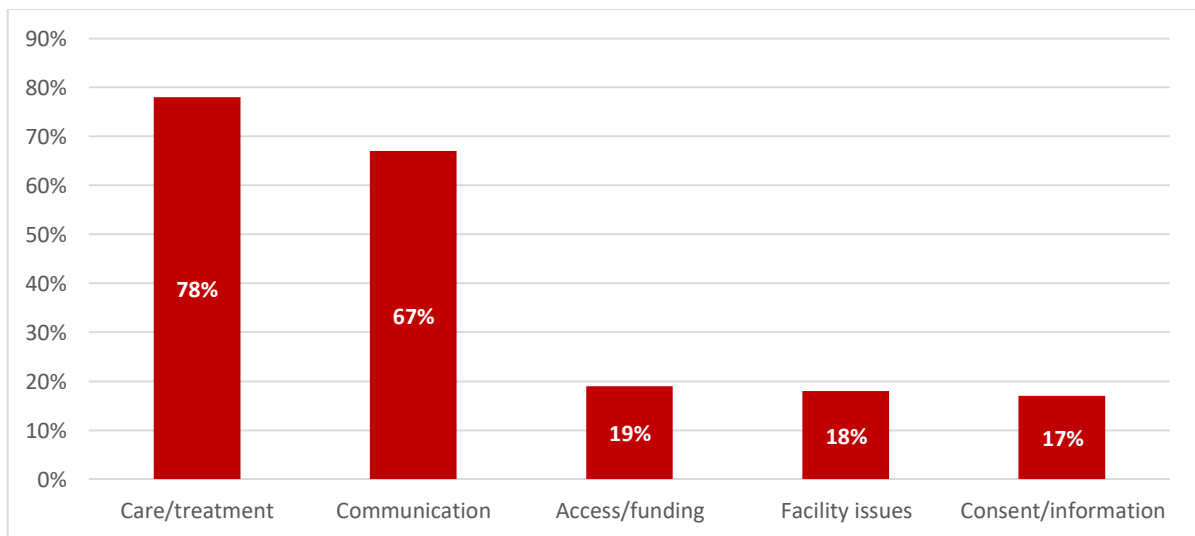
- Impact of COVID-19 on the healthcare system (e.g., delayed care, staffing, etc.) — 43%
- COVID-19-related policies/procedures (e.g., visitor restrictions, mask requirements) — 26%
- Vaccine-related issues (e.g., consent, adverse effects, administration procedure, etc.) — 17%
- Treatment of COVID-19 — 9%

- Testing-related issues (e.g., access to testing, delays in receiving results, etc.) — 4%

## 15.2 All issues

As well as the primary complaint issue, up to six additional other complaint issues are identified for each complaint received by HDC. Figure 7 below shows the most common complaint issues for districts in the Te Manawa Taki region when these additional complaint issues and primary complaint issues are considered.

**Figure 7.** Most common complaint issues



## 15.3 Primary issues complained about by service type

The primary issues complained about in relation to each service by district are set out below.

**Table 34.** Primary issues complained about by service type

Te Whatu Ora — Te Manawa Taki							
Surgery		Medicine		Mental health & addiction		Emergency department	
Unexpected treatment outcome	24%	Inadequate treatment	11%	Involuntary admission/treatment	21%	Missed/delayed diagnosis	41%
Lack of access to services	12%	Missed/delayed diagnosis	7%	Inadequate treatment	11%	Refusal to treat	17%
Waiting list/prioritisation issue	12%	Unexpected treatment outcome	7%	Communication with consumer	11%	Inadequate policies/procedures	14%
Waikato							

Waiting list/prioritisation issue	18%	Inappropriate prescribing	12%	Communication with consumer	22%	Missed/delayed diagnosis	57%
Unexpected treatment outcome	18%	Missed/delayed diagnosis	12%	Involuntary admission/treatment	11%	Refusal to treat	29%
Communication with consumer	9%	Disrespectful manner/attitude	12%	Inadequate treatment	11%	Inadequate policies/procedures	14%
<b>Lakes</b>							
Lack of access to services	20%	Inadequate examination/assessment	25%	Involuntary admission/treatment	50%	Refusal to treat	50%
Inadequate examination/assessment	20%	Inappropriate/delayed discharge	25%	Inappropriate prescribing	50%	Inadequate policies/procedures	50%
Unexpected treatment outcome	20%	Prescribing error	25%	N/A		N/A	
<b>Hauora a Toi Bay of Plenty</b>							
Missed/delayed diagnosis	29%	Inadequate follow-up	50%	Lack of access to services	20%	Missed/delayed diagnosis	50%
Unexpected treatment outcome	29%	Inadequate complaint response	50%	Inadequate treatment	20%	Inadequate follow-up	25%
Failure to accommodate cultural needs	14%	N/A		Involuntary admission/treatment	20%	Delay in treatment	25%
<b>Tairāwhiti</b>							
Waiting list/prioritisation issue	50%	Delay in treatment	100%	Involuntary admission/treatment	100%	Inadequate monitoring	25%
Unexpected treatment outcome	50%	N/A		N/A		Inadequate treatment	25%
N/A		N/A		N/A		Missed/delayed diagnosis	25%
<b>Taranaki</b>							
N/A		Lack of access to services	25%	Disrespectful manner/attitude	50%	N/A	
N/A		Inadequate treatment	25%	Refusal to prescribe/dispense	50%	N/A	
N/A		Unexpected treatment outcome	25%	N/A		N/A	

## 16. Complaints closed about Te Whatu Ora — Te Manawa Taki

### 16.1 Outcomes of complaints closed

The outcomes of all complaints closed about districts in Te Manawa Taki region in Jan–Jun 2022 are shown in Table 35.

**Table 35.** Outcomes of complaints closed for districts within the Te Manawa Taki region<sup>11</sup>

Outcome for district	Waikato	Lakes	Hauora a Toi Bay of Plenty	Tairāwhiti	Taranaki
<b>Investigation</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>3</b>
Breach finding — Referred to Director of Proceedings	-	-	-	-	1
Breach finding	2	-	-	1	-
No breach finding with adverse comment and recommendations	-	-	-	-	1
No breach finding	--	-	1	-	1
<b>Other resolution following assessment</b>	<b>40</b>	<b>10</b>	<b>23</b>	<b>6</b>	<b>10</b>
No further action with recommendations or educational comment	10	1	2	-	1
Referred to other agency	-	-	-	-	1
Referred to District Inspector	1	1	1	-	-
Referred to District	3	4	4	2	2
Referred to Advocacy	15	3	8	2	3
No further action	11	1	8	2	3
<b>TOTAL</b>	<b>42</b>	<b>10</b>	<b>24</b>	<b>7</b>	<b>13</b>

<sup>11</sup> Note that outcomes are displayed in descending order. If there is more than one outcome for a Te Whatu Ora district upon resolution of a complaint then only the outcome listed highest up in the table is included.



# Data for Te Whatu Ora — Central North Island

Please note that data reported captures only those complaints in which the districts within the Te Whatu Ora — Central North Island region were identified as a provider by the complainant or subsequently was identified by HDC as a party. Where a complaint is made about an individual practitioner and a Te Whatu Ora district is not identified, the complaint may not be included in these reports.

## 17. Complaints received about Central North Island

### 17.1 Number of complaints received

In the period Jan–Jun 2022, HDC received a total of 128<sup>12</sup> complaints about care provided by districts within the Central North Island region of Te Whatu Ora.

### 17.2 Rate of complaints received

Table 36 shows the rate of complaints to HDC per total discharges for districts within the Central North Island region (84,193) compared to the rate of complaints per total discharges nationally (453,671).

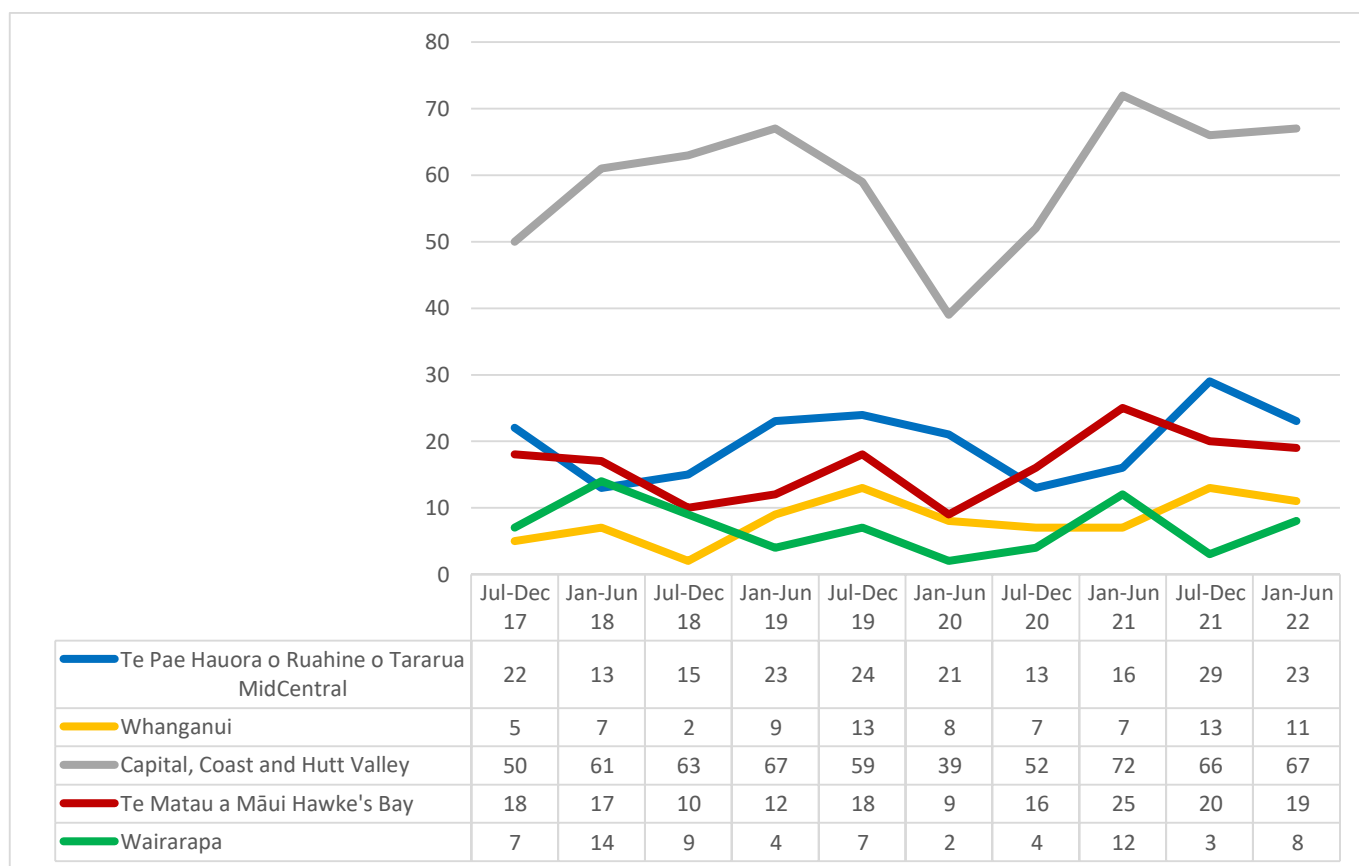
The number of total discharges excludes short-stay discharges from emergency departments, and patients attending outpatient clinics.

**Table 36.** Number and rate of complaints per total discharges

	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
<b>Central North Island</b>	<b>128</b>	<b>84,193</b>	<b>152.03</b>
Te Pae Hauora o Ruahine o Tararua MidCentral	23	13,970	164.64
Whanganui	11	6,627	165.99
Capital, Coast and Hutt Valley	67	42,531	157.53
Te Matau a Māui Hawke's Bay	19	17,110	111.05
Wairarapa	8	3,955	202.28
<b>National (all districts)</b>	<b>566</b>	<b>453,671</b>	<b>124.76</b>

<sup>12</sup> Provisional as of date of extraction (1 September 2022).

**Figure 8.** Number of complaints received over the past 5 years by district



## 18. Who complained?

### 18.1 Consumer gender

The gender of consumers in complaints to HDC about districts within the Central North Island region in Jan–Jun 2022 is detailed below.

**Table 37.** Consumer gender

Consumer gender	Number of complaints	Proportion of complaints
Female	78	61%
Male	48	38%
Unknown/did not wish to answer	2	2%

## 18.2 Consumer age

The age of consumers in complaints to HDC about districts within the Central North Island region in Jan–Jun 2022 is detailed below.

**Table 38.** Consumer age

Consumer age	Number of complaints	Proportion of complaints
0 to 17 years	13	10%
18 to 24 years	10	8%
25 to 34 years	20	16%
35 to 49 years	17	13%
50 to 64 years	22	17%
65+ years	23	18%
Unknown/did not wish to answer	23	18%

## 18.3 Consumer ethnicity

The ethnicity of consumers in complaints to HDC about districts within the Central North Island region in Jan–Jun 2022 is detailed below.

**Table 39.** Consumer ethnicity

Consumer ethnicity	Number of complaints	Proportion of complaints
Māori	24	19%
Pacific	4	3%
Middle Eastern/African/Latin American	2	2%
Asian	7	5%
Other European	7	5%
New Zealand European	53	41%
Unknown/did not wish to answer	31	24%

## 19. Service types complained about for Central North Island

For the complaints received, the services concerned and the numbers of complaints about these services are shown in Table 40. Please note that some complaints involve more than one district/hospital, and therefore, although there were 128 complaints about districts within the Central North Island region, 129 services were complained about.

**Table 40.** Service types complained about

Service type	Number of complaints	Percentage
<b>Assisted dying</b>	<b>2</b>	<b>2%</b>
<b>Disability services</b>	<b>1</b>	<b>Less than 1%</b>
<b>Diagnostics</b>	<b>4</b>	<b>3%</b>
<b>District nursing</b>	<b>1</b>	<b>Less than 1%</b>
<b>Emergency department</b>	<b>22</b>	<b>17%</b>
<b>Medicine</b>	<b>17</b>	<b>13%</b>
Cardiology	4	3%
Dermatology	1	0.8%
Endocrinology	1	0.8%
Gastroenterology	1	0.8%
General medicine	2	2%
Geriatric medicine	1	0.8%
Neurology	1	0.8%
Oncology	2	2%
Rheumatology	2	2%
Other/unspecified	2	2%
<b>Intensive care/critical care</b>	<b>1</b>	<b>Less than 1%</b>
<b>Maternity</b>	<b>10</b>	<b>8%</b>
<b>Mental health</b>	<b>34</b>	<b>26%</b>
<b>Paediatrics (not surgical)</b>	<b>1</b>	<b>Less than 1%</b>
<b>Physiotherapy</b>	<b>2</b>	<b>2%</b>
<b>Surgery</b>	<b>32</b>	<b>25%</b>
Cardiothoracic	1	0.8%
General	8	6%
Gynaecology	7	5%
Ophthalmology	4	3%
Orthopaedics	8	6%
Otolaryngology	1	0.8%
Paediatric	2	2%
Urology	1	0.8%
<b>Other services</b>	<b>2</b>	<b>2%</b>
<b>TOTAL</b>	<b>129</b>	

Similar to national trends, mental health (26%), surgery (25%), emergency department (17%), and medicine (13%) were the most commonly complained about service types for districts in the Central North Island region in Jan–Jun 2022.

Table 41 outlines the most commonly complained about service types for each district.

**Table 41.** Most commonly complained about service types for each district

Service type	Te Pae Hauora o Ruahine o Tararua MidCentral	Whanganui	Capital, Coast and Hutt Valley	Te Matau a Māui Hawke's Bay	Wairarapa
Emergency department	7 (30%)	3 (27%)	10 (15%)	1 (5%)	1 (13%)
Maternity	2 (9%)	0	5 (7%)	1 (5%)	2 (25%)
Medicine	6 (26%)	1 (9%)	9 (13%)	1 (5%)	0
Mental health & addictions	6 (26%)	2 (18%)	19 (28%)	4 (21%)	3 (38%)
Surgery	2 (9%)	2 (18%)	19 (28%)	9 (47%)	0

Compared to the previous period, **Te Pae Hauora o Ruahine o Tararua MidCentral** saw an increase in complaints about emergency department services in Jan–Jun 2022 (from 7% to 30%).

The most common surgical specialty complained about for **Capital, Coast and Hutt Valley** was gynaecology (7 complaints).

The most common surgical specialty complained about for **Te Matau a Māui Hawke's Bay** was general surgery (8 complaints). Compared to the previous period, Te Matau a Māui Hawke's Bay saw an increase in the proportion of complaints about surgery and mental health and addiction services in Jan–Jun 2022, and a decrease in complaints about medicine services.

## 20. Issues complained about for Central North Island

### 20.1 Primary issues

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received about districts within the Central North Island region are listed in Table 42.

**Table 42.** Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
<b>Access/funding</b>	<b>22</b>	<b>17%</b>
Lack of access to services	6	5%
Lack of access to subsidies/funding	2	2%
Waiting list/prioritisation issue	14	11%
<b>Boundary violation</b>	<b>2</b>	<b>2%</b>
<b>Care/treatment</b>	<b>66</b>	<b>52%</b>
Delay in treatment	6	5%
Inadequate coordination of care or treatment	3	2%
Inadequate/inappropriate clinical treatment	11	9%
Inadequate/inappropriate examination/assessment	7	5%
Inadequate/inappropriate follow-up	2	2%
Inadequate/inappropriate monitoring	4	3%
Inadequate/inappropriate non-clinical care	1	Less than 1%
Inappropriate admission/failure to admit	1	Less than 1%
Inappropriate/delayed discharge/transfer	5	4%
Missed/incorrect/delayed diagnosis	8	6%
Refusal to treat	5	4%
Rough/painful care or treatment	2	2%
Unexpected treatment outcome	11	9%
<b>Communication</b>	<b>10</b>	<b>8%</b>
Disrespectful manner/attitude	6	5%
Failure to communicate openly/honestly/effectively with consumer	3	2%
Failure to communicate openly/honestly/effectively with whānau/family	1	Less than 1%
<b>Complaints process</b>	<b>1</b>	<b>Less than 1%</b>
<b>Consent/information</b>	<b>9</b>	<b>7%</b>
Consent not obtained/adequate	3	2%
Inadequate information provided re treatment	1	Less than 1%
Issues with involuntary admission/treatment	5	4%
<b>Documentation</b>	<b>2</b>	<b>2%</b>
<b>Facility issue</b>	<b>7</b>	<b>5%</b>
Inadequate/inappropriate policies/procedures	3	2%
General safety issue for consumer in facility	2	2%

Other facility-related issues	2	2%
<b>Medication</b>	<b>4</b>	<b>3%</b>
Inappropriate administration	1	Less than 1%
Inappropriate prescribing	1	Less than 1%
Refusal to prescribe/dispense/supply	2	2%
<b>Professional conduct</b>	<b>2</b>	<b>2%</b>
<b>Report/certificate</b>	<b>3</b>	<b>2%</b>
<b>TOTAL</b>	<b>128</b>	

The most common primary complaint issues for districts within the Te Whatu Ora – Central North Island region were “waiting list/prioritisation issue” (11%), “unexpected treatment outcome” (9%), and “Inadequate/inappropriate clinical treatment” (9%).

Table 43 shows the most common primary issues complained about for each district.

**Table 43.** Top five primary issues complained about

Te Pae Hauora o Ruahine o Tararua MidCentral		Whanganui		Capital, Coast and Hutt Valley		Te Matau a Māui Hawke’s Bay		Wairarapa	
Inadequate examination/assessment	17%	Lack of access to funding	18%	Waiting list/prioritisation issue	13%	Unexpected treatment outcome	26%	Missed/delayed diagnosis	13%
Delay in treatment	13%	Unexpected treatment outcome	18%	Inadequate treatment	9%	Missed/delayed diagnosis	11%	Inadequate treatment	13%
Waiting list/prioritisation issue	9%	Inadequate treatment	18%	Lack of access to services	7%	Waiting list/prioritisation issue	11%	Inadequate treatment	13%

Compared to the previous period:

- **Te Pae Hauora Ruahine o Tararua MidCentral** saw an increase in complaints primarily about “delays in treatment” and “inadequate examination/assessment”.
- **Te Matau a Māui Hawke’s Bay** saw an increase in complaints primarily about an “unexpected treatment outcome”.

### Complaints related to COVID-19

HDC received 21 complaints about COVID-19-related issues for districts within the Central North Island region in Jan–Jun 2022. Complaints by district were as follows:

- Te Pae Hauora Ruahine o Tararua MidCentral — 7 complaints
- Whanganui — 0 complaints
- Capital, Coast and Hutt Valley — 9 complaints
- Te Matau a Māui Hawke’s Bay — 5 complaints
- Wairarapa — 0 complaints

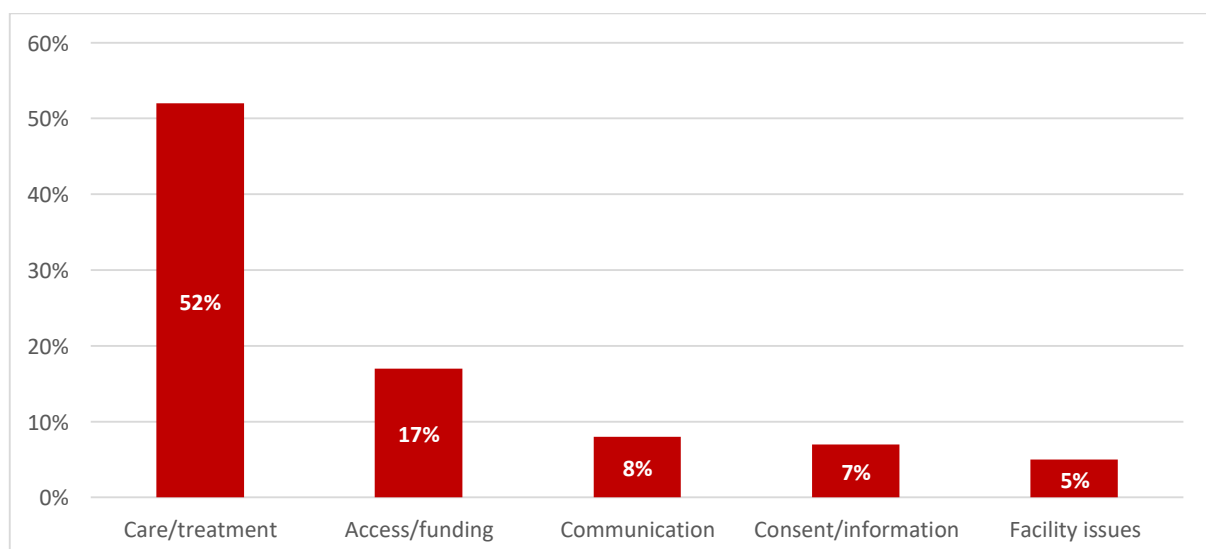
Complaints related to:

- COVID-19-related policies/procedures (e.g., visitor restrictions, mask requirements) — 52%
- Impact of COVID-19 on the healthcare system (e.g., delayed care, staffing, etc.) — 33%
- Treatment of COVID-19 — 9%
- Vaccine-related issues — 5%

## 20.2 All issues

As well as the primary complaint issue, up to six additional other complaint issues are identified for each complaint received by HDC. Figure 9 below shows the most common complaint issues for districts in the Central North Island region when both these additional complaint issues and primary complaint issues are considered.

**Figure 9.** Most common complaint issue categories complained about





## 20.3 Primary issues complained about by service type

The primary issues complained about in relation to each service are set out below.

**Table 44.** Primary issues complained about for each service

<b>Te Whatu Ora — Central North Island</b>							
<b>Surgery</b>		<b>Medicine</b>		<b>Mental health &amp; addiction</b>		<b>Emergency department</b>	
Waiting list/prioritisation issue	25%	Lack of access to services	24%	Involuntary admission/treatment	15%	Delay in treatment	18%
Unexpected treatment outcome	25%	Inadequate/policies/procedure	12%	Inadequate examination/assessment	9%	Waiting list/prioritisation issue	14%
Missed/delayed diagnosis	9%	Communication with consumer	12%	Inappropriate discharge	9%	Inadequate treatment	14%
<b>Te Pae Hauora o Ruahine o Taranaki MidCentral</b>							
Delay in treatment	50%	Inadequate care	17%	Inadequate examination	33%	Waiting list/prioritisation	29%
Inadequate/examination	50%	Refusal to treat	17%	Inappropriate discharge	17%	Delay in treatment	29%
N/A		Communication with consumer	17%	Inadequate follow-up	17%	Missed/delayed diagnosis	14%
<b>Whanganui</b>							
Waiting list/prioritisation	50%	Inappropriate discharge	100%	Inadequate treatment	50%	Delay in treatment	33%
Unexpected treatment outcome	50%	N/A		Refusal to prescribe	50%	Inadequate treatment	33%
N/A		N/A		N/A		Disrespectful manner	33%
<b>Capital, Coast and Hutt Valley</b>							
Waiting list/prioritisation	32%	Lack of access to services	33%	Involuntary admission/treatment	21%	Waiting list/prioritisation	5%
Unexpected treatment outcome	16%	Inadequate policies	22%	Inadequate examination/assessment	16%	Refusal to treat	5%
Missed/delayed diagnosis	11%	Unexpected treatment outcome	11%	Inappropriate/delayed discharge	11%	Missed/delayed diagnosis	5%
<b>Te Matau a Māui Hawke's Bay</b>							
Unexpected treatment outcome	44%	Lack of access to services	100%	Missed/delayed diagnosis	25%	Delay in treatment	100%
Consent not adequate	11%	N/A		Involuntary admission/treatment	25%	N/A	

Waiting list/ prioritisation	11%	N/A		Safety issue for consumer in facility	25%	N/A	
<b>Wairarapa</b>							
N/A		N/A		Inappropriate admission or failure to admit	33%	Inadequate follow-up	100%
N/A		N/A		Consent not adequate	33%	N/A	
N/A		N/A		Inaccurate report/ certificate	33%	N/A	

## 21. Complaints closed about Te Whatu Ora — Central North Island

### 21.1 Outcomes of complaints closed

The outcomes of complaints closed about districts in the Central North Island region in Jan–Jun 2022 are shown in Table 45.

**Table 45.** Outcomes of complaints closed for districts within the Central North Island region<sup>13</sup>

Outcome for district	Te Pae Hauora o Ruahine o Tararua MidCentral	Whanganui	Capital, Coast & Hutt Valley	Te Matau a Māui Hawke's Bay	Wairarapa
<b>Investigation</b>	<b>2</b>	<b>3</b>	<b>5</b>	<b>1</b>	<b>1</b>
Breach finding — Referred to Director of Proceedings	1	1	-	-	-
Breach finding	-	1	2	1	1
No breach finding with adverse comment and recommendations	1	1	2	-	-
No breach finding with recommendations	-	-	1	-	-
<b>Other resolution following assessment</b>	<b>17</b>	<b>3</b>	<b>60</b>	<b>13</b>	<b>4</b>
No further action with recommendations or educational comment	1	-	6	1	1
Referred to other agency	-	-	-	1	-
Referred to District Inspector	-	-	4	1	-
Referred to District	3	-	14	3	2
Referred to Advocacy	4	2	15	4	-
No further action	9	1	21	3	1
<b>TOTAL</b>	<b>19</b>	<b>6</b>	<b>65</b>	<b>14</b>	<b>5</b>

<sup>13</sup> Note that outcomes are displayed in descending order. If there is more than one outcome for a Te Whatu Ora district upon resolution of a complaint then only the outcome listed highest up in the table is included.

# Data for Te Whatu Ora — Te Waipounamu

Please note that data reported captures only those complaints in which districts within the Te Whatu Ora — Te Waipounamu region was identified as a provider by the complainant or subsequently was identified by HDC as a party. Where a complaint is made about an individual practitioner and a Te Whatu Ora district is not identified, the complaint may not be included in these reports.

## 22. Complaints received about Te Waipounamu

### 22.1 Number of complaints received

In the period Jan–Jun 2022, HDC received a total of 145<sup>14</sup> complaints about care provided by districts within the Te Waipounamu region of Te Whatu Ora.

### 22.2 Rate of complaints received

Table 46 shows the rate of complaints to HDC per total discharges for districts within the Te Waipounamu region of Te Whatu Ora (98,090) compared to the rate of complaints per total discharges nationally (453,671).

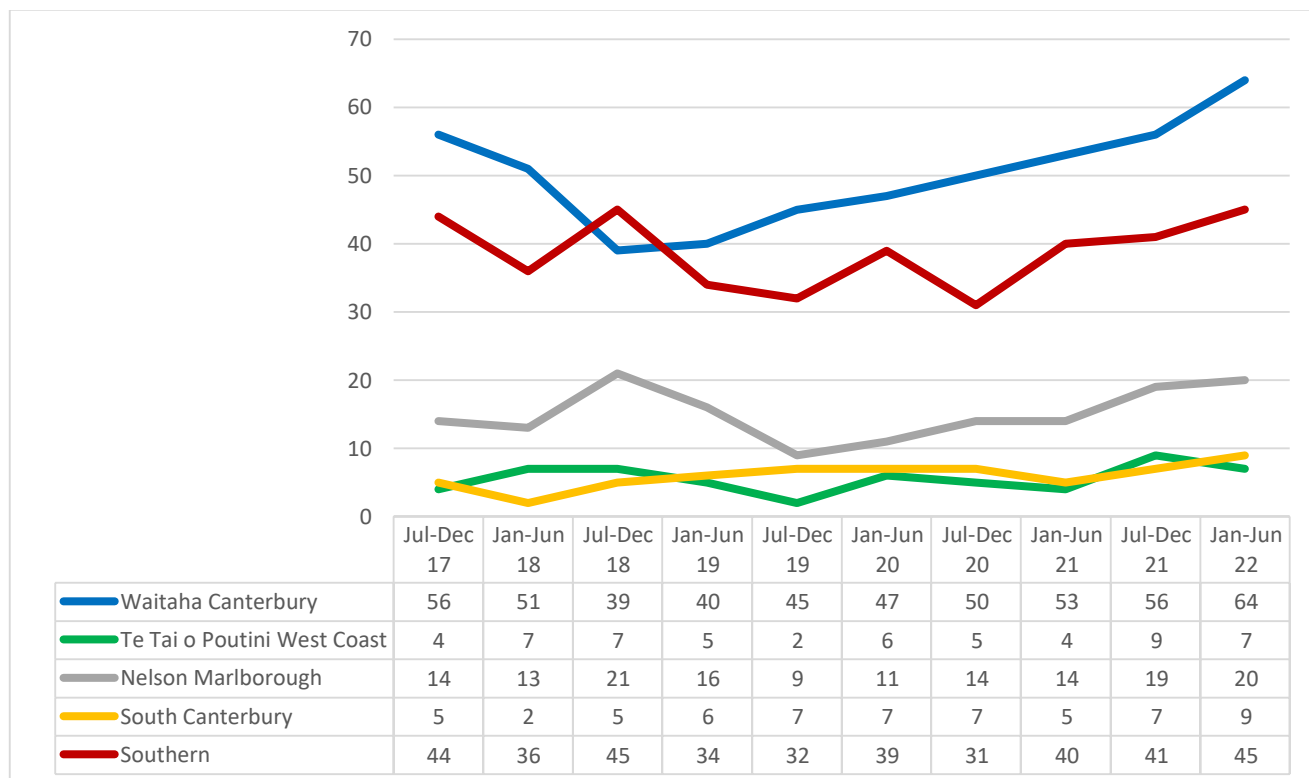
The number of total discharges excludes short-stay discharges from emergency departments, and patients attending outpatient clinics.

**Table 46.** Number and rate of complaints per total discharges

Region and district	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
<b>Te Waipounamu</b>	<b>145</b>	<b>98,090</b>	<b>147.82</b>
Waitaha Canterbury	64	53,802	118.95
Te Tai o Poutini West Coast	7	2,727	256.69
Nelson Marlborough	20	11,537	173.36
South Canterbury	9	5,797	155.25
Southern	45	24,227	185.74
<b>National (all districts)</b>	<b>566</b>	<b>453,671</b>	<b>124.76</b>

<sup>14</sup> Provisional as of date of extraction (1 September 2022).

**Figure 10.** Number of complaints received by district over past five years



## 23. Who complained?

### 23.1 Consumer gender

The gender of consumers in complaints to HDC about districts within the Te Waipounamu region in Jan–Jun 2022 is detailed below.

**Table 47.** Consumer gender

Consumer gender	Number of complaints	Proportion of complaints
Female	88	61%
Male	55	38%
Unknown/did not wish to answer	2	1%

## 23.2 Consumer age

The age of consumers in complaints to HDC about districts within the Te Waipounamu region in Jan–Jun 2022 is detailed below.

**Table 48.** Consumer age

Consumer age	Number of complaints	Proportion of complaints
0 to 17 years	10	7%
18 to 24 years	9	6%
25 to 34 years	25	17%
35 to 49 years	19	13%
50 to 64 years	26	18%
65+ years	44	30%
Unknown/did not wish to answer	12	8%

## 23.3 Consumer ethnicity

The ethnicity of consumers in complaints to HDC about districts within the Te Waipounamu region in Jan–Jun 2022 is detailed below.

**Table 49.** Consumer ethnicity

Consumer ethnicity	Number of complaints	Proportion of complaints
Māori	16	11%
Pacific	2	1%
Middle Eastern/African/Latin American	1	1%
Asian	3	2%
Other European	6	4%
New Zealand European	87	60%
Unknown/did not wish to answer	30	21%

## 24. Service types complained about for Te Waipounamu

For the complaints received, the services concerned and the numbers of complaints about these services are shown in Table 20. Please note that some complaints involve more than one district/hospital, and therefore, although there were 145 complaints about districts within the Te Waipounamu region of Te Whatu Ora, 149 services were complained about.

**Table 50.** Service types complained about

Service type	Number of complaints	Percentage
<b>Diagnostics</b>	<b>7</b>	<b>5%</b>
<b>Disability</b>	<b>3</b>	<b>2%</b>
<b>Dental</b>	<b>16</b>	<b>11%</b>
<b>Emergency department</b>	<b>6</b>	<b>4%</b>
<b>Medicine</b>	<b>31</b>	<b>20%</b>
Cardiology	6	4%
Endocrinology	1	Less than 1%
Gastroenterology	4	3%
General medicine	2	1%
Geriatric medicine	4	3%
Neurology	4	3%
Oncology	3	2%
Palliative care	2	1%
Respiratory	3	2%
Other/unspecified	2	1%
<b>Intensive care/critical care</b>	<b>1</b>	<b>Less than 1%</b>
<b>Maternity</b>	<b>12</b>	<b>8%</b>
<b>Mental Health</b>	<b>25</b>	<b>17%</b>
<b>Paediatrics</b>	<b>1</b>	<b>Less than 1%</b>
<b>Surgery</b>	<b>43</b>	<b>29%</b>
General	13	9%
Gynaecology	5	3%
Neurosurgery	5	3%
Ophthalmology	2	1%
Orthopaedics	11	7%
Otolaryngology	3	2%
Paediatric	1	Less than 1%
Urology	2	1%
Vascular	1	Less than 1%
<b>Other/unknown health service</b>	<b>4</b>	<b>3%</b>
<b>TOTAL</b>	<b>149</b>	

Similar to national trends, surgery (29%) and medicine (20%) were the most commonly complained about service types for districts within the Te Waipounamu region in Jan–Jun 2022. Orthopaedics and general surgery were the most commonly complained about surgical specialties.

The most common service types complained about for each district is outlined below.

**Table 51.** Most common service types complained about by district

Service type	Waitaha Canterbury	Te Tai o Poutini West Coast	Nelson Marlborough	South Canterbury	Southern
Emergency department	5 (8%)	N/A	3 (15%)	1 (11%)	7 (15%)
Maternity	5 (8%)	0	3 (15%)	0	4 (9%)
Medicine	11 (17%)	3 (43%)	2 (10%)	6 (67%)	9 (19%)
Mental health & addictions	13 (20%)	1 (14%)	5 (25%)	1 (11%)	5 (11%)
Surgery	23 (35%)	1 (14%)	2 (10%)	N/A	17 (36%)

General surgery (9 complaints) was the most commonly complained about surgical specialty for **Waitaha Canterbury**, followed by orthopaedics (5 complaints) and otolaryngology (3 complaints). Compared to the previous period, Waitaha Canterbury saw an increase in complaints about general surgery (from 3 complaints to 9 complaints), and a decrease in complaints about medicine services.

Compared to the previous period, **Nelson Marlborough** saw an increase in the proportion of complaints about mental health and addiction services (from 16% to 25%), and a decrease in complaints about surgical services in Jan–Jun 2022.

Orthopaedics (5 complaints) and neurosurgery (4 complaints) were the most commonly complained about surgical specialties for **Southern** in Jan–Jun 2022. Compared to the previous period, Southern saw an increase in the proportion of complaints about ED services (from 7% to 15%), and a decrease in complaints about mental health and addiction services in Jan–Jun 2022.

## 25. Issues complained about for Te Waipounamu

### 25.1 Primary issues

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received about districts within the Te Waipounamu region are listed in Table 52.

**Table 52.** Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
<b>Access/funding</b>	<b>28</b>	<b>19%</b>
Lack of access to services	17	12%
Lack of access to subsidies/funding	2	1%
Waiting list/prioritisation issue	9	6%
<b>Boundary violation</b>	<b>1</b>	<b>Less than 1%</b>
<b>Care/treatment</b>	<b>75</b>	<b>52%</b>
Delay in treatment	7	5%
Inadequate coordination of care or treatment	2	1%
Inadequate/inappropriate non-clinical care	3	2%
Inadequate/inappropriate follow-up	1	Less than 1%
Inadequate/inappropriate monitoring	2	1%
Inadequate/inappropriate clinical treatment	17	12%
Inappropriate admission/failure to admit	1	Less than 1%
Inappropriate withdrawal of treatment	1	Less than 1%
Inappropriate/delayed discharge/transfer	1	Less than 1%
Missed/incorrect/delayed diagnosis	24	17%
Refusal to assist/attend	1	Less than 1%
Refusal to treat	2	1%
Rough/painful care or treatment	1	Less than 1%
Unexpected treatment outcome	12	8%
<b>Communication</b>	<b>6</b>	<b>4%</b>
Disrespectful manner/attitude	3	2%
Failure to communicate openly/honestly/effectively with whānau/family	3	2%
<b>Complaints process</b>	<b>1</b>	<b>Less than 1%</b>
<b>Consent/information</b>	<b>15</b>	<b>10%</b>
Consent not obtained/adequate	6	4%
Inadequate information provided to consumer	3	2%
Issues with involuntary admission/treatment	6	4%
<b>Documentation</b>	<b>1</b>	<b>Less than 1%</b>
<b>Facility issues</b>	<b>12</b>	<b>8%</b>
Inadequate/inappropriate policies/procedures	5	3%
Waiting times	1	Less than 1%



General safety issue for consumer in facility	6	4%
<b>Medication</b>	<b>3</b>	<b>2%</b>
Inappropriate/unlawful prescribing	1	Less than 1%
Refusal to prescribe/dispense/supply	2	1%
<b>Professional conduct</b>	<b>3</b>	<b>2%</b>
<b>TOTAL</b>	<b>145</b>	

The most common primary complaint issues for districts within the Te Waipounamu region were “missed/incorrect/delayed diagnosis” (17%), “inadequate/inappropriate clinical treatment” (12%), and “lack of access to services” (12%). Te Waipounamu saw a higher number of complaints primarily about access issues than was seen nationally.

The most common primary issues complained about for each district are outlined below.

**Table 53.** Most common primary complaint issues for each district

Waitaha Canterbury		Te Tai o Poutini West Coast		Nelson Marlborough		South Canterbury		Southern	
Lack of access to services	14%	Missed/delayed diagnosis	29%	Inadequate treatment	25%	Missed/delayed diagnosis	33%	Missed/delayed diagnosis	20%
Unexpected treatment outcome	13%	Unexpected treatment outcome	14%	Missed/delayed diagnosis	15%	Consent not obtained/adequate	11%	Lack of access to services	13%
Inadequate treatment	13%	Waiting list/prioritisation issue	14%	Lack of access to services	10%	Inappropriate withdrawal of treatment	11%	Waiting list/prioritisation issue	11%

Compared to the previous period:

- **Waitaha Canterbury** saw an increase in complaints primarily about access to services (from 2% to 14%); and
- **Southern** also saw an increase in complaints primarily about access to services (from 2% to 13%).

### **Complaints related to COVID-19**

HDC received 36 complaints about COVID-19-related issues for districts within the Te Waipounamu region in Jan–Jun 2022. Complaints by district were as follows:

- Waitaha Canterbury — 16 complaints
- Te Tai o Poutini West Coast — 2 complaints
- Nelson Marlborough — 4 complaints
- South Canterbury — 1 complaint
- Southern — 13 complaints

Complaints related to:

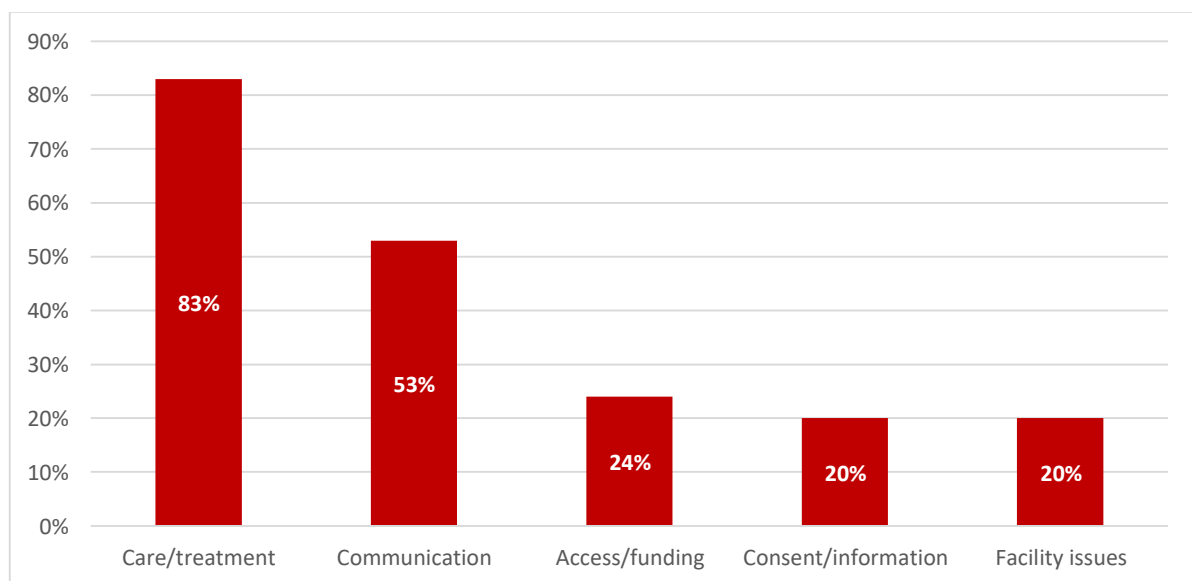
- Impact of COVID-19 on the healthcare system (e.g., delayed care, staffing, etc.) — 42%
- COVID-19-related policies/procedures (e.g., visitor restrictions, mask requirements) — 36%
- Vaccine-related issues (e.g., consent, adverse effects, administration procedure, etc.) — 11%
- Testing-related issues (e.g., access to testing, delays in receiving results, etc.) — 8%
- Treatment of COVID-19 — 3%

## 25.2 All issues

As well as the primary complaint issue, up to six additional other complaint issues are identified for each complaint received by HDC. Figure 11 below shows the most common complaint issues for districts within the Te Waipounamu region when these additional complaint issues and primary complaint issues are considered.

While complaint issues for districts within the Te Waipounamu are similar to what was seen nationally, the region saw more complaints related to “facility issues”.

**Figure 11.** Most common complaint issue categories complained about



## 25.3 Primary issues complained about by service type

The primary issues complained about in relation to each service for each district are set out below.

**Table 54.** Primary issues complained about by service type

<b>Te Whatu Ora — Te Waipounamu</b>							
<b>Surgery</b>		<b>Medicine</b>		<b>Mental health &amp; addiction</b>		<b>Emergency department</b>	
Unexpected treatment outcome	19%	Missed/delayed diagnosis	23%	Involuntary admission/treatment	20%	Missed/delayed diagnosis	31%
Waiting list/prioritisation issue	16%	Lack of access to services	13%	Lack of access to services	16%	Inadequate treatment	19%
Lack of access to services	14%	Inadequate care	7%	General safety issue for consumer in facility	12%	Delay in treatment	6%
<b>Waitaha Canterbury</b>							
Lack of access to services	22%	Missed/delayed diagnosis	27%	Involuntary admission/treatment	31%	Professional conduct issue	40%
Unexpected treatment outcome	12%	Inadequate treatment	18%	Inadequate treatment	23%	Disrespectful manner/attitude	20%
Inadequate treatment	13%	Lack of access to services	9%	General safety issue for consumer in facility	15%	Missed/delayed diagnosis	20%
<b>Te Tai o Poutini West Coast</b>							
Unexpected treatment outcome	100%	Waiting list/prioritisation issue	33%	Inadequate coordination of care or treatment	100%	N/A	
N/A		Rough/painful care or treatment	33%	N/A		N/A	
N/A		Missed/delayed diagnosis	33%	N/A		N/A	
<b>Nelson Marlborough</b>							
Inappropriate/delayed discharge	50%	Inadequate treatment	50%	General safety issue for consumer in facility	20%	Inadequate treatment	33%
Inadequate treatment	50%	Lack of access to services	50%	Lack of access to services	20%	Refusal to treat	33%
N/A		N/A		Refusal to prescribe/dispense	20%	Missed/delayed diagnosis	33%
<b>South Canterbury</b>							
N/A		Missed/delayed diagnosis	17%	Consent not obtained/adequate	100%	Missed/delayed diagnosis	100%
N/A		Communication with whānau	17%	N/A		N/A	
N/A		Inadequate coordination of care	17%	N/A		N/A	
<b>Southern</b>							
Waiting list/prioritisation issue	29%	Lack of access to services	22%	Consent not obtained/adequate	20%	Missed/delayed diagnosis	29%
Missed/delayed diagnosis	18%	Missed/delayed diagnosis	22%	Lack of access to services	20%	Inadequate treatment	29%
Delay in treatment	12%	Delay in treatment	11%	Involuntary admission/treatment	20%	Delay in treatment	14%

## 26. Complaints closed about Te Whatu Ora — Te Waipounamu

### 26.1 Outcomes of complaints closed

The outcomes of all complaints closed about Te Waipounamu in Jan–Jun 2022 are shown in Table 55.

**Table 55.** Outcome of complaints closed about districts in Te Waipounamu region<sup>15</sup>

Outcome for district	Waitaha Canterbury	Te Tai o Poutini West Coast	Nelson Marlborough	South Canterbury	Southern
<b>Investigation</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>6</b>
Breach finding	1	-	1	-	2
No breach finding with adverse comment and recommendations	-	-	-	-	2
No breach finding	-	-	-	-	1
Withdrawn	-	-	-	1	1
<b>Other resolution following assessment</b>	<b>59</b>	<b>6</b>	<b>16</b>	<b>4</b>	<b>42</b>
No further action with recommendations or educational comment	10	2	2	-	5
Referred to other agency	2	-	-	-	-
Referred to District Inspector	4	-	-	-	-
Referred to District	7	-	2	-	7
Referred to Advocacy	16	3	7	3	12
No further action	19	1	5	1	18
Withdrawn	1	-	-	-	-
<b>TOTAL</b>	<b>60</b>	<b>6</b>	<b>17</b>	<b>5</b>	<b>48</b>

<sup>15</sup> Note that outcomes are displayed in descending order. If there is more than one outcome for a Te Whatu Ora region upon resolution of a complaint then only the outcome listed highest up in the table is included.