The Hon Craig Knowles
Minister for Health
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Minister

Report of activities for the year ended 30 June 2000

I am pleased to present the Annual Report and financial statements of the Health Care Complaints Commission for the financial year ended 30 June 2000, for presentation to the Parliament of NSW.

The Report has ben prepared and produced in accordance with the provisions of the Annual Reports (Departments) Act 1985, the Annual Reports (Statutory Bodies) Act 1984, the Public Finance and Audit Act 1983, and the Health Care Complaints Act 1993.

The report covers the work of the Commission and its committed staff in the maintenance and improvement of health care standards and quality services in NSW.

Yours sincerely

Amanda Adrian
Commissioner

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Commissioner's foreword

The work of the Health Care Complaints Commission covers the full spectrum of the health system in NSW and complaints come from a wide range of sources. Since becoming Health Care Complaints Commissioner in June 2000 I have been impressed with the extensive knowledge and information held by the Commission about the way our NSW health system operates and the quality of care provided. From the thousands of complaints we receive, the thousands of concerns we resolve informally, and the many investigations, inquiries, reviews and consultations we carry out, the Commission has a rather unique view of the reality of the provision and outcomes of health care, for both the consumers and the providers of health care. A wealth of information and stories depicting the lives of people connecting with the health system comes our way. It is the only health care complaints mechanism in the country to have an overview of professional standards issues as well as the quality of health services provided in both the public and private sectors. This information can and should better inform the government, service providers, consumers, and their advocates and families, about the challenges and opportunities for improvement that exist within our health system in relation to the quality of the care provided.

The Commission acknowledges the many strengths in the NSW health system. However, there are weaknesses in the delivery of health care. Some of the major issues of concern to the Commission are:

- lack of culturally appropriate health services for indigenous people;
- clinicians not providing people with comprehensive and sensitively expressed information about their health, alternatives for treatment, possible complications, the cost and long term management options to enable them to make informed choices;
- breakdowns in the continuity of care for people, particularly for those with chronic and multiple physical and mental illnesses;
- the system's response to people with physical and mental disabilities; and
- consequences of technology driven changes to service delivery.

The Commission recognises that strategies are becoming well developed for dealing with the conduct, impairment and performance of individual health service providers. However, there is much to be done in developing the governance strategies of organisations responsible for providing health services. It is critical that organisations accept their corporate responsibility for ensuring that the systems within their control are capable of providing services that are safe, effective, appropriate, accessible and efficient, and have a high level of consumer input into all aspects of service delivery. Just as there are appropriate protective remedies that can be used when an individual health practitioner does not perform at an acceptable level of professional competence or ethics, the community should have better information about the performance of their health services and remedies for situations where the health service as a whole lets them down. In many instances, the conduct of individual health practitioners is dependent upon the organisational infrastructure, supervision and support of the system. If aspects of these are flawed or missing, the quality of health services for the community are compromised and the individual practitioner may unnecessarily be at risk of criticism.

For example, the Commission became significantly concerned about the services being provided by a key employee health assessment service during the year, and after discussions with the NSW Ombudsman, instigated an inquiry which is reported on in the Annual Report. The year also saw two major Commission investigations into surgical adverse events: one in relation to eye surgery at Dubbo Base Hospital; and the second relating to gall bladder surgery at Canterbury Hospital. These latter two investigations resulted in recommendations being made about system-wide improvements.

The good news is that we are seeing the positive results of many initiatives with which the Commission has been involved including: the ongoing work of the Ministerial Council on the Quality of Health; the roll-out of the State-wide policy *A Framework for Managing the Quality of Health Services in NSW*; getting pressure ulcer management onto the State-wide quality improvement agenda; and the work being done on fall prevention

and continuity of care.

During the year the Minister for Health launched *The Cosmetic Surgery Report,* the outcome of the Cosmetic Surgery Inquiry. This Report documents some stories from people with experiences of cosmetic surgery and provides a way forward for the stakeholders.

Other highlights of the year included the development of the partnership agreement between the Commission and the National Aboriginal Health and Medical Research Council. The Council has already provided invaluable guidance to the Commission in the development of a Patient Support Officer position to provide a service to Aboriginal communities. The Commission also conducted consultations with Aboriginal communities in the far west of the State and to Tamworth and Armidale. These meetings provided rich, yet sobering insights into the experiences of Aboriginal people accessing health services in rural and remote communities. The Commission will be providing the Minister with a report on those and more recent consultations towards the end of 2000.

The development of a generic investigation training program commissioned jointly by the Commission and the Senior Executive Forum of NSW Health has been another watershed for the Commission. Funded by the Area Health Services, the Commission has embarked on a year-long project to provide training to Area Health Service (including the Corrections Health Service, the Ambulance Service and the New Children's Hospital) staff who are involved in the handling of complaints. The feedback to date has been very positive.

On another positive note, the Commission developed its own web site during the year with the assistance of the Department of Health - www.hccc.nsw.gov.au. As well as developing its electronic capacity, the Commission also distributed over 110,000 'hard copy' publications during the year to promote the services of the Commission.

During the year the Parliamentary Committee on the Health Care Complaints Commission undertook two inquiries. One into the Commission's function to investigate and monitor civil malpractice claims and the other into conciliation processes. The Commission has made submissions to both inquiries and the Committee's Reports are awaited with interest.

I am impressed by the high level of cooperation with the Commission at large, including the support of the Minister for Health, the Director-General of Health and the Presidents of the health professional registration authorities. I also appreciate the support given by consumers, health providers and the consumer and professional peak bodies.

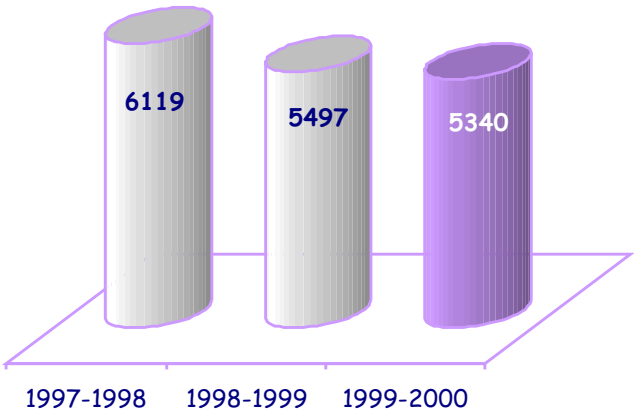
I congratulate the staff of the Commission and all those who have aided and assisted the Commission in undertaking its work during this year. I also wish to thank all of those who have participated in consultative processes through the Commission's Consumer Consultative Committee, the rural consultations and the many other liaison mechanisms that the Commission uses. Your input enables the Commission to better understand and represent the issues confronting consumers in the delivery of health services throughout the State. It also provides improved complaint handling mechanisms that are sensitive to the different needs of the range of cultures relating to age, gender, racial and religious backgrounds that make up our diverse community.

Finally I wish to thank the previous Commissioner, Merrilyn Walton for her enormous contribution in establishing and nurturing the Commission in its evolution into a dynamic organisation that takes its responsibilities in representing the public interest very seriously. This is reflected in the strong show of support the Commission continues to receive from the community, health care providers and most importantly, the health system's increasing responsiveness in using the indicators for improvement that the Commission generates. There is no doubt that there is a necessary and ongoing nexus between the work of the Commission and the health system's quality improvement agenda.

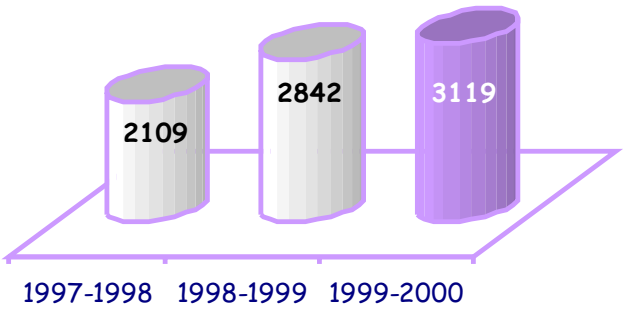
Amanda Adrian
Commissioner

The Year at a Glance 1999-2000

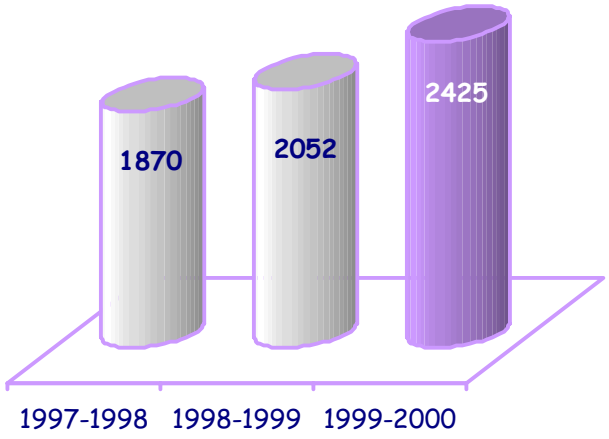
Number of telephone inquiries received 1997-2000



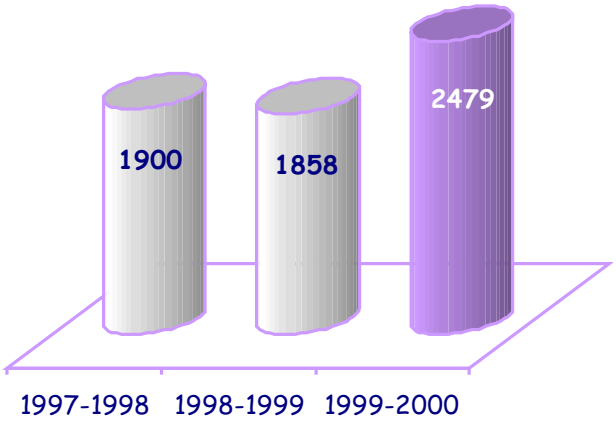
Number of Patient Support Office clients 1997-2000



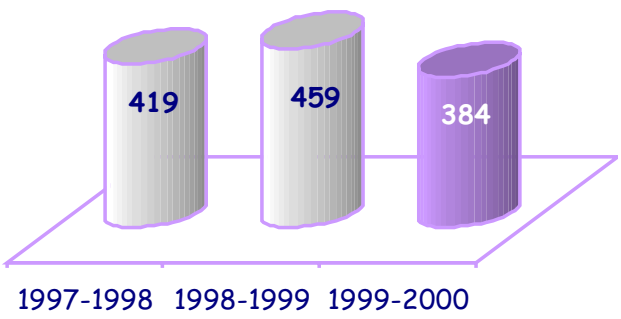
Number of complaints received 1997-2000



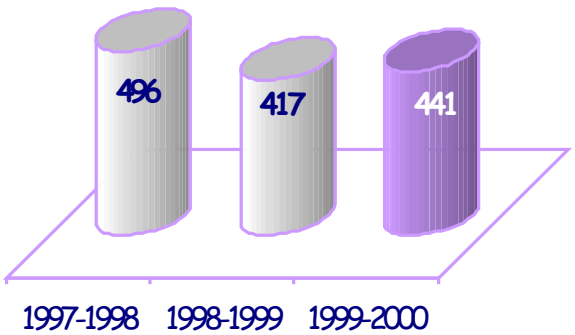
Number of complaints closed 1997-2000



Number of complaints referred for Commission investigation 1997-2000



Number of investigations finalised by the Commission 1997-2000



Performance Measures 1999-2000

Assess complaints in a timely, fair and independent manner

- Received a total of 2425 complaints in 1999-2000
- 50% of complaints were assessed within one week of receipt by the Commission
- Assessed all complaints made to registration authorities about health practitioners

Provide a timely, thorough and independent investigation of complaints which arise from the delivery of health services in NSW

- 1000 complaints were finalised in less than 42 days
- 1610 complaints were finalised in less than 100 days
- Finalised 441 investigations in 1999-2000
- Substantiated in full or in part 278 investigations

Ensure appropriate action is taken as a result of investigations

- Referred 173 cases for disciplinary action to Tribunals, Professional Standards Committees and various registration boards
- Prosecuted 39 health care providers before Professional Standards Committees and 45 practitioners before Tribunals or appellate courts

Manage internal and external liaison, public education, communication and representation

- Distributed over 110,000 brochures and 5,000 posters
- Brochures available in up to 17 languages
- Gave over 94 presentations to consumer and provider groups; estimated number of people attending exceeded 4000
- Held rural and Aboriginal information sessions in 11 country towns
- Participated in many radio, television and newspaper interviews
- Produced articles for journals and conference papers
- Held three meetings with the Consumer Consultative Committee
- Met regularly with all registration boards

Corporate Plan 1999 to 2002

Vision

To protect the people of NSW by ensuring that appropriate standards of health services are provided and to be a leader and effective partner in providing diverse complaint handling services.

Mission

To act in the public interest by investigating, monitoring, reviewing and resolving complaints about health care with a view to maintaining, promoting and improving health standards and the quality of health care services in New South Wales.

Guarantee of service

The Commission guarantees it will be:

- sensitive, understanding and accessible to all people of NSW;
- fair and expeditious in the investigation of complaints;
- accountable for all processes and decisions;
- pro-active in ensuring complainants and respondents are notified and updated as to progress, until the complaint is closed; and
- be fair in conducting disciplinary proceedings.

Role and functions of the Commission

The role and functions of the Commission are to:

- receive and deal with complaints concerning professional practice and conduct of health practitioners and health services;
- resolve complaints with the parties;
- provide opportunities for people to resolve their complaints and concerns locally;
- investigate complaints, recommend and take appropriate action;
- prosecute disciplinary cases before appropriate Tribunals and committees;
- publish and distribute helpful information about Commission work and activities;
- advise the Minister and others on trends in complaints; and
- consult with key consumers and other stakeholders.

Stakeholders

- The people of NSW
- Minister for Health
- Parliamentary Joint Committee
- Department of Health
- Area Health Services
- Consumer Consultative Committee
- Health Reference Panel
- Health Registration Boards
- Health Practitioners & Facilities
- Health Conciliation Registry
- Health Professional & Educational Bodies
- Other Government Agencies

Goals

- facilitate the resolution of complaints;
- provide a timely, thorough and independent investigation of complaints which arise from the delivery of health services in NSW;
- ensure that appropriate action is taken as a result of investigations;
- undertake impartial and fair prosecutions in disciplinary matters;
- manage internal and external liaison, public education, communication and representation; and
- provide staff with a just and safe working environment.

Organisation Chart as at 30 June 2000

Highlights of the Year

Investigation Training

During 1999 the Commission reached an agreement with the Department of Health and the Area Health Services for the Commission to provide a training and advisory service for a period of 12 months to Area Health staff in relation to the investigation of complaints.

Between March and 30 June 2000, 15 training courses were conducted with 222 participants attending.

Further details about this program are on page 11.

Aboriginal Community Consultations

In July 1999, the Commission started a program of visits to Aboriginal communities in rural NSW to promote the role and function of the Commission and to hear from the Communities about their concerns with the NSW health system. The Commission visited communities in the far west - in Broken Hill, Willcannia, Menindee, Ivanhoe, Balranald and Dareton. The Commission also visited communities in Armidale, Guyra, Walcha, Glenn Inness and Tamworth. Further details are on page 73.

Agreement with AH&MRC

The Commission entered into a partnership agreement with the Aboriginal Health and Medical Research Council during the year. This agreement will ensure that the expertise of Aboriginal communities and Health Services can be better utilised by the Commission so as to improve Commission services to Aboriginal communities in NSW.

Investigations into Adverse Events at Dubbo and Canterbury Hospitals

During the 1999-2000 year the Division conducted major investigations into incidents at Dubbo Base Hospital and Canterbury Hospital, both of which attracted significant public interest.

Both incidents raised very serious issues as to the safety and welfare of patients within the NSW public health system and required urgent investigation by the Commission to ensure that these issues were identified and resolved as quickly as possible.

Details of both investigations can be found under the heading "Major Investigations" on page 68.

Web Presence

In April 2000, the Commission, with assistance from the NSW Health Department launched its own website. The website offers information to consumers and providers of health care services about the role and function of the Commission and how to make a complaint. The website is located at www.hccc.nsw.gov.au.

Ministerial Inquiry into Cosmetic Surgery

As reported in the Commission's 1998-1999 Annual Report, The NSW Minister for Health appointed a Committee of Inquiry into Cosmetic Surgery in October 1998. The Committee was chaired by Ms Merrilyn Walton, the then Health Care Complaints Commissioner. The inquiry was completed and a report was launched by the Hon Craig Knowles, Minister for Health, in October 1999. More details about the findings of the Inquiry are in the "Inquiries" section on page 70

The **Division of Complaint Resolution** includes two sections of the Commission - the Complaint Assessment and Resolution section and the Patient Support Office. The strategic foci of the Division for the financial year are better complaint handling and improved complaint resolution. The strategic activities of the Division and the key activities of each section are reported on below.

Strategic Initiatives

The Commission has as one of its strategic aims improved complaint handling. The Commission observed through the monitoring of complaints referred by it to Area Health Services the potential for improving local complaint handling practices. Two of the principles of best practice complaint handling concern timeliness and local resolution. While the Commission provides oversight and feedback to the Area Health Services on referred individual complaints, the Commission has sought to systemically influence local complaint handling practice. The Commission developed three strategies: firstly to offer training and advice to Area Health Service staff in the investigation of complaints; secondly, to assist Area Health Services using the Consultative Resolution Model to resolve complaints with broad policy implications and affect those changes; and thirdly, to involve the Patient Support Office in all complaints referred to other agencies for investigation.

Investigations Training and Consultancy Service

During 1999 the Commission reached an agreement with the Senior Executive Forum of the NSW Health Department and the Area Health Services for the Commission to provide a training and advisory service for a period of 12 months to area health service staff in relation to the investigation of complaints. During the 1999-2000 reporting period the temporary position was filled. The Investigations Advisor initially conducted a needs analysis and obtained input into the design and content of the course.

The Investigations Advisor developed and has been conducting a number of training courses for each Area Health Service and provided a consultancy service for Area Health Service staff conducting investigations. The Investigations Advisor also produced a manual to assist Area Health staff responsible for investigations. The resource manual addresses topics covered in the training sessions in greater detail and provides other information.

The program was designed to ensure attendees would:

- understand the link between complaints and quality management, and the value system underpinning complaints management, investigations and service enhancement;
- develop a working understanding of the principles of investigation;
- be able to understand and apply a generic framework for investigation processes;
- understand the requirements of procedural fairness;
- identify the purpose of an investigation;
- understand and be able to apply investigation planning and monitoring tools;
- identify information gathering strategies;
- know how to document the investigation process and information obtained during interviews;
- be able to structure and write an investigation report;
- understand the requirements of making recommendations as the result of an investigation; and
- know who to contact for advice/support to enhance local complaint handling.

Between March and 30 June 2000, 15 training courses were conducted with 222 participants attending. In addition to the Area Health Services, training has been provided to Corrections Health Service, NSW Ambulance Service, and the New Children's Hospital. At the end of the program in November it is expected over 700 health care managers and staff will have attended the training course. Placements at the training workshops have also been provided to officers from the Private Health Care Branch and the Pharmaceutical Services Branch of the NSW Department of Health and interstate health officers.

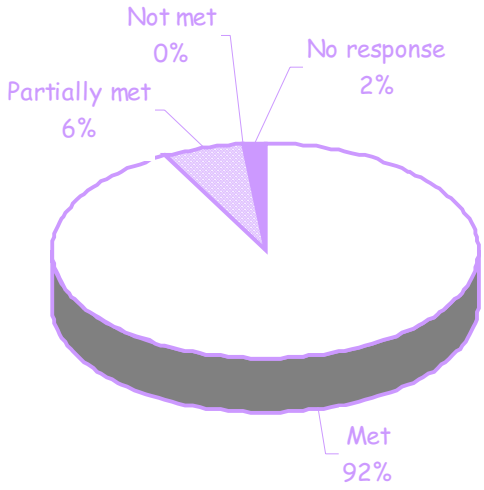
The training program has afforded the Commission the invaluable opportunity of exchanging information with metropolitan, rural and remote health service managers. As a result the Commission is more fully informed of the challenges experienced by managers in the delivery of services.

The Program is being evaluated through participant survey of the training material, its delivery and the course workbook. The course has been rated very highly to date. The evaluation results of the first 15 training courses involving 222 participants follow:

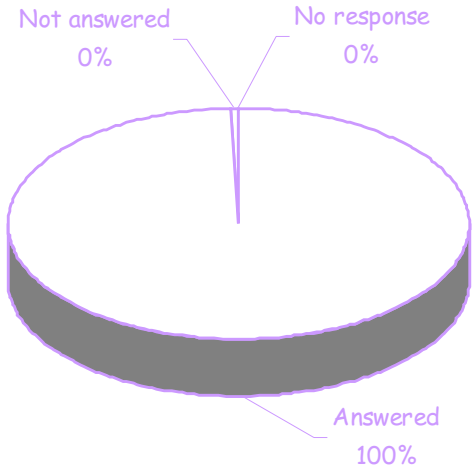
Course Evaluation:

Use of case studies

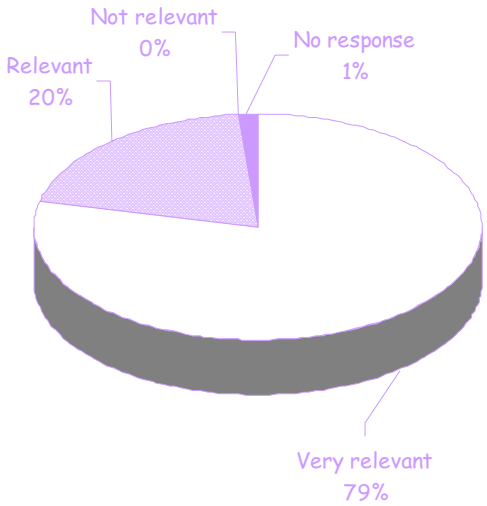
Objectives met



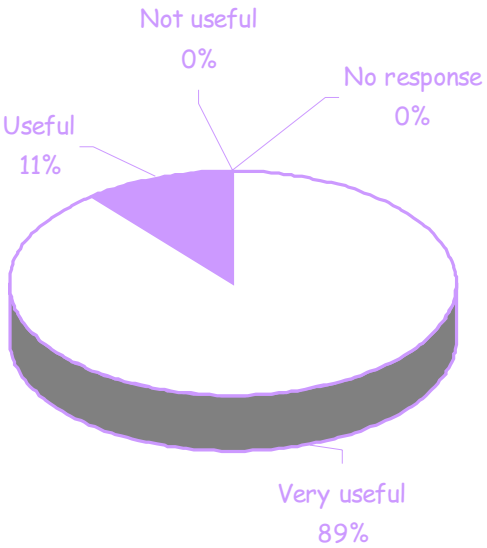
Participant questions answered



Topic relevance



Course content



Participants were invited to comment on the training course's strengths and weaknesses along with any other general comments. Typical comments provided were:

- I have already thought about so many ways to improve complaint handling.
- I have been deficient in my investigations in the past but feel much better prepared for any future investigations.
- I will now view complaints in a totally different way.
- I am now better prepared 'let the complaints begin'.
- A useful and essential guide for conducting investigations.

It is envisaged the Investigations Training Program, together with health service and Departmental initiatives, will enhance the health system's ability to conduct competent investigations and act on opportunities to enhance the quality of health services. Two training courses will continue to be held each week until November 2000.

Consultative Resolution Model

A model to facilitate policy/service enhancement

Section 26 of the Health Care Complaints Act 1993 empowers the Commission to refer complaints to other agencies for investigation where it appears the complaint raises issues which require investigation by the other person or body. Most referrals are made to Area Health Services. The Commission may request a report on the investigation, findings and outcomes. Historically, a paper-based review of these reports has occurred. A number of complaints with broad policy implications came to the Commission's attention where no adequate action had been taken to prevent reoccurrence.

Consultative resolution is an informal, facilitative framework developed by the Commission during the year to assist health services to identify and rectify:

- inadequate policy related quality processes;
- substandard service quality and effectiveness; and
- inadequate investigative processes or outcomes.

The approach is simple, flexible and non-adversarial. Consultative resolution is different to the advocacy model employed by the Patient Support Office. The Commission representative directs the process in consultation with the health facility and where applicable, the complainant. Rather than advocating on behalf of the complainant the Commission representative uses a quality improvement framework to negotiate quality enhancements.

The development of consultative resolutions has provided the Commission with an effective resolution option that links with quality improvement initiatives in the health system. The process assists health services to critically evaluate service provision, identify service deficiencies and take meaningful action to address the deficiencies. Health services have been responsive to consultative resolutions and have appreciated the provision of resources and support to assist them to develop alternative policies and practices.

The Consultative Resolution Process

The framework for the consultative resolution model (CRM) is by nature, flexible. The amount of information available to the Commission at the time of the decision to utilise CRM will determine what particular actions and tasks are required. The general CRM approach is:

1. Obtain Information

- Documents, including relevant health service policy documents, forms, and records may need to be reviewed. This may occur prior to or at a meeting between the parties.
- Health service responses might need to be obtained on some of the issues raised by the complainant. It is possible that this, in itself, might resolve outstanding HCCC concerns. CRM might not need to go to the stage of a formal consultative conference every time.
- Best practice guidelines, policies or protocols may be obtained to assist the health organisation to identify deficiencies in current policies and practice and serve as a resource in developing new practice and policies.
- The complainant/subject may be interviewed to obtain further detail.

2. Terms of reference

Terms of reference for the consultation are drafted by the Commission to ensure all parties are prepared.

- The terms of reference include an outline of the complaint, patient concerns or issues identified by the Commission and issues to be discussed and addressed during the consultation.
- The particular processes or services to be discussed are clearly described and agreed upon by the conferring parties prior to the meeting.

3. Facilitation of meeting

- The purpose of the consultation is clearly defined, and understood by the health service prior to the meeting. Considerable time may be invested in discussing the concerns of the representatives of the health facility.
- The focus of the consultation is on the enhancement of the service's knowledge and ability to improve its processes and services.
- Attendees are determined by agreement between the Commission and the health service (typically, the facility's Manager, the Director of the Area Health Service's Executive Support section, at times the CEO and Commission representatives).
- The meeting place is determined by agreement but will usually be at the facility which provided the service complained about (this allows for greater understanding of the context of the service, and therefore the complaint and also allows for the viewing of any documents/ settings).
- The Commission representative coordinates the collation and distribution of the Issues Paper and the working documents.

4. Consultative resolution meeting

- The meeting is chaired by the Commission representative.
- The health service representatives discuss their interpretation of the complaint and issues raised.
- The Commission representative provides feedback on service quality and adequacy of existing policy/protocols. These perceptions are discussed with the health service representatives. The policy/protocol or best practice documents circulated prior to the meeting are discussed and are used to assist the hospital representatives to identify and understand the identified concerns.
- Areas of agreement are identified and a process to progress action to enhance service is identified.

5. Post Meeting actions

- The Commission is advised of actions taken by the health service and provided with copies of developed policies/protocols.
- The complainant may be involved in the development of new policies or other activities arising from the resolution meeting.

Case Study - Loss of trust between an Aboriginal community and the local health service

A young mother had several admissions to a small rural hospital. She was receiving treatment for cancer at another hospital and found caring for her children, as a sole parent, difficult. On one of the admissions her baby was diagnosed with a skin disorder which required a topical lotion. Nursing staff applied the lotion with a household paint brush. The complainant did not give permission for the nurses to use the paintbrush and found its use highly offensive and demeaning. The complainant noted the brush used had traces of old paint. The hospital believed the brush was new.

Twenty Aboriginal women co-signed a letter of complaint from the mother to the Commission. A number of concerns were raised about the relationship between the hospital and the local Aboriginal community. The responsible Area Health Service was requested to investigate the complaint and provide a report to the Commission. The response was seen as inadequate by the Commission as it did not acknowledge the cultural inappropriateness of using a paint brush on a three week old baby.

A consultative resolution approach was adopted by the Commission in view of continuing community dissatisfaction and lack of trust in the local hospital. The Commission had been previously advised by Aboriginal communities that they were reluctant to use hospital services as they sometimes found the experience alienating and distressing.

The Commission representative met with the complainant and two community elders. A large number of issues of concern were identified. These ranged from the experiences of the mother to lack of community based services to the Aboriginal community. A meeting was then held with an Area Health representative and the local hospital manager. A significant amount of time was spent allowing the manager to express frustration that the concerns remained despite the earlier

cont...

investigation and attempts at local resolution. The issue of the paint brush was discussed from the perspective of an Aboriginal mother watching two white nurses treat her baby and apply lotion to the baby's body using an old brush. Frameworks of resolution were also discussed.

A joint meeting was held with all the key people. The Aboriginal women told their stories about experiences with the hospital. The health manager was receptive and did not realise the depth of dissatisfaction.

The health manager agreed to:

- stop using paint brushes for applying lotions to people;
- meet with the elders to discuss their ideas about improving health services to the Aboriginal community; and
- work with hospital staff to ensure they understood the unintended consequences of their actions or style of communication.

The complainant and the elders were satisfied with this first step at improving relationships between the Aboriginal community and the local health service.

Case Study - Pain management and responding to distressed patients

A middle aged man was admitted to a district hospital with significant pain. He received medication for his pain but experienced continuing discomfort. After a delay in receiving his medication, he went to the nursing station and demanded his medication then went to the day room to sit alone. Nursing staff found the patient abusive and called security. The patient became agitated when security arrived and left the hospital. The hospital did not make any post-discharge arrangements. The patient presented to the hospital's accident and emergency department the next morning. He remained in pain and left after three hours. He was admitted to another hospital where he was immediately diagnosed with kidney stones and provided with adequate pain relief.

The patient's wife wrote to the Commission and her complaint was referred to the Area Health Service responsible for the hospital. She noted that her husband was in considerable pain during his hospitalisation. The Area provided the Commission with a report on the findings of their investigation. The report was reviewed and many deficiencies in the investigation and service provision were identified.

A consultative resolution approach was identified as a means to address the problems. The Area Health Service agreed to be involved in the meeting. An Issues Paper was drafted and circulated to hospital representatives prior to the meeting. Opportunities for improvement identified in the Issues Paper included:

- failure to respond to some issues raised by the complaint and inadequate examination of the other issues;
- pain management was assessed on the number of injections given with no mention of the patient's level of discomfort;
- no mention was made of a three hour wait in the emergency department without pain relief; and
- the hospital emphasised staff safety and did not critically examine the service provided to the patient.

Hospital and Department of Health policies were obtained that covered patient discharge and managing aggression and assault.

During the consultative resolution meeting hospital representatives expressed their views on the care provided to the patient. The Commission representative offered alternative views on managing patients in pain which were accepted by the hospital. Documentation was reviewed and the hospital identified inadequacies with incident reporting, management review and the policy on managing aggression and assault. The hospital also recognised that staff did not adhere to the requirements of the discharge policy. Following discussion of options, the hospital agreed to review their policies and practice in relation to managing aggression, assault and critical incident reporting.

Statewide Complaint Data Collection Project

Under the Health Care Complaints Act 1993 the Commission is responsible for providing information to the Minister for Health on complaints made about the public health system. To enable the Commission to perform this function, the Commissioner and the Director-General of Health reached an agreement that standardised data be collected. The collection of such data is an important step forward in health services becoming more transparent and accountable to the public for the services provided. This is a move consistent with directions being taken world wide and in other parts of Australia. The collection and analysis of data can lead to service improvements. The project is also contributing to the growing awareness by health services of the importance of complaints and local complaint resolution. During the year the Commission worked closely with the Department of Health and the Area Health Services to establish a standardised mechanism to collect information about the complaints consumers made about services provided.

Last year the Commission reported that a Memorandum of Understanding was yet to be signed between the Commission, Department of Health and the Area Health Services as the Commission was not satisfied that data would be provided in a form which will allow it to perform its function of reporting to the Minister. The parties have now agreed to Commission access to the full data set. Database enhancements are now underway to allow the Commission to electronically receive the data, analyse it and provide the health system with valuable information.

National Health Complaints Information Project

The National Health Complaints Information Project (NHCIP) is an initiative of the National Council of Health Complaints Commissioners and the Commonwealth Department of Health and Aged Care. The Project aims to collect and analyse complaint information from all States and Territories, initially from Health Complaints Commissions. Other health organisations may contribute complaint data as the Project evolves.

For the first time, complaint trends may be identified on a national level thereby increasing the value of complaints and the information they yield.

The Commission has actively participated in the development of the project which has used the Commission's de-identified data set as a basis for the national collection. It is envisaged that data from the Statewide Complaints Data Collection Project, the Commission's own complaint collection and the National Complaint Data Collection will be coded using the same generic data set. Work continues to achieve this objective and the National Health Complaints Information Project released its final report on stage 2 of the project during the year.

Consumer Focus Collaboration

The Task Force on Quality of Australian Health Care identified problems in the health system which could be addressed and the quality of health services enhanced by the participation of consumers of these services in planning and delivery. The Consumer Focus Collaboration (CFC) was formed in 1997 following the *Final Report of the Taskforce in Australian Health Care (1996)* to support and encourage the creation of consumer feedback and participation mechanisms. The Collaboration comprises representatives from Health Complaints Commissions, consumer organisations, professional associations and State and Territory Governments.

The CFC works with key stakeholders to promote, integrate and disseminate information and promote initiatives which increase consumer involvement in health service planning, delivery and evaluation. The CFC recognises the potential of consumer involvement to improve health service accountability and responsiveness to consumers. The CFC also works to promote education and training that supports active consumer involvement in health service planning and delivery. Through projects such as a consumer participation toolkit, a clearing house for consumer feedback methodologies and identifying models for the provision of information to consumers, the CFC has been promoting models to assist health services to implement meaningful programs and dialogue with consumers.

The Health Care Complaints Commission represented the State and Territory Health Complaints Commissions on the CFC during the financial year. A number of new projects were sponsored during the financial year including the Education and Training for Consumer Participation in Health Care project, the production of a Resource Guide for Organisations on Improving Health Services through Consumer Participation, the development of a model to select and support consumer representatives and the Structural and Cultural Marginalisation Project.

The CFC has established key links with the newly formed Australian Council for Safety and Quality in Health Care through shared membership, the formation of a sub-group to support the Council address its priority areas of action and by providing input into various exercises being undertaken for the Council.

Review of Publications and Correspondence

The Commission has continued to review its publications and correspondence. The Commission is aiming to provide clearer information to the community about the complaint process and the role of the Commission. During the year the Commission produced a complaint form which is available in printed form or electronically on the Commission's web site. The Commission has also produced a new pamphlet which provides clear information about the conciliation process. The Commission is about to finalise the contents of a brochure explaining rights in relation to access to medical records and the various processes to get them.

During the year the Commission negotiated to format and print a booklet entitled *"Getting Through"* written by a complainant who had experienced the investigation and prosecution of a sexual misconduct case by the Commission. By agreement with the author, the booklet is provided to complainants who lodge complaints of sexual misconduct with the Commission.

Reporting of Complaints

The Commission reviewed the way it records and reports on the receipt of complaints. Complaints received by the Commission are complaints for the purposes of the Health Care Complaints Act 1993. Complaints received by registration authorities must be notified to the Commission and are then deemed to be complaints under the Health Care Complaints Act 1993. The Commission is required by the Act to include in its annual report the number and types of complaints made to it during the year.

In the past a significant number of complaints received and dismissed by the registration authorities were not recorded by the Commission as a complaint under the Health Care Complaints Act 1993 and therefore not reported in the Commission's Annual Report. For the first time this year the Commission's Annual Report provides a full record of complaints made to the Commission either directly or through the registration authorities.

Last year the Commission received 2052 complaints. This year the Commission received 2425. This represents an increase of 373 complaints. Of the increased number, 233 are as a result of the Commission fulfilling its statutory requirement to report on complaints made under the Act.

Database Development

The Commission's existing database does not have capabilities to enable case management, record management, application of relevant security levels or to act as a sophisticated management information system. A case management system allows the Commission to manage the prosecution function and is becoming critical for the Patient Support Office. The National Health Complaints Information Project and the NSW Statewide Complaint Data Management Project have also highlighted the need for more modern applications and more powerful analytical tools. Licences for the existing database can no longer be purchased and programmers are no longer familiar with the version of software used.

During the year the Commission received an allocation to enhance its database in response to a business case. The Commission reviewed a number of existing complaint databases to evaluate the direction to be taken and commenced the documentation of the additional specifications required.

Patient Support Office for Aboriginal Communities

The Commission embarked on a program of consultations with Aboriginal communities throughout NSW in 1999-2000. The program will extend into 2000-2001. This program would not have been possible without the extensive assistance of the Aboriginal Health and Medical Research Council and the Aboriginal Medical Services throughout the state. The Commission wishes to acknowledge that assistance and thank the many people who have assisted the Commission.

The Commission will shortly be publishing a report on the specific difficulties experienced by members of Aboriginal communities. These include: inaccessibility of health services; the lack of culturally appropriate health services; and a lack of knowledge of health rights and local complaint handling mechanisms. One of the many lessons learnt by the Commission was the inaccessibility and inappropriateness of its own complaint handling process to Aboriginal communities.

As a response to these issues the Commission piloted resolution strategies with Aboriginal communities through the Patient Support Office this financial year. The Commission's budget for the year was augmented to allow the employment of an additional Patient Support Office position. As a result of its consultations with Aboriginal communities, the Commission decided to dedicate the position to servicing Aboriginal communities and commenced recruitment for the position.

Partnership Agreement

The Commission entered into a partnership agreement with the Aboriginal Health and Medical Research Council during the year. The commitment underpinning the memorandum of understanding will ensure the expertise of Aboriginal communities and Aboriginal controlled health services are brought to the activities of the Commission and especially to the development of a Patient Support Office service for Aboriginal communities.

Complaints Received

The **Complaint Assessment and Resolution** section handles initial telephone and in-person inquiries made to the Commission. It provides secretariat assistance to the Complaint Assessment Committee. It is responsible for the statutory function of notifying respondents of the receipt of a complaint and notifying the parties of the Commission's assessment decision. The section undertakes the pre-assessment work on complaints where further information is needed before an assessment decision can be made. After assessment the section refers complaints to the Health Conciliation Registry, other agencies or to other areas of the Commission such as the Patient Support Office or the Division of Investigations and Prosecutions as appropriate.

Telephone Inquiries

The role of the two Telephone Inquiry Officers is to provide information to callers about the role of the Health Care Complaints Commission and to advise callers of options available to them to resolve or deal with their concerns. Telephone Inquiry Officers may obtain and provide information to callers to assist them resolve complaints directly with the practitioner or health facility concerned. If a Telephone Inquiry Officer is unable to resolve a caller's concern, the caller may be referred to a Patient Support Officer, or advised to make a formal complaint to the Commission in writing.

The Commission received 5,340 telephone inquiries in 1999-2000, an equivalent number to the previous year. This number includes only the calls handled by the Telephone Inquiry Officers and does not include calls of an administrative nature such as requests for Commission publications and complaint statistics, or calls made to the Patient Support Office.

The Commission introduced a new complaint form during the year. The form is designed to assist complainants to provide sufficient detail for the Commission to make an assessment decision. It also assists in the accurate identification of those people or organisations being complained about and generally improves the quality of complaint information. Telephone Inquiry Officers send callers a complaint form if they are considering lodging a complaint.

Face to Face Inquiries

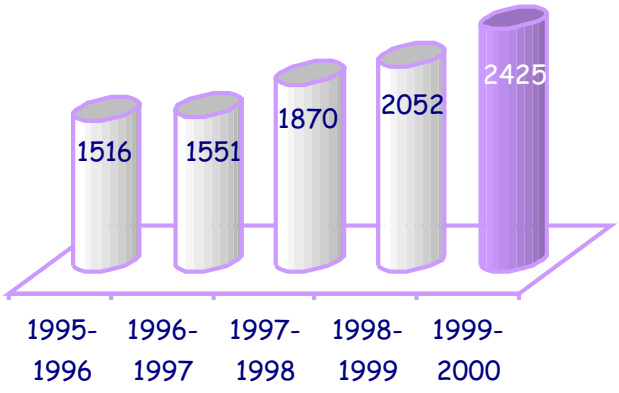
The primary means of contact with the Commission is by telephone or in writing. From time to time people attend the Commission to make inquiries in person. The Complaint Assessment and Resolution staff are available to provide information and/or assist with the preparation of a written complaint as required.

During 1999-2000 an average of six inquiry interviews were conducted each month by Complaint Assessment and Resolution staff.

Complaints Received

In 1999-2000 the Commission received 2425 complaints. The bar graph below indicates the increasing number of complaints being received by the Commission each year.

Total number of complaints received 1995-2000



When the Commission receives and assesses complaints it categorises them. Each complaint is allocated a primary category which reflects the main issue raised by the complaint. Most complaints raise multiple issues and increasingly all this information is being captured also. The following table reports on how the Commission categorised the primary issue raised by complaints received this year.

Complaints received by category 1999-2000

Category & Type	No
Clinical Standards	**1,264**
Adverse treatment outcomes	149
Communication - nil	15
Communication: incorrect/misleading/nil	17
Communication: insensitive/rude	152
Competence	39
Consent	41
Delay in attending	3
Delay in treatment	51
Diagnosis - inadequate/incomplete	99
Diagnosis - incorrect	155
Diagnosis - nil/incorrect	7
Experimental treatments	4
Failure to follow-up results	7
Infection control	38
Innovative treatment	8
Language	1
Medical records	4
Medical records - incomplete	3
Medical records - nil	3
Medical records - quality	12
Prosthetic devices	27
Refusal to attend	10
Refusal to treat	55
Treatment - gross mismanagement	3
Treatment - inadequate	248
Treatment - incorrect/inadequate	108
Unqualified/non-qualified	4
Use of interpreter	1
Quality Of Care	**332**
Administrative practice	25
Delay in admission	3
Delayed transfer	1
Delayed transport	4
Inadequate/un-qualified personnel	2
Inappropriate admission	0
Inappropriate admission (Mental Health)	15
Inappropriate care	65
Inappropriate discharge	8
Inappropriate transport	5
Institutions/hospital practice	70
Premature discharge	9
Refusal to admit	2
Refusal to discharge	1
Standards of care: facilities	110
Standards of care: hygiene	11
Statutory compliance	1

Category & Type	No
Business Practices	**228**
Clinical advertising	1
Commercial advertising	3
Death certificate	4
Fees	57
Inappropriate commercial activities	20
Medical certificates	23
Medico-legal report - nil communication	15
Medico-legal report - rough/inadequate	19
Medico-legal report-inadequate/incorrect	20
Medico-legal reports	63
Refusal to hand over medical records	3
Prescribing Drugs	**171**
Administration	21
Dispensing	65
Diversion	9
Illegal prescribing	8
Over prescribing	18
Wrong/incorrect prescribing	50
Provider/Consumer Relationship	**123**
Coercion	1
Inappropriate examination/treatment	25
Inappropriate relationship	17
Physical assault	35
Sexual assault	24
Sexual harassment	1
Sexual relationship	20
Patient Rights	**101**
Access to records/reports	23
Breach of confidentiality	63
Consent	2
Privacy	8
Records: accuracy	5
Fraud	**52**
Extraordinary claims	11
Falsification/fabrication/plagiarism	10
Financial inducement/advantage	6
Holding out/misrepresentation	15
Overservicing	10
Other Ethical/Improper Conduct	**52**
Acts of dishonesty	13
Inappropriate professional conduct	38
Use of deleterious drugs	1

Cont...

Category & Type	No	Category & Type	No
IMPAIRMENT	**38**	**CHARACTER**	**15**
Breach of conditions	6	Breach of conditions	3
Drugs	17	Conviction/offence under legislation	12
Mental capacity	14	**WAITING LIST**	**8**
Physical capacity	1	Waiting list	8
MISCELLANEOUS	**32**	**COMPLAINTS MANAGEMENT**	**4**
Awaiting more information	18	Dissatisfaction with process/outcome	4
Notification	7	**ILLNESS RELATED**	**4**
Provide information	5	Operative complication	4
Various 'other' categories	2	**RESOURCES**	**1**
		Resources	1
TOTAL		**2,425**	

The following table summarises the complaints received by category in the last three financial years. The table shows that the types of complaints received by the Commission remains relatively stable from year to year.

Summary of complaints received by category 1996-2000

Category	1997-1998 No	1997-1998 %	1998-1999 No	1998-1999 %	1999-2000 No	1999-2000 %
Clinical Standards	1,129	60.4	1,168	56.9	1,264	52.1
Quality of Care	250	13.4	312	15.2	332	13.7
Business Practices	163	8.7	140	6.8	228	9.4
Prescribing Drugs	67	3.6	97	4.7	171	7.1
Provider/Consumer Relationship	87	4.7	129	6.3	123	5.1
Patient Rights	61	3.3	79	3.9	101	4.2
Fraud	23	1.2	47	2.3	52	2.1
Other Ethical/Improper Conduct	30	1.6	39	1.9	52	2.1
Impairment	17	0.9	24	1.2	38	1.6
Miscellaneous	30	1.6	5	0.2	32	1.3
Character	7	0.4	6	0.3	15	0.6
Waiting Lists	0	0	2	0.1	8	0.3
Complaints Management	0	0	0	0	4	0.2
Illness Related	0	0	0	0	4	0.2
Resources	1	0.1	2	0.1	1	0
Re-registration	5	0.3	2	0.1	0	0
Total	**1,870**	**100.0**	**2,052**	**100.0**	**2,425**	**100.0**

Complaints received about health services 1996-2000

Health Service	1997-1998 No	1997-1998 %	1998-1999 No	1998-1999 %	1999-2000 No	1999-2000 %
Public Hospital	323	52.4	336	52.3	406	54.7
Private Hospital	54	8.8	45	7.0	52	7.0
Community Health Service	20	3.2	18	2.8	39	5.3
Medical Centre	31	5.0	36	5.6	36	4.9
Nursing Home	28	4.5	38	5.9	30	4.0
Corrections Health Service	10	1.6	16	2.5	26	3.5
Psychiatric Hospital	22	3.6	44	6.9	24	3.2
Area/District Health Service	8	1.3	6	0.9	17	2.3
Ambulance Service	8	1.3	10	1.6	16	2.2
Private Medical Practice		0.0	6	0.9	12	1.6
Radiology Centre	5	0.8	6	0.9	12	1.6
Alternative Health Service		0.0	2	0.3	8	1.1
Pathology Centre or Laboratory	5	0.8	8	1.2	7	0.9
Drug & Alcohol Service	7	1.1	3	0.5	5	0.7
Pharmacy	4	0.6	1	0.2	5	0.7
Day Procedures Centre	5	0.8	3	0.5	3	0.4
Group Home	2	0.3	4	0.6	2	0.3
Department of Health	8	1.3	0	0.0	2	0.3
Public Dental Unit	12	1.9	6	0.9	2	0.3
Health Funds	2	0.3	0	0.0	2	0.3
Women's Health Centre	2	0.3	3	0.5	1	0.1
Other	60	9.7	51	7.9	35#	4.7
Total	**616**	**100.0**	**642**	**100.0**	**742**	**100.0**

#Other: Dental Surgery - Private 3; Hostel - Aged 2; Other 30

There has been a 20% increase (n= 70) in complaints against public hospitals in 1999-2000. While the percentage increase may appear to be significant, the numerical increase of 70 is not indicative of any particular trend, particularly in the context of the volume of individual services provided in the health sector. The increase may reflect a conscious Commission complaint assessment strategy to view issues within the context of the system within which they arise rather than as the responsibility of individuals. Where individual practitioners are employed to work within a system and a complaint is made against the individual practitioner, the Commission has an increasing practice of naming the respondent as the facility within which the practitioner works, particularly where systems issues may significantly impinge upon the individual's performance.

There was no increase in complaints against public hospitals in rural Area Health Services. The increase occurred in non-rural Area Health Services.

Complaints about public hospitals by Area Health Service 1999-2000

Area Health Service	Admissions*	Non-Admitted Patient Services*	Emergency Department Attendance*	Complaints**	
				No	%
South Eastern Sydney AHS	170,862	3,082,364	213,879	61	15.0
South Western Sydney AHS	132,331	2,046,308	132,635	47	11.6
Western Sydney AHS	132,026	1,803,134	71,432	43	10.6
Central Sydney AHS	63,709	789,277	73,313	43	10.6
Northern Sydney AHS	132,353	1,989,058	94,095	37	9.1
Hunter AHS	111,181	1,396,455	132,551	35	8.6
Central Coast AHS	63,709	789,277	73,313	21	5.2
Illawarra AHS	72,975	899,196	87,468	20	4.9
Mid North Coast HS	50,017	613,356	70,190	15	3.7
Wentworth AHS	51,962	648,602	35,167	13	3.2
Northern Rivers AHS	60,976	795,700	109,430	11	2.7
New England AHS	45,785	508,854	63,576	10	2.5
Greater Murray AHS	59,597	710,864	57,613	10	2.5
Southern AHS	33,220	603,161	61,717	9	2.2
Macquarie AHS	28,695	333,891	32,939	8	2.0
Mid Western AHS	43,554	650,164	68,509	6	1.5
Far West AHS	12,173	272,526	27,808	6	1.5
Other#				11	2.7
TOTAL	**1,265,125**	**17,932,187**	**1,405,635**	**406**	**100.0**

** Figures from NSW Health Department's 1998-1999 Annual Report.*
*** complaints received by the Commission about public hospitals in 1999-2000*
 # Complaints about private hospitals treating public patients.

Complaints received about public hospitals by service area 1999-2000

Service Area	No	%	Service Area	No	%
Accident and Emergency	75	18.5	Neurology	5	1.2
Unidentified Services	73	18.0	Radiography	4	1.0
Other*	36	8.9	Surgery - Vascular	4	1.0
Psychiatry	32	7.9	Rehabilitation Medicine	4	1.0
Obstetrics	29	7.1	Non Health Related	4	1.0
Surgery - General	22	5.4	Developmental Disability	4	1.0
General Medicine	19	4.7	Gastroenterology	4	1.0
Gerontology	12	3.0	Cardiology	4	1.0
Surgery - Orthopaedic	10	2.5	Dentistry	3	0.7
Paediatric Medicine	9	2.2	Intensive Care	3	0.7
Administration - General	8	2.0	Anaesthesia	3	0.7
Gynaecology	7	1.7	Surgery - Hands/Upper Limbs	3	0.7
Palliative Care	7	1.7	Surgery Paediatrics	3	0.7
Oncology - Medical	6	1.5	Midwifery	3	0.7
Surgery - Cardiothoracic	5	1.2	**TOTAL**	**406**	**100.0**
Respiratory	5	1.2			

Other: 2 each: Virology; Physiotherapy; Drugs - Administration; Drugs - Prescribing; Drugs - Dispensing; Personal Care; Radiology; Haematology; Psychology; Opthalmology; Surgery-Neuro. 1 each: Surgery - Urology; Prosthetics; Renal Medicine; Infectious Disease; Occupation Health; Nutrition and Dietetics; Podiatry; Public Health; Waiting Lists; Oncology-Radiation; Drugs & Alcohol Services; Dermatology; Surgery-ENT; Pathology.

Complaints received about professions 1997-2000

Profession	1997-1998 No	1997-1998 %	1998-1999 No	1998-1999 %	1999-2000 No	1999-2000 %
Medical Practitioner	989	78.7	1065	78.3	1,122	66.9
Nurse	89	7.1	114	8.4	179	10.7
Dentist	16	1.3	24	1.8	165	9.8
Pharmacist	6	0.5	9	0.7	74	4.4
Psychologist	48	3.8	34	2.5	39	2.3
Chiropractor & Osteopath	10	0.8	11	0.8	22	1.3
Physiotherapist	9	0.7	12	0.9	17	1.0
Dental Technician & Prosthetist	16	1.3	20	1.5	16	1.0
Other*	29	2.3	26	1.9	14	0.8
Podiatrist	5	0.4	6	0.4	11	0.7
Alternative Health Provider	20	1.6	11	0.8	7	0.4
Optometrist	4	0.3	12	0.9	6	0.4
Social Worker	7	0.6	5	0.4	4	0.2
Psychotherapist	0	0.0	7	0.5	1	0.1
Counsellor/Therapist	8	0.6	4	0.3	1	0.1
Total	**1,256**	**100.0**	**1,360**	**100.0**	**1,678**	**100.0**

**Other: No code available, 12; Administrative or Clerical Staff, 2.*

There has been an increase (n= 296) in complaints against nurses, dentists, pharmacists, psychologists, chiropractors and osteopaths, physiotherapists, chiropodist and podiatrists. Most of these complaints (n= 233) represent those complaints referred by the registration boards and not previously captured. As outlined above, they are reported on for the first time this year due to a change in the manner in which the Commission records and reports complaints. The complaints received this year therefore cannot be compared to those received in previous years. The change to recording complaints did not affect the Commission's practice with respect to medical practitioners. The number of complaints received about doctors is directly comparable to previous years.

There has been a decrease in complaints received against dental technicians/prosthetists and optometrists.

During the year the Commission received a small number of complaints concerning the administration of morphine by nurses. Each complaint involved a large number of individual nurses and this may account for some of the increase in the number of complaints against nurses.

In previous years the Commission has reported on the category of complaints received against medical practitioners and nurses. This year the Commission is reporting on the category of complaint received in relation to all registered professions for the first time.

Complaints received about registered professions by category 1999-2000

Category	Medical Practitioners	Nurses	Dentists	Pharmacists	Psychologists	Chiropractors & Osteopaths	Physiotherapists	Dental Technicians & Prosthetists	Podiatrists	Optometrists
Clinical Standards	677	51	129	2	10	11	8	11	10	4
Fraud	19	4	7	0	2	0	2	2	0	0
Other Ethical/Improper Conduct	20	10	6	0	4	0	3	0	0	1
Miscellaneous	8	5	1	0	0	0	0	2	0	1
Complaints Management	1	0	0	0	0	0	0	0	0	0
Provider/Consumer Relationship	62	24	1	0	11	4	2	0	0	0
Patient Rights	40	9	6	1	3	0	1	0	0	0
Prescribing Drugs	57	21	3	67	0	0	0	0	0	0
Quality Of Care	51	20	1	0	0	2	0	0	0	0
Illness Related	2	0	0	0	0	0	0	0	0	0
Business Practices	170	2	11	3	9	3	0	1	1	0
Impairment	7	28	0	0	0	1	1	0	0	0
Character	8	5	0	1	0	1	0	0	0	0
TOTAL	**1,122**	**179**	**165**	**74**	**39**	**22**	**17**	**16**	**11**	**6**
Total number of registered practitioners as at 30.6.2000	**24,401**	**76,188**	**3,975**	**6,951**	**4,896**	**1,357**	**5,495**	**1,019**	**658**	**1,372**

The table below shows the sources of complaints. That is, the person or organisation who made or referred a complaint to the Commission. The significant rise in the number of complaints made or referred by registration authorities reflects the change in the way the Commission has recorded complaints this financial year.

Source of complaints 1997-2000

Source	1997-1998 No	1997-1998 %	1998-1999 No	1998-1999 %	1999-2000 No	1999-2000 %
Consumer/Patient	881	47.1	921	44.9	978	40.3
Registration Board	228	12.2	399	19.4	585	24.1
Family/Friend	410	21.9	354	17.3	449	18.5
Department of Health (State & Commonwealth)	108	5.8	131	6.4	125	5.2
Parliament/Minister	39	2.1	81	3.9	113	4.7
Legal Representative	61	3.3	51	2.5	78	3.2
Other	36	1.9	52	2.5	37*	1.5
Other Government Department	66	3.5	36	1.8	36	1.5
Health Professional	36	1.9	26	1.3	16	0.7
Coroner's Court	5	0.3	1	0	8	0.3
Total	**1,870**	**100.0**	**2,052**	**100.0**	**2,425**	**100.0**

* *Referred by Consumer Organisation, 15; Others, 11; Professional Association, 6; Local Court, 2; Children's Court 2; Referred by Individual, 1.*

The following table reports on the complaints which were open at the end of the financial year. The table shows the files broken down by the Commission's assessment decision.

Complaints open on 30.6.2000

(including complaints received in past financial years)

Assessment	No
Awaiting assessment	43
Declined to deal with	29
Referred to another body or person for investigation	88
Referred for conciliation	18
Commission investigation underway	770
Referred for direct resolution	20
TOTAL	**968**

Assessment of Complaints

The Commission assesses all complaints about health services, unregistered health practitioners and registered health practitioners made under either the Health Care Complaints Act 1993 or the professional registration Acts. One of the Commission's primary functions is to assess all complaints received by the Commission or registration authorities against registered practitioners. The object of this function is to ensure that the assessment of complaints is objective, consistent, fair, free from bias and made by a body independent of the professions. When assessing complaints about registered practitioners, the Commission is required to consult with the relevant registration authority before it makes a decision.

The Commission's Assessment Committee assesses complaints on receipt. Assessment may not occur immediately on receipt where the material provided is voluminous or where further information is required. The assessment committee usually comprises of the Commissioner, the Director of Complaint Resolution and the Director of Investigations and Prosecutions. Other staff attend from time to time.

The purpose of complaint assessment is to decide how a complaint will be handled. The Commission may decide to handle a complaint by: referring it for conciliation; investigating it; referring it to another agency/organisation for investigation or by deciding not to deal with the complaint. The Commission may refer the complaint to the Patient Support Office for it to facilitate a resolution between the parties.

During 1999-2000, the Commission received 2,425 written complaints, 373 more complaints than the previous year. This amounts to an 18% increase in the number of complaints dealt with by the Commission following the 10% rise reported in 1998-99 Annual Report. As outlined above, the Commission has changed the way it records complaints therefore assessment outcomes are not directly comparable to those of previous years.

The table below shows how the Commission assessed complaints received in the year, taking into account any changes to the decision after review or reassessment.

Outcome of assessment of all complaints 1997-2000

Assessment of complaints	1997-1998 No	1997-1998 %	1998-1999 No	1998-1999 %	1999-2000 No	1999-2000 %
Refer to another body or person	584	31.8	584	29.4	1,052	43.4
Decline	290	15.8	413	20.8	469	19.3
Investigation	419	22.8	459	23.1	384	15.8
Direct resolution between parties	278	15.2	385	19.4	379	15.6
Conciliation consented to or awaiting consent	264	14.4	146*	7.3	98#	4.0
Awaiting assessment as at 30 June of the financial year			65	3.3	43	1.8
Total	**1,835**	**100.0**	**2,052**	**100.0**	**2,425**	**100.0**

**As at 30.6.1999, 100 of these complaints were awaiting consents.*
 # As at 30.6.2000, 31 of these complaints were awaiting consents.

Assessment Decisions

Decline to Deal with a Complaint

The Commission may discontinue dealing with a complaint. The reasons include:

- the subject matter is under investigation by another body;
- it is subject to legal proceedings;
- there is, or was a satisfactory alternative means of dealing with the matter by the complainant;
- the events complained of are more than five years old; or
- the subject matter does not require investigation or conciliation.

During 1999-2000, the Commission declined to deal with 469 complaints. The proportion of complaints declined this year is nearly 3% lower than last year. Many complaints which were declined were also referred to the Patient Support Office to assist the parties as appropriate.

Category of complaints assessed and declined 1999-2000

Category	No	%
Clinical Standards	238	50.7
Business Practices	90	19.2
Quality Of Care	48	10.2
Patient Rights	22	4.7
Other Ethical/Improper Conduct	20	4.3
Provider/Consumer Relationship	14	3.0
Miscellaneous	11	2.3
Fraud	7	1.5
Prescribing Drugs	5	1.1
Character	5	1.1
Complaints Management	4	0.9
Impairment	2	0.4
Waiting List	2	0.4
Resources	1	0.2
TOTAL	**469**	**100.0**

Case study - Public health and swimming pool change rooms

Mr and Ms W had been taking their children to the local public swimming pool for swimming instruction over a period of a few months. During this period they found that the standards of cleanliness in the change room (including the showers and toilets) had deteriorated and posed a health issue. Mr and Ms W wrote a letter of complaint to the Commission outlining their concerns.

The complaint was assessed by the Assessment Committee as one that fell outside of the Health Care Complaints Act 1993. While the Commission decided to decline to deal with the complaint, it did recommend that Mr and Ms W write to their local council and raise the issue with them. Mr and Ms W were notified of the assessment decision.

Case Study - Incorrect treatment by general practitioner

Ms N complained about the treatment of her three year old daughter A by Dr F. Ms N took her three year old daughter, A, to the doctor with symptoms of severe diarrhoea, vomiting and fever. After examining A, the doctor prescribed medication for cold and flu symptoms.

Later that afternoon Ms N took A back to the same medical centre as she was unhappy with the medication prescribed. On this occasion she saw another doctor who provided a medication for symptoms of diarrhoea and vomiting. Ms N asked the doctor what Dr F had written on A's medical file. The doctor stated that Dr F's notes stated cold and flu symptoms and that diarrhoea had been written but it had been crossed out.

Ms N complained that Dr F had incorrectly diagnosed the symptoms and that the treatment was incorrect. The Commission decided to discontinue the complaint as the treatment provided by Dr F was a "wait and see" approach which, in the circumstances was acceptable medical treatment. Ms N was provided with the name of a Patient Support Officer if she required any further assistance.

Refer to Another Person or Body for Investigation Including the Director-General of Health

Under section 26 of the Health Care Complaints Act 1993, the Commission may refer a complaint to another person or body for investigation if it appears the complaint raises issues which require investigation by the other person or body. During 1999-2000, 1,052 complaints were assessed for referral to another body for investigation including the Director-General of Health. These bodies include Area Health Services or the managing body of a private health facility. In 184 cases, the Commission requested a report regarding the conduct and outcome of the investigation. Of the 165 reports received and reviewed during 1999-2000, the Commission determined to investigate three complaints due to the seriousness of the issues arising from the other body's investigation.

Following assessment the Commission must notify the Director-General of Health if it appears to the Commission that a complaint involves a possible breach of Acts administered by the Department of Health. These breaches usually relate to pharmaceutical services, private health care services, or public health matters. The Director-General is required to notify the Commission if he proposes to deal with the complaint and if so, the outcome of the complaint. During 1999-2000, 49 complaints were referred to the Director-General of Health.

Complaints referred for action to another body or person by category 1999-2000

Category	No	%
Clinical Standards	536	51.0
Quality of Care	187	17.8
Prescribing Drugs	104	9.9
Business Practices	78	7.4
Patient Rights	38	3.6
Fraud	35	3.3
Provider/Consumer Relationship	25	2.4
Impairment	19	1.8
Other Ethical/Improper Conduct	14	1.3
Miscellaneous	7	0.7
Waiting List	5	0.5
Character	3	0.3
Illness Related	1	0.1
TOTAL	**1,052**	**100.0**

Assessed for referral to another body or person for action 1999-2000 and finalised by Commission

Body referred to	No	%
Registration Board	485	50.3
AHS/District	336	34.9
Director General	64	6.6
other Body	35	3.6
Other Government Department	15	1.6
Private Health Facility	10	1.0
Other Commonwealth Govt Body	7	0.7
Terminated on Complainant Request	4	0.4
Department of Health	3	0.3
Health Insurance Commission	3	0.3
Direct Resolution	1	0.1
PHICC*	1	0.1
TOTAL	**964**	**100.0**

** Private Health Insurance Complaints Commission*

Reports requested for complaints referred to another body or person for action 1999-2000

Body report requested from	No	%
AHS/District	81	44.0
Registration Board	70	38.0
Director General	19	10.3
Other Body	8	4.3
Other Government Department	3	1.6
Private Health Facility	1	0.5
Department of Health	1	0.5
Other Commonwealth Govt Body	1	0.5
TOTAL	**184**	**100.0**

Commission action on receipt of investigation reports by another body 1999-2000

Action	No	%
No Further Action	162	98.2
Reopen for investigation	3	1.8
TOTAL	**165**	**100.0**

Case study - Foetal hyperthermia and the still birth of a baby

The Commission received a complaint from a couple in relation to the care and treatment they had received at a birthing centre in a major public hospital. The woman's ante-natal care had commenced at 12 weeks gestation with the birthing centre. As the pregnancy was low-risk, the mother had been accepted into the birthing centre. At the end of her term, the mother was admitted to the birthing centre at 8.00pm having commenced spontaneous labour at 7.00am. The labour progressed well. At 2.30am the midwife's first internal examination determined the cervix had dilated to 9.5cms. The foetal heartbeat at this point was strong and regular, as it had been throughout. The mother requested to enter the birthing pool at this time.

As the midwife filled the pool to the required water level, the mother checked the water and told the midwife it was too hot. More cold water was added three times. When the mother had the urge to push at 4.00am the midwife conducted another internal examination. The amniotic sac burst and meconium was evident in the amniotic fluid. The midwife attempted to find a foetal heartbeat without success.

The Mother was admitted to the maternity ward where another midwife unsuccessfully tried internally and externally to locate a foetal heart beat. An obstetrician arrived and attempted a ventouse delivery which was unsuccessful as the mother was not anaesthetised. The mother urged staff to perform an emergency caesarian section. The baby was still-born at 5.08am.

The mother was concerned that foetal hyperthermia serves to increase the risk of oxygen deprivation and foetal distress. The parents were aware of several recorded cases of infant death caused by foetal hyperthermia and that birthing centres usually have stringent policies which include temperature regulation and monitoring to support water birth practice. The parents were concerned that these policies were non existent at the birthing centre.

The Commission received the complaint and its assessment decision was that there were issues which warranted investigation by the Area Health Service. The Commission wrote to the Area Health Service directing its attention to a number of issues. The Area Health Service investigated the complaint by obtaining written statements from the nursing and medical clinicians involved.

As a result of this complaint the birthing centre has put in place a policy to measure and record the water temperature in the record of labour when a woman enters the birth pool. The birth centre is also developing a policy in relation to the care of women using the pool in the second stage of labour. While the Commission still has the complaint under review, the changes already made by the hospital in response to the complaint will ensure that if hyperthermia did contribute to foetal distress on this occasion, steps have been taken to prevent a reoccurrence.

Refer for Conciliation

Conciliation is a process in which a trained conciliator facilitates the resolution of disputes. Once the Commission decides a complaint should be handled through conciliation, the Commission must refer the complaint to the Health Conciliation Registry (HCR), which is a separate body established under the Health Care Complaints Act 1993. Before referring the complaint to the Registry, the Commission must obtain the consent of the parties to do so. Participation in the conciliation process is voluntary.

A complaint may be suitable for conciliation where there has been a breakdown in communication between the parties; where insufficient information was provided; where inadequate explanation was given for an adverse outcome; or where there was an inadequate service.

During 1999-2000, 240 complaints were initially assessed for conciliation. This number is higher than the previous year's initial count of 209 and represents a significant 15% increase in initial assessments for conciliation for the year. The number and type of complaints initially assessed for conciliation appears in the Table below.

Complaint initially assessed as suitable for conciliation during 1999-2000

Category	No	%
Clinical Standards	177	73.8
Quality Of Care	27	11.3
Patient Rights	13	5.4
Business Practices	11	4.6
Prescribing Drugs	5	2.1
Other Ethical/Improper Conduct	2	0.8
Fraud	2	0.8
Provider/Consumer Relationship	2	0.8
Miscellaneous	1	0.4
TOTAL	**240**	**100.0**

The Health Care Complaints Act Review Committee in its final report recommended the development of a conciliation assessment protocol. During the year the Commission developed a protocol which reflected its current practice and requested a senior academic from the University of Sydney to provide comment. The protocol was endorsed. The Commission is yet to forward the protocol to key stakeholders for comment.

Of the 240 complaints assessed for conciliation in the financial year, the Commission referred 67 to the Health Conciliation Registry, more than in the previous year. The Commission held 31 files awaiting consent at the end of the financial year.

During the year, the Commission was unable to obtain the requisite consent in 142 complaints. This represents a conciliation refusal rate of nearly 70%, notably higher than for last year. The Commission process for obtaining consents and the staff handling the process remain unchanged. The increase in parties refusing consent may relate to the Commission's efforts to assess as many complaints as possible for conciliation. It is likely the Commission captured complaints which were previously assessed as not suitable for conciliation.

Complainants refuse to consent to conciliation for a number of reasons. Some have very strong views that their complaints raise serious issues which should be investigated or that the health practitioner will not tell the truth and an investigation by an independent body is the only means by which the facts can be established. The referral of the complaint to another body for conciliation is a significant disincentive for complainants who have complained to the Commission and expect Commission involvement in the resolution of their complaint.

Health providers refuse consent for conciliation because the issues raised have been or are subject to legal proceedings. They also refuse because of the time required and they will not get paid for attendance, or because they place no importance on obtaining consumer feedback about their service or resolving issues. The reasons for refusing consent remain constant for both parties from year to year.

Complaints where parties failed to consent were re-assessed by the Commission. The following table sets out the outcomes of re-assessment for complaints initially assessed for conciliation but not proceeding to conciliation.

Reassessment of complaints not proceeding to conciliation 1999-2000

Reassessment decision	No	%
Refer for direct resolution	61	43.0
Discontinue dealing with	44	31.0
Refer to another body or person for investigation	33	23.2
Refer for investigation	4	2.8
TOTAL	**142**	**100.0**

While the Health Conciliation Registry is independent of the Commission, the Health Care Complaints Act 1993 requires the Commission to report in its Annual Report on the results of conciliations completed during the year. The report on conciliation outcomes provided to the Commission by the Health Conciliation Registry specifies whether or not an agreement was reached, if the parties withdrew from the conciliation process and whether or not there are any public health and safety issues which may require investigation by the Commission.

Last year the Commission reported it had received 46 reports from the Health Conciliation Registry on complaints that had been received and referred in the financial year. This year the Commission received 55 reports on complaints received and referred to the Health Conciliation Registry in the financial year.

This year the Commission has changed the way it reports on conciliation outcomes. The Health Conciliation Registry provided the Commission with 82 reports during 1999-2000 and the results are shown in the table below. This includes reports received on complaints received and/or referred in the previous financial year.

Outcome of complaints closed by HCR in 1999-2000

Outcome	No.	%
Terminated: Agreement reached	63	76.8
Terminated: No Agreement reached	15	18.3
Referred Back: Conciliation cancelled	3	3.7
Referred Back: Conciliator recommended Investigation	1	1.2
TOTAL	**82**	**100.0**

The Health Conciliation Registry conciliation outcome reports indicate that 77% of conciliations conducted in 1999-2000 resulted in agreement being reached compared with 90% last year.

In 1999-2000, the Commission introduced its Complaint Process brochure which sets out in detail how the Commission makes assessment decisions. The Commission also started sending a detailed brochure on the conciliation process to both parties to the complaint once it has been assessed for conciliation. The Commission also began using a complaint form which requests complainants to identify what they would like as an outcome to their complaint. This has made those complaints where the complainant is seeking a conciliation meeting readily identifiable.

During the year the Commission made submissions to the Parliamentary Committee on the Health Care Complaints Commission during its public inquiry into conciliation processes. The Commission also made numerous submissions about the drafting of proposed amendments to the Health Care Complaints Act 1993 which are in response to the Final Report of the Health Care Complaints Act Review Committee. That Committee made several recommendations about the conciliation function including that the Health Conciliation Registry take on the administrative responsibility of obtaining consents and that attendance by respondents be made mandatory. More details on the Parliamentary Committee's public inquiry into conciliation processes are available on page 71 of this report.

Case study - Cataract surgery

Mr J complained to the Commission about the lack of care the hospital provided and his cataract surgery. Mr J had unsuccessfully attempted to speak to the head of ophthalmic surgery as he believed there was some confusion by nursing staff in the operating theatre when he was there about the adequacy of note keeping on his medical file and about his eye surgery.

The Assessment Committee examined Mr J's complaint and identified that Mr J had tried to discuss the issue with the doctor in charge of the ophthalmic ward. Because of the nature of the complaint and because Mr J had been prepared to try and resolve the issues locally, the Commission decided to provide the parties with an opportunity to meet and discuss the issues in formal conciliation. The complaint was forwarded to the hospital and the opthalmic surgeon requesting them to participate in conciliation.

The complaint by Mr J against the opthalmic surgeon was also forwarded to a Patient Support Officer for assistance in preparation for conciliation.

The opthalmic surgeon was unable to participate in the conciliation process as he was away for an extended period. The hospital and Mr J consented to participating in the conciliation process. Detail of the complaint and copies of the consents to participate in conciliation were forwarded to the Health Conciliation Registry.

The conciliation process was terminated after the hospital and Mr J reached an agreement before the arranged meeting for conciliation.

Case Study - Inadequate treatment by a general practitioner and poor hospital record keeping

Mrs J complained that their GP, Dr T, failed to diagnose her husband's illness and that the hospital kept poor medical records of her husband's treatment.

Mrs J's husband had been receiving treatment for chest pain diagnosed as a cyst. Dr T decided that he would remove the cyst and booked Mr J into the local hospital. Mr and Mrs J asked Dr T if x-rays or an ultrasound were required. Dr T told them the treatment was routine and that the tests were unnecessary in the circumstances.

During surgery complications arose. Mr J was transferred to another hospital for more complicated surgery. Mr J recovered from the surgery and went home. Since the surgery he has not regained his former sense of well-being. He continued to see Dr T who treated him for high blood pressure and removal of skin cancers. One morning Mr J was not feeling well and went to see Dr T who arranged for an ambulance to take Mr J to hospital. Mrs J was contacted by Dr T's surgery and advised her husband had been taken to hospital. Mrs J went to the hospital and saw her husband who died later that afternoon.

The Commission decided the complaint could be dealt with by way of conciliation. After the Commission obtained the consent of the parties to attend a conciliation conference, it referred the complaint to the Health Conciliation Registry. The Registry advised the Commission that the conciliation process was terminated when Mrs J, the hospital and Dr T reached agreement.

Refer for Direct Resolution

Section 3 of the Health Care Complaints Act 1993 sets out an objective for the Commission to provide clear mechanisms to resolve complaints. Complaints received by the Commission invariably contain issues important for the parties involved. Many complaints however, if investigated by the Commission, would not necessarily improve health standards in a sustained way. These complaints typically include complaints about access to medical records, rude or insensitive communication and unresponsive staff. The complaints can also be about poor clinical management and other issues. Each of these are improper and unacceptable and the organisation or individual providing that substandard service needs to learn from it.

One positive way of dealing with a complaint that does not warrant investigation by the Commission itself or conciliation through the Health Conciliation Registry, is by direct or assisted resolution. The Commission therefore assists in the resolution of issues where otherwise no service would be provided.

These matters usually do not require the formal structured approach of conciliation. They include matters where it would be unreasonable to expect either the complainant or the respondent to set aside half a day or more and attend the premises of the Registry for a conciliation conference. Complaints of this nature are referred to the Commission's Patient Support Office.

In complaints assessed for direct resolution the Commission writes to both parties and attempts to encourage the parties to resolve the issues directly between themselves. In complaints assessed for assisted resolution, the Commission arranges for a Patient Support Officer to contact both parties to assist them in resolving the issues. The Commission's involvement in these complaints provides an important avenue for educating consumers about their health rights and health practitioners about the importance of consumer participation in the provision of services and decision making. The Commission thereby moulds resolution techniques for both parties with the aim of equipping them to deal with similar situations or to prevent further complaints.

Category of complaints assessed for direct resolution 1999-2000

Category	No	%
Clinical Standards	235	62.0
Quality of Care	46	12.1
Business Practices	45	11.9
Patient Rights	23	6.1
Prescribing Drugs	13	3.4
Provider-Patient/ Client Relationship	5	1.3
Miscellaneous	4	1.1
Fraud	3	0.8
Other Ethical/ Improper conduct	2	0.5
Character	1	0.3
Waiting List	1	0.3
Illness Related	1	0.3
TOTAL	**379**	**100.0**

Case study - Diagnosis and treatment not reflective of mother's concerns

Mrs D wrote to the Commission complaining of the treatment of her ten year old son J who had a severe cough, night sweats, and was vomiting. On his third day of illness Mrs D took him to a general practitioner. Mrs D stated that the doctor examined her son, diagnosed a virus and advised her to "keep up the fluids" because of possible dehydration. The following afternoon J had not improved so Mrs D returned to the doctor with her son. On this occasion they were seen by another doctor in the practice. The second doctor did another examination and advised Mrs D that J had a virus and to keep up the fluids.

cont...

The following evening Mrs D became increasingly concerned as J was not improving. She telephoned an on-call doctor and they discussed J's illness and medication. The on-call doctor advised another cough suppressant and that if there was no improvement to seek further medical advice.

A week after Mrs D had initially taken J to the doctor she decided to take him again as she felt that his illness was not improving. This time she made an appointment with the third doctor. The doctor examined J and diagnosed an ear infection, sinusitis, possible pneumonia and asthma. The doctor referred J for a chest x-ray. The x-ray confirmed pneumonia.

J's medication was changed and he recovered from the pneumonia however his hearing is now damaged.

The Assessment Committee in consultation with the Medical Board determined that the complaint could be appropriately resolved between the parties with the assistance of a Patient Support Officer.

Refer a Complaint for Investigation

In 1999-2000, the Commission assessed 384 complaints as suitable for investigation by the Commission. This is 75 complaints fewer than the previous financial year. The following table shows a breakdown of the type of complaint assessed for investigation.

Category of complaints assessed for investigation 1999-2000

Category	No	%
Clinical Standards	165	43.0
Provider/Consumer Relationship	75	19.5
Prescribing Drugs	46	12.0
Quality Of Care	37	9.6
Impairment	17	4.4
Other Ethical/Improper Conduct	15	3.9
Business Practices	10	2.6
Patient Rights	7	1.8
Fraud	6	1.6
Character	4	1.0
Illness Related	2	0.5
TOTAL	**384**	**100.0**

A more detailed report on investigations and their outcomes is provided under the heading *Investigations and Prosecutions*.

Review of Assessment Decisions

Section 28(6) of the Health Care Complaints Act 1993 entitles complainants to a review of the Commission's assessment decision. All complainants are informed of their right to a review when they are notified of the decision. The great majority of requests for a review result from a belief by the complainant that the Commission should investigate their complaint.

In 1999-2000, the Commission reviewed 128 assessment decisions and the outcomes of these reviews are provided in the table below.

Outcomes of reviews 1999-2000

Assessment review result	No	%
Assessment decision confirmed	99	77.3
Refer to another body	14	10.9
Direct resolution	7	5.5
Reopen for investigation	6	4.7
Conciliation	2	1.6
TOTAL	**128**	**100.0**

Independent Complaints Review Committee

The Independent Complaint Review Committee (ICRC) was established by the Commission to review complaints when a complainant remains dissatisfied with a Commission decision after the statutory review process. Complainants are advised about the ICRC in *The Complaints Process* brochure which is sent to all complainants after a complaint has been lodged. The ICRC reviewed eight complaints after the complainant requested such a review.

The Committee recommended no further action in relation to six complaints and in two complaints, recommended that responses be obtained from the medical practitioners. The Commission decided to refer these complaints to the NSW Medical Board for the Board to obtain a response.

Complainant Profile

Each complainant receives a survey form seeking demographic information which is analysed by the Commission. Information about individuals is provided voluntarily and remains confidential. The information is used to inform the Commission's access strategies.

In 1999-2000, 1994 forms were sent to complainants. Only 89 forms were completed and returned. No one indicated on the forms if they identified as being of Aboriginal and Torres Strait Islander background, or as a person requiring an interpreter. Of all the people who responded to the survey, 24.1% indicated that they had a disability. Following are the results obtained from the survey.

Gender

Gender	%
Female	60.5%
Male	37.3%
Multiple complainants	2.2%

Language spoken at home

Language	%
English	93%
Other than English	7%

Country of birth

Country	%
Australia	76.5
England	3.4
Lebanon	2.3
USA	2.3
Sri Lanka	2.3
New Zealand	1.1
Papua New Guinea	1.1
Vanuatu	1.1
Scotland	1.1
Wales	1.1
Albania	1.1
Austria	1.1
France	1.1
Morocco	1.1
Malaysia	1.1
Vietnam	1.1
China	1.1
Total	**100**

Patient Support Office

The **Patient Support Office** (PSO) assists consumers resolve their concerns with private and public health services at the local level. The PSO aims to:

- promote and protect the rights of health consumers;
- assist in the timely, efficient and effective resolution of health concerns;
- empower people to have a positive and active role in their health care and to resolve concerns in the future;
- facilitate access to appropriate health care; and
- assist consumers and health providers to understand approaches to local resolution of health concerns.

The PSO has seven officers located in Sydney metropolitan area health services at Liverpool, Penrith, Mt Druitt, Zetland, St Leonards, Balmain and the Hunter Region in Newcastle. An additional officer located at the Commission provides a service to rural areas.

Patient Support Officers (PSOs) assist health consumers resolve concerns by facilitating self advocacy or through negotiation and discussion with health service providers. PSOs use a model which empowers people to resolve their own concerns with the assistance of a support person who has a detailed knowledge of the health system, access to information on a variety of services and training in assisting people to clarify their concerns and identify means to resolve them.

Most health consumers respond positively to the PSO. Consumers value help that is independent of the health system, and which encourages them when trying to make a complaint or simply providing constructive feedback to health services. Some PSO clients want the PSO to 'fix the problem' without the client's involvement or think local resolution is a lesser option than an investigation by the Commission. Once an explanation of the service is provided and they experience a positive response to their concerns, the majority of clients are pleased with the service and the outcomes they achieve.

PSOs have had over three years experience in advocating with and on behalf of health consumers. Their experience, flexibility, skills and positive attitude have contributed to the positive outcomes noted in this report.

Why do Health Consumers Contact the PSO

People contact the PSO with a variety of concerns such as delays in diagnosis or treatment, inadequate treatment, inappropriate nursing care, poor facilities, communication issues, medication, access to medical records, inappropriate discharge, billing practices and privacy. Most people want to find out what they can do to improve their current health services or prevent other patients from experiencing the same problems. They are satisfied if their concerns are taken seriously, if relevant information is provided and if appropriate actions are taken to rectify any problems.

Many people comment on the difficulties experienced when making a complaint to health services. They are unsure about whom to contact and about the local process for lodging a complaint. They are also given little assistance by health providers to lodge a complaint. Many consumers have already experienced a negative response to their issues from health services before PSO involvement.

Detainee Patient Support Service

Previously, the Commission identified the NSW Correctional Centres' population as a group that experiences difficulty accessing information on the role of the Commission, lodging complaints or successfully resolving complaints at the local level. In response, PSOs were allocated to three Correctional Centres to promote the service, facilitate attitudes and approaches by health staff that maximise effective local resolution of concerns and to support detainees to resolve concerns and have a positive and active role in their health care.

The outreach service continues in two of the facilities. It was discontinued in the third after an evaluation indicated that there was limited utilisation of the service.

PSOs visit other metropolitan Correctional Centres and provide a service to rural Centres in response to requests by detainees or their advocates.

This program has encountered a number of challenges including difficulties accessing detainees and some health service providers at the local level. The Corrections Health Service has been supportive of the program and its aims.

Complainant Liaison

Each year the Commission receives a number of complaints concerning the violation of professional boundaries. Typically this occurs in complaints against professionals concerning sexual assault and sexual relationships. Many of these complaints are investigated by the Commission as they usually provide grounds for disciplinary action.

Complainants in these cases can have a need for special support during the investigation process. Boundary violations are inherently traumatic not only because of the nature of the act performed but because of the serious breach of trust implicit in a professional relationship. The investigation process is necessarily intrusive and can cause the resurfacing of distress. Many potential complainants do not lodge complaints of any nature because:

- of a perception that a professional, in a relative position of power, will be believed over them;
- of the possible impact of disclosure on themselves and their families;
- of the possible impact of the complaint handling process on themselves and their families;
- of a fear of retribution from the respondent; or
- they have no desire to see the respondent again, even from the witness box.

These factors highlight the need for the special support of these complainants. The complainant may also need information, support or referral to external services because other remedies may be available, counselling or therapy may be required.

During the past year the function of complainant liaison within the Commission was transferred to the PSO. PSOs now provide support during the investigation process to people who have lodged complaints with the Commission about relationship boundary violations by health professionals.

Providing a support service to people who have complained about and experienced sexual and other boundary violations is consistent with PSO service values of patient respect, autonomy and self determination, as well as service accessibility and empowerment of patients. The aim is to provide active support tailored to each complainant's needs. The PSO does not provide a counselling service or any other service usually provided by the Commission's investigation officer.

In practice a PSO meets with the complainant at the beginning of the investigation to offer the support service and is available for the duration of the investigation. If the matter results in a disciplinary hearing the PSO familiarises the complainant with the hearing room and disciplinary procedures. The PSO, if requested, may attend meetings with solicitors or barristers as well as the actual hearing especially during the time when the complainant is scheduled to give evidence. The PSO is also available after the hearing to provide limited support.

PSO Service for Aboriginal Communities

The PSO has begun the process of establishing a service for Aboriginal communities in rural and remote NSW. This was reported on under Strategic Initiatives.

Once the Patient Support Officer has been appointed they will contribute to a review of existing advocacy, networking and information distribution models and evaluate their appropriateness to indigenous rural communities.

The officer will also contribute to the development of a model of health consumer support and pilot it in a selected area. The pilot and evaluation will be in partnership with the Aboriginal Health and Medical Research Council and in collaboration with local communities and Aboriginal Community Controlled Health Services. When an appropriate model of service has been developed the service will be extended to locations in other Areas.

Because the officer will be located outside any particular community, the officer will focus on liaising with, resourcing and supporting key Aboriginal representatives who function both within and outside the health system. Where Aboriginal Liaison Officers operate, the PSO will place special emphasis on developing a positive working relationship to identify and work with key people within Aboriginal communities who are able to assist with local resolution of health concerns.

The PSO will offer information and support to the key representatives of health services and community representatives especially in the areas of patient rights, complaints handling, advocacy and conflict resolution. The PSO will maintain an on-going relationship with community representatives and provide a consultancy service.

The PSO will have direct contact with consumers who have complex complaints and will advocate on their behalf. As well, the PSO will, if desired by the community, provide information sessions to community groups and organisations.

The PSO will also be available to resource health services in the development of improved complaints handling strategies for Aboriginal communities.

Presentations

PSOs conducted 46 presentations during the year, 36 to consumers and 10 to provider groups. Topics at presentations included: the role of the PSO; patient rights and responsibilities; local resolution of concerns; and reducing consumer dissatisfaction with health services.

Most presentations were to small to medium sized groups. PSOs conducted fewer presentations this financial year than last year due to the increase in client numbers and resultant service delivery demands.

Presentations remain a priority for PSO as they provide an opportunity to meet with different community groups and learn about their particular needs or experiences of the health system. They also provide an opportunity to promote the services of the PSO and the Commission.

Relationship with Health Services and Providers

Patient Support Officers do not seek to duplicate services. They refer clients who have concerns about public hospitals to hospital patient representatives, where they exist, and advise the client to recontact if they are unhappy with the outcome. Clients sometimes decline such a referral as they believe a patient representative cannot represent the interests of both the client and hospital.

Once the PSO role is explained, most service providers are comfortable with PSO involvement in the resolution process. Some hospitals invite PSO involvement when they have already attempted resolution or refer clients who have complex issues and who would benefit from independent support. As providers learn about the PSO and experience the resolution process, understanding and confidence increases.

Relationship with Area Health Services

The Commission acknowledges the valuable support of the PSO program by Area Health Services. Areas provide office space and office support and assist with matters where facilities resist local resolution.

During the year the Commission provided a report to all Area Health Services in metropolitan Sydney and the Hunter on the concerns raised by PSO clients, the relationship with the AHS, issues arising from client concerns, display of PSO material and identified problems.

PSO Service Provision

This financial year PSOs provided a service to 3,119 people with concerns about the provision of health services. This represents a 10% increase compared with the previous year. 42% of clients were provided with information to assist them to obtain health or community services, exercise their health rights or find out how to contact consumer support groups or who to talk to about a health issue. The majority of clients (58%) were provided with assisted advocacy services that include arranging and/or attending resolution meetings between the consumer and the health service, assistance with writing a letter, locating health services that address the client's needs and other means of facilitating local resolution.

The provision of information may be a simple matter of looking up a community directory or it may involve research involving other organisations. Assisted advocacy may involve a number of meetings or discussions with the client to clarify issues and desired outcomes and work with both parties to prepare for resolution meetings. Should the client decide to write to a provider or health organisation the PSO may be involved in reviewing the response with the client and assist with any required follow up.

Data collected from the satisfaction survey shows that 18% of clients had one or two contacts with the PSO, 50% had three to five contacts and 21% had more than five contacts. (11% of respondents did not indicate the number of times they contacted the PSO.)

Outcomes

The various outcomes of PSO support are noted in the Table on page 45. Of the 2,232 cases where PSOs were involved during the whole resolution process 69% were resolved, 18% partially resolved, 8% not resolved and 5% unable to be resolved. In 1,110 cases where the client initiated the process with the PSO but later pursued the matter with another body/person it is not possible to identify the outcome. Similarly it is not possible to identify the outcome in 504 cases that were referred to PSOs where contact was not possible or the client

declined involvement. Client feedback via the satisfaction survey indicates a lower rate of resolution than that indicated by the PSO evaluation. The variation may be due to the different sample sizes and other methodological differences.

A relatively small percentage of concerns were not resolved due to a range of reasons including: the refusal of the health provider to engage in local resolution; the client's expectations were unrealistic; disagreement on facts; or options for resolution were not acceptable to the client or provider. Other instances where local resolution was not successful were due to: lost medical records or reports; the age of the event presented difficulties in locating health providers; the client was unwilling to pursue after the resolution process commenced; or information relating to a third party could not be obtained.

Results of Satisfaction Survey

The PSO seeks client feedback during and after provision of service. The information that follows came from satisfaction surveys and letters from PSO clients.

The Commission received 280 completed surveys from a total of 892 surveys that were issued (31.4% response rate). Key results include:

- 94% thought PSOs were sensitive to their concerns.
- 92% found PSOs were prompt in returning their calls.
- 84% were satisfied with the service they received.
- 68% of concerns were partially or totally resolved.
- 88.5% would use the PSO service again.

About 10% of respondents expressed dissatisfaction with the service they received and 10% had problems contacting a patient support officer. Generally they did not like leaving messages on voicemail despite most people noting their calls were promptly returned. Some of the respondents who noted on the questionnaire that they were dissatisfied with the service they received (10% of respondents) indicated that they were dissatisfied with the outcome rather than the service. In some instances the client's desired outcome could not be achieved through advocacy.

The results obtained for this financial year were similar to those for 1998-1999.

Service Improvement Suggestions by Consumers

- Follow up. After the meeting I was never contacted again to establish whether what had been complained about had improved or not.
- Give the PSO more power to deal with doctors.
- There should be PSOs in country areas.
- Advertise the service more. I was never aware of this Department during all the years I have attended hospital. I think the public should be made more aware.
- It would be better to speak personally to a PSO. More home visits.
- PSOs need to return calls more promptly and keep appointments.
- I would prefer to get on to someone straight away and not an answering machine
- The PSO is situated in a hospital. I feel the workplace should be more impartial.

Action Taken as a Result of Client Feedback

- Efforts continue to ensure PSO promotional material is displayed in health service facilities.
- Presentations to continue next financial year despite increased level of client contact.
- Clients are encouraged to re-contact the PSO if they have not resolved their concerns. Follow up of clients judged to need additional assistance has been promoted within the team.
- The proposed service to Aboriginal communities will focus on rural areas.
- Most PSOs have a second telephone line to improve access to voicemail. Concerns with access to PSOs is monitored through feedback from satisfaction surveys.
- Mechanisms are in place to share peak workloads between team members to reduce time taken to return calls.
- PSOs offer face to face interviews in their office with people who request them. They also make home visits if clients are unable to travel because of their age or disability.

Case study - Methadone program, patient rights

The PSO was contacted by the consumer who had a chronic back problem as the result of an accident. The client travelled some distance to the methadone clinic each week day and received two take-away doses for the weekend.

The client was unable to get out of bed one morning as he had extreme back pain. He contacted the methadone clinic to explain the situation and requested home-dosing. The client was told that he needed a medical certificate before he could be 'home-dosed' for two days. The client's doctor attended that afternoon and he was given a medical certificate.

Over the next week the client was visited at home on two occasions and on each of those occasions was given two extra doses for self management. When the client returned to attend the clinic during the second week he was told that his weekend takeaway doses would not be given to him as he had already been given them during the week. The client was very confused about the policy regarding home-dosing and take-away doses and felt that staff attitudes towards him changed after he asked for information about the policies and guidelines for the methadone program. The client requested assistance from the PSO to arrange and attend a meeting with the Nurse Unit Manger (NUM) of the clinic to resolve his concerns.

The PSO made contact with the NUM and discussed the client's concerns. A meeting was organised and attended by the NUM, client and PSO. During the meeting the client was given information about home-dosing and takeaway doses. The NUM apologised to the client for the lack of clear information and said he would discuss the issue at the next staff meeting. The NUM also stated that clients could expect dignified, respectful communications from the staff of the clinic and apologised to the client for the occasions when that had not been the case.

The client was very pleased with the outcome of the meeting. He was satisfied: that he had been heard; that he had been given information about his rights and the availability of services at the clinic; and that it had been acknowledged that clients of the service should be treated respectfully.

Case study - Communication breakdown

A client, who suffers from a rare heart disease, complained to a PSO that his cardiologist told him to "get out" of his surgery and refused to see him again. The doctor had become very annoyed about questions that the patient wanted answered. The client also said that the doctor performed unnecessary tests and had charged him $1,000.

The client was distressed because the heart specialist is one of the few in Australia with knowledge of the rare condition. He feared for his life because the doctor/patient relationship had broken down and he knew of no other doctor who could treat him. The client had not paid the bill for the consultation or the tests.

The client asked the PSO if anything could be done to repair the relationship and to see whether the bill could be reduced so that he could manage it.

The PSO contacted the cardiologist who was reluctant to respond positively to the client's request. He said the client had become offensive when he wanted to terminate the consultation after one and a half hours. The patient had refused to leave. He said the patient kept asking the same questions, had not listened to him and had insulted him. He was annoyed also that the patient had not paid the bill. He said he would not see the patient again.

The PSO spent time discussing the patient's needs and asked if the doctor would consider further contact if the patient apologised. He said he might if the apology was written. During further negotiation he said he was prepared to accept the Medicare rebate for the tests but insisted on his full fee for the long consultation.

cont...

The PSO contacted the client who eventually agreed to apologise and who was satisfied with the fee reduction. The PSO reviewed the written apology and recommended that it be reworded to avoid inflaming the situation.

Strategies were then developed to avoid a repeat of the communication problems at further consultations. The cardiologist had claimed that the patient often repeated the same questions during consultations and did not listen carefully to his responses. The client suggested he would write the questions down and send them to the doctor prior to the consultation.

The cardiologist agreed to this strategy and suggested his own strategy of clear and agreed consultation periods. He accepted the written apology. The client paid the bill in full and sent his list of questions to the doctor when a new consultation was organised.

The cardiologist then contacted the PSO to see if he would come to the consultation to act as a mediator in case of communication difficulties. The PSO clarified that he would attend only if the patient was in agreement. The client was happy with the proposal.

The consultation was very successful. At the beginning the doctor clearly stated how much time was available for the consultation. He then answered all the written questions in order and made sure the client understood each answer before moving to the next question. Both parties agreed that they would use the same strategies in future and were confident of avoiding future problems. They both thanked the PSO for his assistance.

Case study - Child cut during removal of a cast from his arm

A mother contacted the PSO upset that her son had been cut during the removal of a cast on his arm and by the attitude of the doctor over the incident. The doctor had sawed the cast off while telling the 10 year old boy that it would not hurt unless he moved. The child was stoic, but at one stage said "ow, it's hurting." The doctor continued sawing for a few inches before stopping. When the cast came off there was a line along the boy's arm which was bleeding. The mother told the doctor that the skin was broken, but he did not respond except by applying a lotion and a bandage.

The caller was very angry about the incident and questioned the competence of the doctor to remove casts and his insensitivity to the patient's discomfort. After discussing the matter with the PSO, clarifying her concerns and desired outcomes, the caller agreed to phone the doctor to discuss her concerns and request an explanation for what happened.

The mother later phoned the PSO to say that the doctor had acknowledged that he had cut her son's arm. He also provided an explanation saying that the type of plastic padding used with waterproof castes is tough and sticks to the skin and is therefore very difficult to remove. He agreed to apologize directly to her son.

The child listened to the doctor's apology and explanation and then told the doctor he had been hurt when the doctor did not stop, that his arm was still sore and that he did not want it to happen to anyone else.

The caller was still not totally satisfied with this outcome. She wanted reassurance that, in future, the doctor would stop immediately if a patient voiced discomfort; that he would use clean sharp blades and that he would take the matter seriously. The PSO agreed to discuss the issues with the doctor and get back to her.

During that discussion the doctor decided that he would not take off those particular casts in future and that, when taking off regular castes, he would make special efforts to explain the procedure to patients and tell them to indicate if it was hurting. If they did he would stop. The mother was happy with the outcome. She was satisfied the doctor had apologised and that he had taken steps to make sure it did not happen to anyone else.

cont...

The caller noted that her complaint had made a strong impression on the doctor. The PSO reminded the caller that she had been a good self advocate, and that her own phone call had achieved a great deal. The caller also acknowledged the important role of the PSO in helping her see that what she wanted was an explanation rather than to make an accusation and that it had been a good learning experience for her.

Case study - Inadequate dental treatment

A woman contacted the PSO concerned about the treatment she had received from a private dental surgery. On her first visit to the surgery the woman had her teeth cleaned and x-rays taken. She reported her teeth were sensitive and she was in pain. The dentist advised the woman to use toothpaste for sensitive teeth and to return for further cleaning and scaling.

One month later the woman visited the dental surgery and was seen by a different dentist. On examination this dentist found one tooth was badly decayed. The woman questioned this dentist as to how such a large cavity was not picked up when she had the x-rays. The dentist replied he was more experienced. The dentist filled the tooth but when drilling deep into the tooth he hit a nerve. The woman was prescribed panadeine forte for pain relief by her doctor.

The dentist telephoned the woman the following day to inquire how she was. He explained that he might still have to extract the tooth or perform root canal therapy. Three weeks later the woman was still unable to eat properly due to pain in the tooth. She returned to the dentist who commenced root canal therapy.

After discussing her concerns with the PSO the woman wrote a letter to the dental surgery. She wanted an acknowledgment that a mistake had been made and a refund of the fees paid. When she had not received a response a few weeks later the woman asked the PSO to contact the first dentist. The dentist had received the letter, admitted a mistake had been made and said some reimbursement would be appropriate.

The dentist sought advice from the Australian Dental Association and then agreed to refund all monies paid by the woman on the condition the woman signed a deed of release. The woman was satisfied with this outcome and appreciative of PSO support.

Case study - Potential harmful effects of a delay in dental treatment averted

The PSO was contacted by a client who was concerned about the treatment she had received at a public dental clinic. The client's front tooth had broken off near the gum. Two previous attempts to cap the tooth were unsuccessful.

The client had requested the dental service perform a different procedure to address the problem but was advised that the procedure was not available and there would be a two year wait for a partial denture to be provided.

The client was very distressed and self conscious about her appearance. The client informed the PSO that she had a mental illness and requested assistance in addressing her concerns with the dental service. The client asked the PSO to talk with her psychiatrist about the detrimental effect the lack of treatment was having on her mental health and to pass on the psychiatrist's opinion to the dental service.

The client's psychiatrist advised the PSO that a two year delay in treatment would affect the client adversely as it would erode her self confidence and might even make her feel suicidal. The PSO then contacted the Director of the Area Health Service Dental Unit who agreed to discuss other options with staff in the clinic.

cont...

As a result an appointment was promptly arranged with another dentist who had been successful with a different type of cap. The Director agreed to contact the client to discuss the new procedure and confirm the appointment.

The client contacted the PSO the day after her discussion with the Director to express her gratitude. She was extremely pleased that the delay would be avoided and a new procedure performed.

Case study - Inadequate complaints management

The PSO was contacted by the client who had been attempting to resolve a number of concerns with a private hospital. She had attended one meeting with hospital representatives and had not received a written response following the meeting. The written response was to detail the actions the hospital had taken in response to the outstanding issues identified during the meeting.

The client requested assistance from the PSO in preparing an agenda for a second meeting and attending the meeting with her. She wanted to discuss two issues. The first was the actions taken by the hospital after her complaint about a psychologist practising in the hospital, who had on numerous occasions breached patient confidentiality by discussing other patients with her. The second was the poor complaints management by the hospital demonstrated by not following through with agreements made with complainants.

The PSO attended a Resolution Meeting with the client and the Chief Executive Officer (CEO) and deputy CEO of the facility. The CEO outlined a course of action to address the breaches of confidentiality. He had spoken to the psychologist directly and was given an assurance that such breaches would not occur again. The CEO was to monitor future incidents and would terminate employment if a second complaint was lodged and proved. An apology was given by the hospital and the client was encouraged to lodge a formal complaint with the Psychologists Registration Board regarding the practitioner's past behaviour.

The hospital made a commitment to ongoing training of staff in relation to complaints management. The Commission had already provided an investigations training session and the hospital reiterated their commitment to future staff training in complaints management and investigations.

The client was satisfied that her concerns had been satisfactorily addressed.

Feedback

- I found it comforting to know there was someone to discuss how I felt and to suggest another line of action.
- A valuable service which gave me the encouragement (on more than one occasion) to pursue my complaint.
- The PSO provided great support. He was very persistent in obtaining information and documentation that I was unable to get.
- The PSO was always thorough and always available.
- It is helpful know the Patient Support service is available to speak to someone independently.
- I found the PSO to be a compassionate listener with constructive views and information and a very positive person to call on at any time.
- The PSO was always helpful and encouraging and her follow up of the matter concerned saw it resolved. I would have probably given up.
- Very supportive person. Not bureaucratic. Listened well. I will use them again.

PSO Service Details

Consumer Characteristics	No	%
Aged (70+)	498	15.97
Mental Illness*	323	10.36
NESB	320	10.26
Child (0-12)	145	4.65
Physical Disability*	143	4.58
Methadone user*	79	2.53
Youth (12-18)	49	1.57
Aboriginal/Torres Strait Islander	39	1.25
Unemployed	36	1.15
Developmental Disability*	31	0.99
Drug/Alcohol*	28	0.90
None of the above	1,428	45.78
Total	**3,119#**	**100.0**

* *clients identified themselves as being in these categories*

\# *This figure includes clients who have contacted the PSO more than once about different issues.*

Type of Service	No	%
Assisted Advocacy (AA)	1,876	57.88
Information Only (IO)	1,365	42.12
TOTAL	**3,241**	**100.0**

* *this total differs from the total number of clients because some clients raised concerns about more than one health provider*

Knowledge of Service obtained*	No	%
HCCC	1,963	62.94
PSO promotion	513	16.45
Other/not stated	316	10.13
Health provider/facility	114	3.66
Government body	69	2.21
Consumer/community organisations	62	1.99
Directories	62	1.99
Member of Parliament	20	0.64
TOTAL	**3,119**	**100.0**

* *ie where people obtained information on the PSO*

Type of concern raised by PSO clients	No	%
Clinical Standards	1,866	38.29
Quality of Care	854	17.53
Communication	841	17.26
Miscellaneous	438	8.99
Patient Rights	278	5.70
Business Practices	258	5.29
Provider/Consumer Relationship	92	1.89
Complaints Management	78	1.60
Prescribing Drugs	69	1.42
Waiting List	33	0.68
Other Ethical/Improper Conduct	22	0.45
Fraud	14	0.29
Illness Related	13	0.27
Impairment	9	0.18
Resources	8	0.16
Total	**4,873**	**100.0**

PSO service outcomes	No	%
Resolved	1,547	40.22
Client pursued matter with another body/person	1,110	28.86
No contact or patient declined involvement	504	13.10
Incomplete resolution	398	10.35
Not Resolved	170	4.42
Unable to be resolved	117	3.04
Total*	**3,846**	**100.0**

* *This total does not match the total number of concerns as outcome codes are not provided for information only inquiries. In other cases more than one outcome code may be recorded.*

Breakdown of concerns by location and service sector

Location	Public[1]	Private[2]	NGO[3]	Other*	Total
Central Coast	35	41	0	7	83
Central Sydney	167	121	6	22	316
Corrections HS	91	1	0	2	94
Far West	21	5	0	0	26
Greater Murray	25	30	0	1	56
Hunter	142	96	7	29	274
Illawarra	39	40	0	7	86
Interstate/International	2	6	0	1	9
Macquarie	16	9	1	2	28
Mid North Coast	40	33	0	3	76
Mid Western	17	17	0	0	34
New England	29	19	0	4	52
Northern Rivers	28	25	0	0	53
Northern Sydney	150	194	5	36	385
Not known	92	140	4	97	333
South Eastern Sydney	206	237	4	39	486
South Western Sydney	166	158	2	12	338
Southern	34	25	0	4	63
Wentworth	47	41	2	6	96
Western Sydney	174	134	6	39	353
Totals	**1,521**	**1,372**	**37**	**311**	**3,241#**

 # this total differs from the total number of clients because some clients raised concerns about more than one health provider

** The 'other' column includes concerns about system wide issues, access to services that involve all sectors and matters that were not coded.*

1. Public: all public health services including public hospitals, community health centres

2. Private: all private health services

3. NGO: Non Government Organisations' health services

Note that the Private and NGO health services are located within the geographical boundaries of an Area Health Service but not under its control. Some NGO health services may receive funding from an Area Health Service.

Total presentations given

Audience	No	%
Consumers	36	78.3
Providers	10	21.7
Total	**46**	**100.0**

Target groups for presentations

Group Characteristics	No of Talks	No Attending
Aged	12	479
NESB	4	245
General	11	188
Mental Health	11	178
ATSI	3	104
Disability	3	81
Women	2	59
Total	**46**	**1,334**

Strategic Initiatives

Investigations into Adverse Events at Dubbo and Canterbury Hospitals

During the 1999-2000 year the Division conducted major investigations into incidents at Dubbo Base Hospital and Canterbury Hospital, both of which attracted wide public interest. Details of both investigations can be found under the heading "Major Investigations"on page 68.

Both incidents raised very serious issues as to the safety and welfare of people cared for in the NSW public health system and required urgent investigation by the Commission to ensure that the issues were identified and resolved as quickly as possible. The Commission responded to these demands by allocating three officers to each investigation on a full time basis until the major part of the investigation was completed and the report provided to the Minister. After the report was provided, investigations continued into the conduct of individual health practitioners.

Both investigations resulted in important recommendations on a range of systemic issues which were identified as contributing to the adverse health outcomes for a number of people. Some of these issues had implications for the entire public health system in NSW. The investigations have resulted in disciplinary action being taken against several health practitioners. One aspect of the Dubbo complaint is still under investigation.

The strategy used by the Commission in these cases was an effective means of dealing with major investigations. It enabled officers to focus exclusively on the issues arising out of the complaint and address both the individuals' responsibilities and also the wider systemic issues relating to the quality of services provided. It also enabled the investigations to be quickly progressed while events remained fresh in the memories of witnesses.

Peer Reviewers

During the course of the year the Commission conducted three training seminars for its Peer Reviewers. These health practitioners provide professional opinions on the conduct of practitioners who are the subject of complaints under investigation and advise the Commission of acceptable standards of clinical and ethical conduct. The seminars aimed to provide the reviewers with information about their role in investigations and the disciplinary investigations. The seminars also provided an effective forum for training and exchange of information. The Commission will continue to organise these seminars.

The Commission highly values the commitment, expertise and professionalism of these health providers and their contribution to the Commission's work is vital.

Investigation Delays

During the course of the year the Investigations Committee of the Commission continued to review the investigation process to identify areas where improvements could be made. Areas were identified and steps are being taken to change the process to ensure, as far as possible, that there are no avoidable delays in the process. Particular attention was given to the issue of investigation planning to ensure information was obtained simultaneously, rather than consecutively. The form and content of various Commission correspondence was also reviewed. This review will continue next year. The increasing focus on actual investigations will continue.

Investigations

The Commission assessed 2,425 complaints and referred 394 of those for investigation in 1999-2000. The reduction in the number of complaints assessed for investigation is due to the increased use of alternate methods of dealing with complaints, particularly the increasing involvement of the professional boards and the Area Health Services to resolve complaints. As described above, the Commission has been developing the skills of health managers and clinicians in investigations techniques at the frontline. There is a growing confidence that complaints referred from the Commission to health services will be taken seriously, investigated rigorously and resolved appropriately. The availability of the registration boards and Area Health Services to pursue less serious complaints has enabled the Commission to apply a more rigorous test in assessing complaints for investigation, while complying with its statutory obligations. A consequence of this is, however, that a higher overall proportion of complaints that are investigated are likely to result in disciplinary action against individual health practitioners. This is borne out by the figures in the tables below and the figures for disciplinary hearings.

Outcome of all investigations finalised 1998-2000

Outcome of investigation	1998-1999		1999-2000	
	No	%	No	%
Substantiated	155	37.2	246	55.8
Partially Substantiated	38	9.1	26	5.9
Not Substantiated	117	28.1	119	27.0
Referred to Other Body	31	7.4	7	1.6
Investigation Terminated	76	18.2	43	9.7
TOTAL	**417**	**100.0**	**441**	**100.0**

A total of 441 investigations were completed over the year. This is an improvement over last year, when 417 investigations were completed . The number of investigations terminated by the Commission has decreased markedly from last year, (9.7% compared to 18.2%). There has been a major increase in the percentage of substantiated complaints, (55.8% compared to 37.2%), and a smaller percentage of complaints were not substantiated, (27% compared to 28.1%).

Complaints are terminated where, for one reason or another, the investigation stops before the entire investigative process is completed, for example, where a respondent has died. The classification "Not Substantiated" is used where the investigation has been completed but there was not sufficient evidence to substantiate the complaint. It does not mean that the complaint was without foundation. A large number of the complaints which were substantiated resulted in disciplinary action and this explains, to some extent, the increase in the number of disciplinary cases presently being conducted by the Commission.

Investigations finalised about facilities 1998-2000

Facility	1998-1999		1999-2000	
	No	%	No	%
Public Hospital - Inpatients	29	49.2	35	46.7
Public Hospital - Outpatients	5	8.5	10	13.3
Private Hospital	11	18.6	7	9.3
Private Nursing Home	0	0	5	6.7
Men's Health Clinic	2	3.4	4	5.3
Public Psychiatric Hospital	0	0	3	4.0
Medical Centre - Private	4	6.8	3	4.0
Regional Office/Area Health Service	1	1.7	2	2.7
Other	6	10.2	2	2.7
Radiology Practice	0	0	1	1.3
Drug & Alcohol Service	0	0	1	1.3
Public Nursing Home	1	1.7	1	1.3
Alternative Health Service	0	0	1	1.3
TOTAL	**59**	**100.0**	**75**	**100.0**

Outcome of investigations finalised about facilities 1998-2000

Investigation Outcome	1998-1999		1999-2000	
	No	%	No	%
Substantiated	19	32.2	33	44.0
Partially Substantiated	10	16.9	14	18.7
Not Substantiated	24	40.7	23	30.7
Referred to another body to investigate	0	0	4	5.3
Terminated by Commission	6	10.2	1	1.3
TOTAL	**59**	**100.0**	**75**	**100.0**

The percentage of complaints substantiated against facilities has risen by 11.8% over the same figure last year, while the percentages for unsubstantiated complaints has fallen by 10%. The Commission also finalised more complaints about facilities than last year.

Investigations finalised about health practitioners in 1998-2000

Profession	1998-1999		1999-2000	
	No	%	No	%
Medical Practitioner	277	77.4	255	69.7
Nurse	34	9.5	56	15.3
Psychologist	12	3.4	15	4.1
Chiropractor	4	1.1	6	1.6
Unregistered (Counsellor/Therapist)	0	0	6	1.6
Alternative Therapist	5	1.4	5	1.4
Physiotherapist	3	0.8	5	1.4
Chiropodist/Podiatrist	0	0	3	0.8
Other	9	2.5	3	0.8
Dentist	1	0.3	3	0.8
Social Worker	0	0	2	0.5
Optometrist	0	0	2	0.5
Dental Technician and Prosthetist	4	1.1	2	0.5
Pharmacist	3	0.8	2	0.5
Osteopath	3	0.8	1	0.3
Deregistered health practitioner	3	0.8	0	0
TOTAL	**358**	**100.0**	**366**	**100.0**

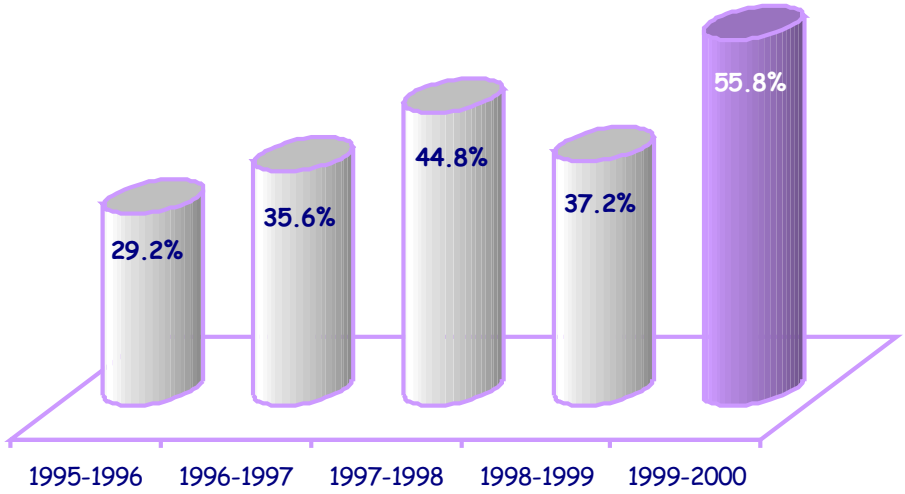
Outcome of investigations finalised about health practitioners 1998-2000

Outcome of Investigation	1998-1999		1999-2000	
	No	%	No	%
Substantiated	136	38.0	213	58.2
Partially Substantiated	28	7.8	12	3.3
Not Substantiated	93	26.0	96	26.2
Terminated by Commission	70	19.5	42	11.5
Referred to Another Body	31	8.7	3	0.8
TOTAL	**358**	**100.0**	**366**	**100.0**

The percentage of complaints substantiated about health providers has increased by 20.2% from last year, which is consistent with the figure in relation to facilities. The number of complaints terminated about health providers by the Commission has fallen by 8%, which is also consistent with complaints against facilities, where the reduction was slightly less than 9%.

When the figures over the last five years for substantiated complaints are compared a generally increasing trend is evident.

Percentage of complaints substantiated 1995-2000



Category of finalised investigations in 1999-2000

Category	No	%	Category	No	%
Clinical Standards	244	55.3	Patient Rights	9	2.0
Provider/Consumer Relationship	66	15.0	Business Practices	7	1.6
Quality Of Care	35	7.9	Character	3	0.7
Prescribing Drugs	26	5.9	Pattern of Practice	2	0.5
Fraud	18	4.0	Miscellaneous	2	0.5
Impairment	17	3.9	Professional Practice	1	0.2
Other Ethical/Improper Conduct	11	2.5	**TOTAL**	**441**	**100.0**

Category of all open investigations on 30.6.2000

Category	No	%	Category	No	%
Clinical Standards	378	48.7	Fraud	17	2.2
Provider/Consumer Relationship	131	16.9	Patient Rights	15	1.9
Prescribing Drugs	85	10.9	Impairment	15	1.9
Quality Of Care	73	9.4	Miscellaneous	7	0.9
Other Ethical/Improper Conduct	29	3.7	Character	5	0.6
Business Practices	19	2.5	Illness Related	2	0.3
			Re-registration	1	0.1
			TOTAL	**777**	**100.0**

Disciplinary Action

The past year has seen an increase in the number of disciplinary matters involving health providers before the various disciplinary bodies provided for under the health registration acts. In 1999-2000, 122 complaints were referred for prosecution. This is an increase of 37 over 1998-1999.

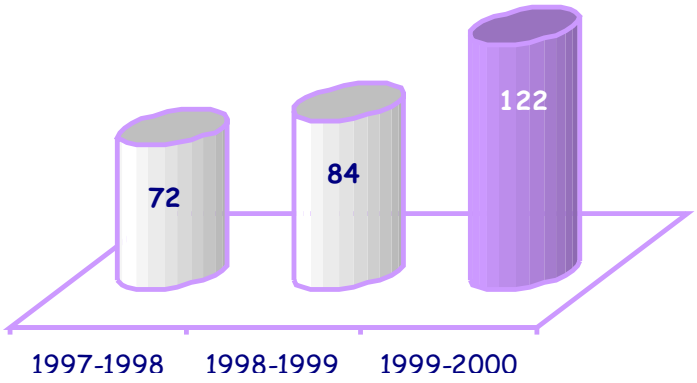
At the end of the financial year, 70 cases had been decided before the various bodies, and a further 15 appeals dealt with. In 1998-1999, 58 cases were decided and 7 appeals dealt with. In addition, as at 30 June 2000, 70 cases were awaiting hearings and a further 28 cases had been heard and were awaiting judgements.

There has been a large increase in the number of disciplinary matters being prepared and conducted by the prosecutions and advisings team at the Commission. In 1998 the figure was 76 and in 1999 the figure was 74, however this year the figure has increased to 122, an increase of 65% over the last year.

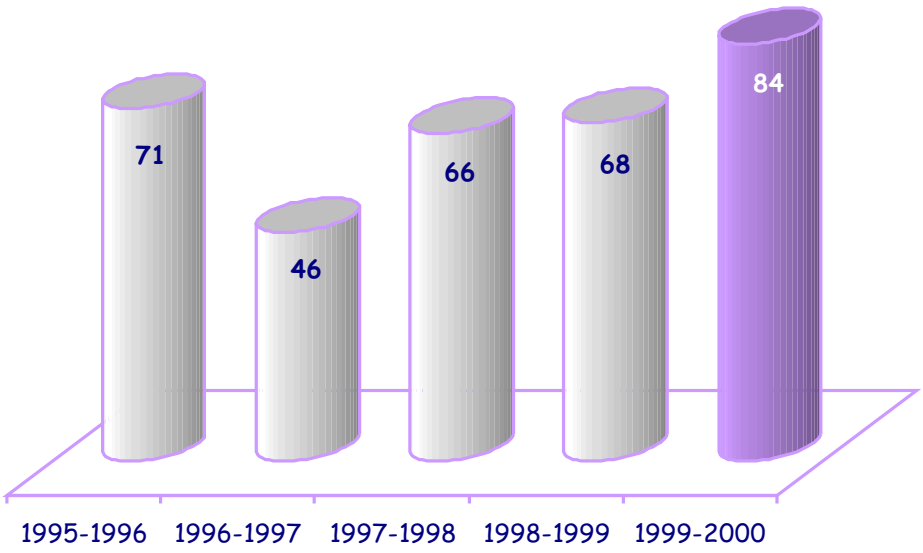
Substantiated investigations referred for disciplinary action in 1998-2000

Disciplinary body referred to	1998-1999		1999-2000	
	No	%	No	%
Medical PSC	29	25.7	46	27.2
Medical Tribunal	36	31.9	39	23.0
Medical Board	27	23.9	35	20.7
Nurses PSC	7	6.2	13	7.7
Nurses Tribunal	2	1.8	12	7.1
Nurses Board	2	1.8	9	5.3
Psychologists Board	0	0	4	2.4
Psychologists PSC	7	6.2	3	1.8
Physiotherapists Board	0	0	3	1.8
Pharmacy Board	0	0	2	1.2
Chiropractors & Osteopaths Tribunal	2	1.8	1	0.6
Podiatrists Board	0	0	1	0.6
Dental Technicians & Prosthetists Board	1	0.9	1	0.6
TOTAL	**113**	**100.0**	**169**	**100.0**

Number of complaints referred for prosecution 1997-2000



Disciplinary cases prosecuted 1995-2000



Current projections, based on a preliminary assessment of complaints currently under investigation, suggest there will be a continuation of the present level of activity over at least the next year.

As a result of the increase in disciplinary cases there was an associated increase in expenditure for legal expenses for the year. The number of disciplinary cases is not expected to decrease in the next year and the Commission estimates its expenditure on prosecutions will remain at a high level.

Outcome of Disciplinary Action Taken 1999-2000

Professional Misconduct

Medical Tribunal

PROVED

De-registered: (Dr Abou-Hatoum; Dr Simmons; Dr Gregory; Dr Dalley; Dr Smithson; name suppressed)	6
Reprimand: (Dr Accardi; Dr Qidwai)	2
Reprimand and fine: (Dr Wolfe)	1
Fine and conditions: (Dr Miliotis)	1
Conditions on registration: (Dr Lindsey)	1

NOT PROVED

Dismissed: (Dr Clarke; Dr Zipser)	2
Terminated by Tribunal: (name suppressed)	1

NO EVIDENCE OFFERED

Dismissed	1

Nurses Tribunal

PROVED

De-registered: (Mr Walker; Ms Feeney; Ms Lecky-Thompson; Mr Cox)	4
Suspended and conditions: (Ms Hung; Ms McLennan)	2

Pharmacy Board

Proved & De-registered	1

Psychologists Professional Standards Committee

Proved & De-registered	1

Physiotherapists Board

PROVED

De-registered	1
Suspended	1

Chiropractors and Osteopaths Tribunal

Not proved & Dismissed	1

TOTAL 26

Unsatisfactory Professional Conduct

Medical Professional Standards Committee

PROVED

Reprimand and conditions	5
Reprimand	1
De-registration recommendation	2
Conditions on registration	3

PARTIALLY PROVED

Reprimand and conditions	11
Reprimand	1
Conditions on registration	3

NOT PROVED

Dismissed	3
Practitioner deceased	1

REFERRED TO MEDICAL TRIBUNAL 2

Nurses Professional Standards Committee

PROVED

Reprimand and conditions	5
Referred to Nurses Tribunal	1

TOTAL 38

Re-registration applications (doctors)

Medical Tribunal

Dismissed (Mr Tsiutis; Mr Amar)	2
Withdrawn (Mr Litchfield; Mr Edelsten)	2

Medical Board

Dismissed	1

TOTAL 5

Appeals	Outcome	No
Medical Tribunal		
Appeal against Medical PSC decision	Dismissed	3
Appeal by HCCC against Medical PSC decision	Upheld	1
High Court		
Special leave application by Doctor against Court of Appeal decision (Dr Gorman)	Dismissed	1
Court of Appeal		
HCCC Appeal against District Court decision (Mr Beck)	Upheld	1
Appeal by psychologist against District Court decision	Upheld	1
Appeal by Doctor against Supreme Court decision (Dr Gorman)	Dismissed	1
Appeal by Doctor against de-registration (Dr Barich)	Dismissed	1
Supreme Court		
Summons to appeal against Nurses Tribunal decision (Ms Lecky Thompson)	Dismissed	1
Appeal concerning access to documents	Upheld	1
District Court		
Appeal by pharmacist against de-registration (Mr Villanyi)	Dismissed	1
Appeal by psychologist against de-registration	Dismissed	1
Appeal by pharmacist against de-registration (Mr Beck)	Dismissed	1
Appeal by psychologist against Psychologists Board decision	Dismissed	1
TOTAL		**15**

Investigation Times

The Health Care Complaints Act requires the Commission to obtain a statutory declaration from the Complainant before commencing an investigation. It also requires the Commission to report on the time intervals involved in the complaints process. In previous annual reports a table has been produced, showing elapsed times based on the date of receipt of the complaint. This table showed the maximum, minimum, medium and average times for completion of investigations. This did not, however provide a full picture of the time taken to complete an investigation, particularly because it was based on the date of receipt of the original complaint. There is often a significant period of time which elapses between the original receipt of the complaint and the receipt of a properly executed statutory declaration. While it was able to show the maximum and minimum times for an investigation the table did not show when investigations were started. A new table has been prepared, which shows the investigation times, based on the date of the Statutory Declaration, which is a more accurate indication of the time taken to complete an investigation. It should be noted that the times shown in the table are not directly comparable to tables shown in previous annual reports.

Length of time taken to complete investigations in 1999-2000

Calculated from receipt of Statutory Declaration

Month	Facility		Health Provider	
	No	%	No	%
<6 months	4	5.9	35	10.4
7-12 months	10	14.7	42	12.5
13-18 months	6	8.8	50	14.8
19-24 months	7	10.3	43	12.8
25-30 months	14	20.6	68	20.2
31-36 months	17	25.0	62	18.4
>37 months	10	14.7	37	11.0
Date of receipt unknown	8	10.5	35	9.4
TOTAL	**76**	**100.0**	**372**	**100.0**

It should also be noted that the same matter may contain complaints about both facilities and individual practitioners.

The oldest complaint in each category is the same complaint, where issues were raised against both the Hospital and attending medical practitioners. There are a number of factors which can cause delays in investigations, apart from resource and staffing issues. These include:

- the addition of further respondents to complaints, when the investigation has already been underway for some time. This has an effect on the time taken to complete the investigation as fresh issues have to be explored and statutory requirements complied with;
- awaiting the return of respondents or delays in obtaining responses and other data; and
- the quality of information received from witnesses and respondents was not adequate and the Commission was obliged to pursue inquiries further.

The Commission has also decided to employ a number of additional investigation officers on 12 month contracts in order to address the backlog of complaints.

Impaired Practitioner Complaints

An impairment is any disability, condition or disorder which detrimentally affects or is likely to detrimentally affect a person's physical or mental capacity to practise. Habitual drunkenness or addiction to a deleterious drug is considered to be an impairment. Complaints concerning impaired practitioners are dealt with by a designated investigation officer.

Practitioners who suffer an impairment are monitored by the relevant registration board if there are impairment provisions in its Act. Referral to an impaired registrant program is an alternative to dealing with the matter in a disciplinary forum such as a professional standards committee or tribunal. The practitioner gives undertakings to the board to comply with monitoring protocols or conditions on practice. Where appropriate, and subject to undertakings and conditions of registration, the relevant board may decide that the practitioner may continue to practise. If the practitioner fails to comply with conditions of their registration, boards may refer the matter as a complaint to the Commission for investigation.

Practitioners who fail to comply with conditions on registration give rise to concerns for public safety.

The Commission seeks to investigate complaints about such failures within three months of assessment. Between 1 July 1999 and 30 June 2000, 43 complaints relating to impairment issues were referred for investigation, 31 were finalised. Twenty six investigations were completed within three months, three within five months and one within nine months.

Investigation outcomes of impairment prosecutions 1999-2000

Registration Board	Other*	Referred to an IRP#	Referred to a PSC	Referred to a Tribunal	Files Open as at 30.6.2000	Total
Medical	1	3	10	3	6	23
Nurses		4	3	6	5	18
Physiotherapists				1		1
Chiropractors & Osteopaths					1	1
Total	**1**	**7**	**13**	**10**	**12**	**43**

* *Whereabouts unknown*

#. *Impaired Registrants Program*

Reviews of Investigation Outcomes

The Health Care Complaints Act provides that complainants may seek a review of the Commission's decision about the action should be taken as a result of an investigation. There is currently no time limit on when a complainant may seek that review, although an amendment to the Act in relation to this issue is currently under consideration. In 1999-2000, eight reviews were conducted, each review monitored by a Team Manager; one resulted in the investigation being re-opened with the rest of the investigations remaining closed.

In addition the Division reviewed the outcome of 165 complaints which have been referred under s26 of the Act to other agencies for investigation. The Division examines the response of the agency in order to ensure that all significant issues in the complaint were addressed appropriately. If the Commission is not satisfied with the manner in which the complaint was dealt with it; requests further information, becomes more directly involved, particularly using Patient Support Officers; and in some cases re-assesses matters for investigation Three matters were re-assessed for investigation as a result of this review process.

Policy Recommendations

The Commission recognises that its role is far wider than the simple identification and prosecution of individuals whose conduct fails to meet an appropriate standard. The Commission has a very real and direct role to play in the improvement of the standard of health care in NSW. One of the most effective means available to the Commission in this role is the identification of instances where current policies and procedures have been shown to be deficient in the course of an investigation. The Commission regularly reviews all current investigations to identify systemic problems and issues with policies and procedures. Wherever a problem is identified the Commission makes recommendations based on the investigation to improve the policy or procedure. During the past financial year the most cogent examples of this process were in the Dubbo and Canterbury investigations where systemic recommendations were made both at the Area Health Service and hospital level and at the statewide level. The detailed recommendations are set out under the heading of "Major Investigations" on page 68. Other instances of policy recommendations can be found in the case studies below.

It should also be acknowledged that in many instances Area Health Services and other bodies involved in investigations have pro-actively

amended their own procedures during the course of Commission investigations, often with the assistance of the relevant Investigation Officer.

The Commission has also been exploring other ways to identify and resolve gaps in health service and health service policies. Recently, experienced Commission officers and senior staff at some facilities under investigation have met to discuss policy deficiencies and ways to improve the level of service delivery prior to the completion of the investigation. To date the results are suggesting this will be an effective initiative.

Case Studies - Investigations

Unaccounted retractor - adverse comments

Mrs A's medical history included having had four caesarean sections in a ten year period. The second and third operations were performed at B Hospital, and the fourth at C Hospital. Two months after her fourth caesarean Mrs A re-presented to C Hospital with severe anal pain. Dr D performed an anal dilation under a general anaesthetic and retrieved a surgical retractor from the rectum. The instrument was fifteen centimetres long by about two centimetres wide, with curved ends, of a type commonly used in NSW hospitals. Engraved initials indicated that it came from the operating theatre of B Hospital. Dr D believed that the retractor had been left inside Mrs A after one of the caesareans. The Area Health Service for Hospital C forwarded an incident report to the NSW Director-General of Health, who referred it to the Commission.

The Commission reviewed Mrs A's medical records, x-rays and ultrasound films and examined relevant policy documents of the NSW Health Department and B Hospital. The Commission also obtained opinions by an expert radiologist and two experts in obstetrics and gynaecology. The report on a pelvic x-ray taken prior to the second caesarean excluded the presence of a retractor at that time. The second and third caesareans had been performed by Dr E. Dr E agreed that he would have used retractors and that these would have been held by his assistant, under his direction. Dr E said that at the end of each procedure he was informed by the scrub sister that the instrument count was correct. The operation reports showed no discrepancies or alterations, suggesting a correct count, but did not state the number of retractors used. Retractors were not required to be specifically counted. Mrs A suffered no unusual symptoms or signs after the third caesarean. Although an ultrasound had been taken, this was of no assistance to the investigation as the expert radiologist said that a retractor would not be shown on an ultrasound. Although an x-ray would have shown it clearly, no x-rays had been taken during the relevant period. Nothing unusual occurred during the fourth caesarean and Mrs A's subsequent recovery was uneventful. However during the procedure the surgeon noted the presence of gross adhesions, or scarring, to the peritoneum. No scarring had been seen by Dr E during the third caesarean two years earlier. If the retractor had been left behind during surgery, it appeared likely to have occurred after the third caesarean. Dr E agreed that he was responsible for the proper conduct of his operations, including the correct count of all instruments. However the Commission could find no conclusive evidence as to how the incident occurred or whether any individual had demonstrated an inadequate standard of practice.

Dr D's view was that the retractor had worked its way gradually through the peritoneum into the rectum however, Dr E and the expert reviewers considered this to be extremely unlikely. Due to the unusual circumstances of the case and the lack of clear evidence the Commission was not able to determine how the surgical retractor came to be lodged inside Mrs A. The Commission therefore made no finding against Dr E or any other individual. The Commission found that B Hospital's procedures for checking and counting surgical items had been inadequate and was not satisfied that the current procedures were sufficient. The Commission finalised the matter by making adverse comments to B Hospital about its procedures. The Commission also made a recommendation to the NSW Department of Health that its policy should be reviewed and revised to include retractors in the list of accountable surgical instruments. The Chief Health Officer subsequently informed the Commission that the Operating Theatre Working Party, an expert committee, would be reconvened to consider the Commission's recommendation.

Failure to check a child's intravenous drip site - adverse comments

Ms P brought her daughter, who was almost two years old, into the Emergency Department of a regional hospital on a Friday evening. The child had a recent history of a 'chesty cold' and had already been seen as an outpatient at that hospital and at another hospital.

The medical officer in the Emergency Department admitted the child for treatment of pneumonia. An intravenous (IV) cannula was inserted in her left upper foot and a bandage applied.

The child was admitted to the ward where she was under the care of the nursing staff and a general practitioner Visiting Medical Officer over the weekend. The bandage on her foot was not removed until the early evening on Sunday. There was an area of necrosis noted on the left heel and ulcers developed later on the left upper foot.

After discharge and outpatient treatment locally the child was eventually admitted to a Sydney children's hospital. She required ongoing treatment and also developed behavioural problems as a result of her experiences.

The medical peer reviewer told the Commission that the skin and subcutaneous tissues of infants is more tender than those of adults. Potentially, pressure necrosis is inevitable if there is enough pressure on an area of tissue for long enough. The reviewer said that damage to the tissues can occur within 8 to 12 hours depending on the degree of pressure. However, this is a recognised risk and is usually avoided by a combination of vigilance and technique.

The nursing peer reviewer was critical of the overall standard of nursing care because:

- the bandage should have been loosened, given initial concerns about its firmness;
- circulatory observations should have been made at regular intervals; and
- the IV site should have been checked regularly and assessment details noted.

The medical peer reviewer was critical of the medical practitioners' care because:

- the child's limb was bandaged tightly, failing to protect the underlying tissue;
- the medical officer in the Emergency Department did not record and highlight the risk in the medical record and the need for the ward staff to attend to the bandaging as a priority procedure; and
- the Visiting Medical Officer did not personally examine the drip site after he had assumed responsibility for the child's care.

The Commission found that this was a matter where mildly sub-standard care of an infant by all health practitioners involved led cumulatively to a very serious outcome. The medical peer reviewer noted that if any of the parties had acted according to well-established protocols, a predictable adverse outcome might well have been avoided or lessened.

As a result of this incident, the hospital had amended its protocol for paediatric IV therapy, including securing the cannula and tubing. The medical peer reviewer concluded that the original protocol had been adequate but was not observed in this child's case. The reviewer considered that the amended protocol was overly cautious and impracticable.

The Commission made adverse comments with respect to all three parties in this matter, that is, the two medical practitioners and the hospital nursing staff.

Poor treatment for obesity by a general practitioner - adverse comments

Mr H complained that Dr C (General Practitioner) inappropriately prescribed Duromine (a drug for the treatment of obesity) to his wife on 5 occasions over the previous 6 months. Mr H stated that his wife had a history of eating disorders, including anorexia and bulimia, and was not overweight. Mr H alleged that Dr C only made a cursory examination of Mrs H, prior to issuing her with prescriptions for the strength of Duromine she requested.

The matter was initially referred to the Pharmaceutical Services Branch (PSB). Following receipt of the PSB report, the Commission assessed the matter as one requiring investigation. Neither Mr nor Mrs H were willing to provide a Statutory Declaration. Because of the seriousness of the allegations, the NSW Medical Board provided a Statutory Declaration to allow the investigation to proceed.

Dr C was not willing initially to provide a report to the Commission as Mrs H had not been provided an authority allowing him to release information. However, as the PSB investigation included an interview of Dr C, prescriptions from the local pharmacies and a copy of Mrs H's medical records, the Commission sought the opinion of an independent General Practitioner reviewer, based on the information already obtained.

The reviewer was moderately critical of a number of aspects of Dr C's management of Mrs H. Dr C subsequently provided a report in which he admitted that he had inadequately treated Mrs H, in that he did not obtain an adequate history, he did not monitor her condition adequately and he did not realise that Duromine could be subject to abuse. Dr C advised the Commission that he had taken remedial action and had improved his management of patients who requested treatment for weight loss.

As Dr C had shown insight into the inadequacies of his previous management and had taken remedial action, the Commission decided, in consultation with the NSW Medical Board, not to take disciplinary action but to make adverse comments to Dr C about the deficiencies of his management of Mrs H. The Commission also recommended that as Dr C appeared to be professionally isolated, he should undertake continuing general practice education to give him the opportunity to discuss the management of common general practice conditions with his peers.

A ruptured ectopic pregnancy - disciplinary counselling

Ms A complained about the ultrasound service she was provided by Dr F (radiologist) on 24 November 1998. Ms A was 6.5 weeks pregnant (via donor insemination) and had been referred by her general practitioner for an urgent abdominal ultrasound. Ms A had trans-abdominal and trans-vaginal ultrasounds performed the results of which were suggestive of a right sided ectopic pregnancy. Ms A said that at some point during the procedure the radiographer inquired as to when she would be consulting her medical practitioner. Ms A said that she indicated that it would be at midday on 25 November 1998. Ms A said that the only discussion which followed that was whether she would take the films with her or whether the Clinic would have them couriered to the specialist and that it was finally decided that she would take them with her. Ms A was given the films in a sealed envelope marked *"To be opened only by the referring doctor"*. She then left the Clinic and proceeded home. At no time was she advised of the seriousness of her condition nor was she advised to report to her doctor immediately. Ms A arrived home and decided to open the envelope and read the ultrasound report. She immediately understood the gravity of her situation and initiated an urgent telephone call to her general practitioner , Dr H, who then contacted Dr F. Dr H then contacted Ms A and advised that she needed to be admitted to hospital immediately. Ms A was admitted to hospital and at 9pm on 24 November 1998 underwent major abdominal surgery for a ruptured ectopic pregnancy. Ms A complained that if her situation was so serious (as demonstrated by the ultrasound findings, Dr H's response to these findings, and her subsequent surgery on that same day) why was :

- she not informed of the seriousness of her condition

cont...

- she was allowed to leave the x-ray clinic when the staff there did not know her next destination.
- Dr H not informed immediately of the ultrasound findings by Dr F and/or staff from the x-ray clinic.

The Commission investigated the failure of Dr F to inform Ms A of a possible ectopic pregnancy following a pelvic ultrasound examination conducted on 24 November 1998. Dr F admitted that neither he nor any staff member from the x-ray clinic:

- informed Ms A of the diagnosis of a possible ectopic pregnancy and the need for her to seek immediate medical attention for a potential life threatening situation.
- ensured that contact was made with Dr H before Ms A left the x-ray clinic.

On his own behalf and on behalf of the x-ray clinic Dr F admitted that Ms A's examination and diagnosis fell into the category of requiring immediate reporting for her to return immediately to her referring doctor with the report for immediate attention. Dr F expressed regret that he *"made the incorrect assumption that she...* (Ms A)... *would return to her doctor at once"*. Dr F was referred to the NSW Medical Board for disciplinary counselling. The objectives of counselling were for Dr F:

- to explore his failure to immediately report on Ms A's ultrasound and ensure that both Ms A and/or her referring doctor were advised of the ultrasound findings before Ms A left the clinic.
- to state the appropriate method of managing a situation in which an ultrasound reveals a possibly life threatening condition.
- to acknowledge that he departed from an adequate standard of care by failing to advise Ms A and/or her referring doctor of the ultrasound findings, before Ms A left the clinic.

Case Studies - Impairments

Impaired nurse

Ms B, a registered nurse, came to the notice of her hospital employers after a patient sought pain relief. The patient's medical record Drug Register indicated Ms B had administered Morphine an hour previously, before going off night-duty. When contacted by phone, Ms B stated she had given the Morphine but failed to have a witness when she gave the injection, which is required.

The next day, Ms B voluntarily met with the Director of Nursing and disclosed that she had not given the patient the Morphine, and had in fact been misappropriating Morphine and Pethidine over a period of several months in order to commit suicide. The night before, after finishing the shift at the Hospital she had inserted an intravenous infusion, rigged-up in her own bathroom, to self-administer the drugs, but had woken up that morning to find the needle had dislodged.

The Nurses Registration Board referred Ms B for a medical assessment. Ms B was diagnosed as suffering from serious depression triggered by the stressors associated with working, night shifts, the care of three children under 5 years old, and supporting her mother.

The Nurses Board obtained undertakings from Ms B that she would continue psychiatric treatment and on that basis permitted her to continue to practise.

Ms B failed to keep her undertaking and the matter was referred to the Commission. During the investigation it was noted that Ms B, had no legal representative and very limited financial resources. She also seemed to receive minimal personal support as her family refused to acknowledge her illness. The Commission assisted Ms B to find appropriate and affordable assistance, and to identify ways to assist her family to understand mental illness. A Professional Standards Committee subsequently considered Ms B's situation and imposed conditions on her registration that she remain in treatment, and to participate in the Board Impaired Registrant Program in order to monitor her situation.

Impaired medical practitioner

As a medical student, Dr Y suffered an episode of depressive illness which was treated with medication. Dr Y returned to his studies and subsequently graduated with distinction. During his internship he became mentally ill and was admitted as an involuntary patient for psychiatric treatment and was discharged on condition he remain under psychiatric care and treatment. Dr Y resumed medical practice with conditions on his registration imposed through the Medical Board impaired registrant program. While he complied with treatment, Dr Y's clinical skills and knowledge were described as excellent. However, Dr Y subsequently failed to comply with treatment and conditions of his registration.

The Medical Board referred the matter to the Commission for investigation. The investigation revealed Dr Y, newly graduated, had misrepresented his qualifications at hospitals, and had worked at one hospital until his behaviour raised concern that he might suffer from an impairment. In addition, reports from other hospitals where Dr Y presented as a patient, indicated that Dr Y was self-administering narcotics, including heroin. The Commission lodged a complaint against Dr Y alleging an incapacity to practise medicine, which was substantiated following a hearing by a Professional Standards Committee. Dr Y was subsequently deregistered.

Case Studies - Professional Standards Committees

Inappropriate medications for child with nausea

Mrs A was on holiday with her family including her 8 year old daughter, Miss B. Mrs A took Miss B to the doctor because she was vomiting and unwell. It was her belief that she was suffering asthma and needed to be placed on a nebuliser. She had already approached a local chemist and ascertained that a nebuliser was available for hire. Dr C diagnosed nausea secondary to an ear infection and prescribed an antibiotic. He gave an injection of largactil, maxolon and atropine to treat the nausea. Miss B suffered diminished consciousness and was admitted to a small local hospital, then transferred to a larger centre with respiratory symptoms.

Mrs A's complaint was put to Dr C, who replied that he had used the combination countless times since it was recommended to him when working in a remote area in his internship year. He said that it was a means of avoiding hospitalisation.

The case was reviewed by a GP who was highly critical of the use of the cocktail. The Commission made a complaint to a Professional Standards Committee that:

- the drugs were not an appropriate choice to treat nausea in children because of the potential for adverse reactions and the difficulty in monitoring the child's subsequent condition;
- inadequate information about the drugs used was provided to Mrs A.

The Committee heard evidence from Mrs A, the GP who reviewed the case for the Commission, and a practitioner who reviewed the case for Dr C. Dr C told the Committee that he had accepted the view of his medical colleagues that he should not use this treatment in future. He was found guilty of unsatisfactory professional conduct and reprimanded.

Haemorrhaging undetected

Mr D, a thirty nine year old father of three, presented at hospital in the early afternoon and was diagnosed as suffering from migraine and possible withdrawal from the drug Physeptone (methadone) which he took for chronic back pain. He was sent home with medication to relieve the pain. He re-presented that evening after collapsing at home, becoming incontinent and still experiencing the headache. The same diagnosis was given by a different doctor. He deteriorated overnight, continued to be incontinent and suffered reduced consciousness. A third doctor, who gave the same diagnosis, commenced alcohol withdrawal observations. Early in the morning his condition worsened and after being seen by a senior medical officer he was diagnosed as having a subarachnoid haemorrhage. He was transferred to another hospital by helicopter but his condition was by then inoperable. He died later that night.

His wife complained to the Commission that her husband had been labelled a drug abuser, was left for five hours without medical attention and was treated by inexperienced doctors, all factors she considered to have contributed to her husband's death.

The investigation considered the adequacy of assessment by the doctors at each presentation and the appropriateness of the diagnosis of physeptone withdrawal. It also addressed the adequacy of hospital policies covering presentation with severe headache, of re-presentation with the same symptoms and of referral to more senior staff prior to discharge when a diagnosis had not been clearly made, and hospital practices concerning the employment of casual locum staff.

There was an Inquest into Mr D's death which found that the lack of a CT scanner was a major factor. The hospital revised its practices concerning the employment of locum staff, the referral of patients for CT scan, patients re-presenting with similar symptoms and improved guidelines concerning inappropriate labelling of patients "as drug addicts". The Commission's concern was with the failure to consider subarachnoid haemorrhage as a diagnosis, the failure to take into account that the patient was on warfarin, the assumption that Mr D was a drug user and the adequacy of assessments.

cont...

The actions of three of the doctors attracted criticism by an expert in emergency medicine. Adverse comments were made against one of the doctors in respect of the diagnosis of physeptone withdrawal but no further action was taken against him as he was a junior doctor at the time of the incident, under supervision.

Two other doctors were referred to Professional Standards Committees. Both were reprimanded and ordered to undertake further training in emergency medicine in respect of their failure to assess the patient, to adequately examine him, to order appropriate treatment and failure to act appropriately when Mr D's condition deteriorated. One was ordered not to work unsupervised in an emergency department. The Committees in both cases remarked on the dismissive nature of the treatment of Mr D and failed to accept the defence that the emergency department was chronically under-resourced, emphasising that patients are entitled to timely and appropriate care.

In respect of the hospital, the Commission took account of the hospital's attempts to revise its policies, but when a similar incident occurred just 9 months later (in which the patient was fortunately saved because his son took him to a private practitioner who arranged a CT scan and urgent transfer to a major teaching hospital), the Commission sought to ensure that the issues arising had been fully addressed, including availability of patient records for a patient re-presenting at hospital given that such patients are at higher risk of serious illness, education of staff about revised emergency department guidelines, standards of documentation, staffing levels, senior emergency specialist cover including support for junior staff and the quality review process.

Copies of the findings were forwarded to the College of Emergency Medicine and to the Director-General for Health.

Arthroscopy performed on wrong knee

Mr X injured his left knee exercising and was referred to Dr Y, an orthopaedic surgeon by his GP. Dr Y obtained consent to perform an examination of the left knee under anaesthetic (EUA) as a day surgery procedure.

Mr X attended for day surgery. Two Registered Nurses confirmed as part of ordinary pre-operative processes that his signature appeared on the consent form for EUA on his left knee. Dr Y talked to him before he entered the operating theatre, but did not confirm which knee was to be operated on.

Mr X was taken into the operating theatre and anaesthetised. The anaesthetic nurse saw a tourniquet draped over his right leg and applied it. She and the wardsman applied a bandage to limit blood flow.

The Enrolled Nurse who set up the theatre had checked the intended side on the theatre list as this affected how the theatre was set up. When she saw that Dr Y was preparing the right leg she told him that she thought the other leg was the intended operative site. The doctor was heard by both the Enrolled Nurse and the scrub nurse to disagree. The right (incorrect) knee was operated on.

The Commission made a complaint to a Professional Standards Committee that Dr. Y failed to make a final check of the operating site and operated without consent. The orthopaedic surgeon who reviewed the case and gave evidence to the Committee was mildly critical of the failure to check the final operative site, but became moderately critical because the nurse had questioned the doctor.

The Committee found that both particulars of the Commission's complaint were conceded and proven. Dr Y was reprimanded and required to submit to the Board a written protocol setting out his future practice to ensure that his error was not repeated.

Case Studies - Tribunals

Dr Clive Wolfe

The Commission referred a complaint of professional misconduct against Dr Wolfe to the Medical Tribunal concerning his prescribing of Rohypnol following an investigation conducted by the Pharmaceutical Services Branch of the Department of Health into Rohypnol prescribing.

The prescribing of Rohypnol by Dr Wolfe particularised by the Commission in the Medical Tribunal proceedings occurred between January 1992 and May 1995 to nine different patients. Whilst Dr Wolfe did not dispute he had prescribed Rohypnol, he denied his conduct amounted to professional misconduct. After hearing detailed evidence concerning each individual patient and expert evidence about the prescription of benzodiazepines to drug dependant patients, the Tribunal found the complaints proved with respect to eight of the nine patients. In its judgment dated 18 November 1999, it noted;

"Dr Wolfe was practising as a general practitioner In the Kings Cross area of Sydney which area is notorious for having a significant number of drug abusers... In the circumstances the Tribunal considers Dr Wolfe should have taken appropriate steps to fully inform himself of the nature and problems of benzodiazepines and especially Rohypnol and the abuse thereof together with the appropriate methods of attempting to manage benzodiazepine dependency before prescribing such drugs. The fact he failed initially to acquire such knowledge but nevertheless proceeded to prescribe supra-therapeutic doses of Rohypnol to persons whom he knew were benzodiazepine dependant in the circumstances (set out in its decision) over a total period of three and a half years reinforces the Tribunal's decision that his actions constituted professional misconduct.'

In deciding what protective orders to impose the Tribunal took into account the fact that Dr Wolfe had of his own volition ceased such conduct when he acquired the appropriate knowledge and before the Pharmaceutical Services Branch began making inquiries into his prescribing. The Tribunal reprimanded Dr Wolfe and ordered him to be fined the sum of $10,000.

Dr George Abou-Hatoum

The complaint against Dr Abou-Hatoum alleged that he had been guilty of professional misconduct in that he had engaged in inappropriate conduct during three separate consultations with three different female patients. The conduct included inappropriate and improper comments and inappropriate touching in the context of physical examinations when the patients were partly clothed. The consultations occurred between July and September 1996.

The three patients made independent complaints to the Commission and were not known to each other. Prior to the Medical Tribunal hearing, criminal charges with respect to two of the patients' complaints had been heard in the District Court and the doctor had been acquitted of all charges. Dr Abou-Hatoum denied any impropriety before the Medical Tribunal.

The Tribunal delivered its judgment on 6 August 1999. It found the complaint proved with respect to each of the three patients. It carefully examined each of the evidence of the patients and the doctor's evidence. There was evidence before the Tribunal that one of the patients had continued to consult the doctor for several months after the improper conduct had occurred. The Tribunal dealt with the issue as follows:

"Patient B appeared to the Tribunal to possess a robust personality. She presented as a worldly wise woman who was not sexually naive. The Tribunal considers that she was reasonably equipped to cope with what had occurred to her. It is obvious that women of differing sensitivities would react to such an occurrence in a variety of ways. Many women would not subject themselves to embarrassment of such reporting such an assault, others would refrain from complaining because of fear of being disbelieved. There would be those who would simply not go through the hassle involving a complaint and simply get on with their lives. These matters have influenced the Tribunal to accept her claim that she was in fact seeking to put the experience behind her."

cont...

Whilst the Tribunal considers the failure to report her experience and to continue to attend upon the practitioner is unusual conduct, it is explicable.

In its written decision the Tribunal referred to the decision of the Court of Appeal in *Zaidi -v- HCCC 44 NSWLR* with respect to similar fact evidence but noted; *"It did not use the evidence and findings as to the other patients when considering the allegations raised by any particular patient. Such was its conviction that each patient had given a reliable account that there was no necessity to adopt this course."*

Having found the complaint proved, the Tribunal ordered the name of Dr George Abou-Hatoum to be removed from the Register and imposed a three-year period during which the doctor may not apply for a review of the Tribunal's decision.

Dr Christos Miliotis

The complaint against Dr Miliotis, a general practitioner with an interest in homeopathic medicine, related to care he had provided to a female patient, patient A, between July 1996 and January 1997. The patient was suffering from obsessive compulsive disorder ("OCD"), a serious and debilitating psychiatric illness. The following aspects of Dr Miliotis' treatment and professional conduct were found to constitute professional misconduct by the Medical Tribunal:

- inappropriately arranging for another female patient of his, Patient B, to contact Patient A to try and persuade Patient A to undergo treatment by the practitioner with intravenous and intra muscular injections of homeopathic substances.
- arranging for Patient A and other patients to take delivery of homeopathic substances from overseas suppliers that he had ordered and paid for, in an effort to avoid compliance with requirements under the Therapeutic Goods Act (Cwth) 1989 relating to the importation of therapeutic substances.
- inappropriately administering homeopathic substances intravenously and intra muscularly to Patient A in circumstances where:
  - there was no scientific basis for reputable medical opinion to support the use of the homeopathic substances to treat OCD; and
  - the substances were not approved under the Therapeutic Goods Act (Cwth) 1989 for intravenous or intra muscular use in Australia.
- Charging Patient A and other patients a fee for homeopathic substances in excess of the cost to him of the substances, contrary to s.28(2) of the Pharmacy Act 1964.
- Providing exposure and response prevention therapy to Patient A in a manner that did not accord with accepted techniques and practices and which caused Patient A unnecessary distress, upset and humiliation.
- Failing to maintain proper professional boundaries with Patient A in that he:
  - hugged her during sessions;
  - discussed her appearance and her sexual life during sessions in an inappropriate manner; and
  - telephoned her at home between sessions.
- inviting Patient A and other patients to pay to attend and donate to fund-raising events held in December 1996, the proceeds of which or part of the proceeds of which, were used by the practitioner to conduct research.

In relation to the arrangements for the importation of homeopathic medications, their use to treat OCD and in a manner that was not approved in Australia and their sale by the practitioner direct to patients, the Tribunal noted:

cont...

"The practitioner undertook a course of conduct in deliberate contravention of the Pharmacy Act. He did so for his own financial gain. His behaviour was systematic and he involved others. He involved himself in gross contravention of laws directed towards regulating the conduct of medical practitioners in the interests of protecting the public. The Tribunal has concluded his behaviour warrants a substantial fine.

In relation to the particulars of complaint relating to inappropriate exposure and response prevention therapy, the Commission presented evidence from a psychiatrist and a general practitioner who specialized in counselling as to the appropriate manner to conduct such therapy. Three particular incidents that occurred during professional consultations were considered to be inappropriate and potentially harmful to the patient. They were:

- an occasion when the practitioner asked the patient to eat out of date yoghurt,
- an occasion when the practitioner took the patient into the men's toilets at his consulting rooms, locked the door behind her and placed her hand on the rim of the toilet,
- an occasion when the practitioner took Patient A to the Botanic Gardens and threw compost or manure in the patient's direction.

The Tribunal noted that the Respondent in his evidence:

" *gave the impression of having some distance to go in recognizing his inexperience and lack of judgement. It is for these reasons that the Tribunal decided to impose conditions on the Respondent's practice of medicine designed to overcome the demonstrated problems and enable the Respondent to practice without placing future patients at risk. In reaching the conclusion as to the appropriate orders, in the public interest, to the practitioner's conduct the Tribunal has borne in mind that he appears to have been well intentioned. However, he had no conception of the damage being done to the patient and gave the impression he has not yet developed a full insight into his impact upon the patient."*

The Tribunal ordered that Dr Miliotis be fined the sum of $25,000 and that at the expiration of one month from the date of the Tribunal's decision, 15 June 2000, the registration of the practitioner under the Medical Practice Act be subjected to the following conditions:

- The Respondent must complete a period of two years full time equivalent working in a supervised position at a public hospital commencing at the level of intern.
- The Respondent must not engage in practice outside the public hospital environment during the period in order 2(a).
- The level of supervision may be varied with approval of the Medical Board from time to time during the period of the order for supervision.

Major Investigations

Adverse Events at Canterbury Hospital

In June 1999, the Commission received a complaint from the Chief Executive Officer (CEO) of an Area Health Service about an incident in the Operating Theatres at Canterbury Hospital. The CEO complained that up to 22 patients may have been injected with an inappropriate caustic solution in place of a standard contrast medium during procedures in the Operating Theatre.

The complainant identified that the incident may have been repeated over at least the preceding three months, therefore the Commission decided it was important to act quickly in the public interest to identify the factors that led to the Operating Theatre incident, describe any systemic problems and make policy recommendations.

An investigation team was immediately formed to visit the hospital concerned and begin the investigation. At the same time, the hospital planned to interview most of the patients who had been injected with the caustic solution and subsequently released a statement about the incident to the media.

The Commission was aware of the importance of identifying factors that led to the incident, as part of its role in monitoring the standards of health care in NSW and reporting to the Minister for Health. It was also important to address the issue in an expeditious way to address the fears of patients facing a similar hospital admission.

The investigation was completed within three months and a report provided to the NSW Minister for Health.

Recommendations

The proposed recommendations for Canterbury hospital were:

- that Canterbury Hospital develop as a matter of priority policies, protocols or guidelines to address the deficiencies in the requisition and supply of goods in the Pharmacy Department and the Operating Theatre;
- that processes be developed to ensure that unusual orders for goods, (such as first time use of a special purpose product, increased use of a product or increased cost) are flagged and followed up by the supply service;
- that Canterbury Hospital review the roles and responsibilities of nursing staff in the Operating Theatre, including the checking of solutions in use in the Operating Theatre, and involve all staff in mandatory in-service education about these responsibilities;
- that Canterbury Hospital develop and implement a review program for surgeon's preference sheets and guidelines for operative procedures;
- that Canterbury Hospital develop a comprehensive annual rotating education program to include appropriate documentation in the operating theatre, roles and responsibilities of the nurse, and practice standards to maintain patient safety;
- that there is a system in place to monitor costs in the operating theatre, to detect at an early stage deviations from expected expenditure, and take appropriate action to identify the problem.

An incident at Dubbo Base Hospital

Within a month of starting the Canterbury investigation, the Commission received a complaint from Macquarie Area Health Service about a high number of adverse outcomes following cataract surgery at Dubbo Base Hospital on 8 February 1999.

Twelve out of 19 patients who underwent surgery on 8 February 1999 experienced significant permanent damage to their corneas and visual impairment. A solution named "Eyestream" was introduced into the surgical procedures during the course of the Surgical List. The box and bottle containing this solution bear warnings to the effect that it is not to be used for intra-ocular surgery. The Commission assessed the matter as one warranting investigation. The Commission also investigated the Hospital's response when notified about those adverse outcomes.

During the investigation a number of staff at Dubbo Base hospital were interviewed and policies and data were reviewed by the Commission. In addition the Commission had the assistance of an experienced opthalmologist to provide guidance in technical matters. As a result of the investigation it was apparent that a number of systemic issues needed to be addressed. A Report was prepared and provided to the Minister in September 1999. It contained a number of recommendations.

Recommendations

Recommendations resulting from the Dubbo investigation were:

1. The Hospital and the Area Health Service conduct a review and develop the current policy and practice for the ordering of surgical stores. The policy should include the following:
   - Documents should show the actual date the materials are required.
   - Order documents should be able to identify the status of the requisition, in particular, whether it is urgent or non-urgent.
   - Order documents should show the actual address to which the stores are delivered.
2. Relationships with suppliers be developed by the Hospital and Area Health Service to ensure that any ambiguity or variation in the Order form is capable of being clarified informally prior to supply.
3. The Hospital and Area Health Service ensure that a full and detailed description of the processes involved in the acquisition of stores is available to those primarily responsible for ordering stores.
4. (a) Clear procedures be set in place to check and record the physical receipt of goods at both Area Supply Service and Hospital, irrespective of when the goods are delivered or where they are to be delivered.
   (b) The above procedure should include a process whereby the nursing staff for the Theatre for which the goods are ordered are advised as early as possible of the receipt and adequacy of the goods supplied.
5. The Hospital develop a written protocol for the proper identification of substances introduced into Theatres. Identification should include the assessment of the suitability of the product for its intended purpose. The protocol should also identify the individual responsibilities of each of the Surgical and Nursing Team members.
6. The Hospital review and develop its Quality Assurance Operating Rooms Skills Test to ensure it fully examines the competence of the person in respect of each of the key processes involved in identifying the suitability of substances for surgical purposes.
7. The Hospital review and develop the Hospital Policy entitled "Handling of Medications" to ensure that it includes the identification and assessment of pharmaceutical items and to ensure that it is clearly applicable to Theatres and all relevant professional groups involved.
8. The Area Health Service conduct an audit of the adherence by the Hospital to Departmental Circular No. 95/37, titled " Guidelines for the handling of medication in NSW Public Hospitals", and take steps to ensure future adherence with the policy.
9. The Hospital Pharmacy policy be reviewed to ensure that the same involvement and consultation provided by pharmacists to the Wards is provided to Theatres.
10. The Hospital and Area Health Service review the appropriateness and effectiveness of the current Critical Incident Policy and identify the means to ensure the policy is widely disseminated and staff understand and act on their obligations under the policy.

Statewide Recommendations

Statewide recommendations made to the Director-General of Health due to the systemic similarities of both investigations:

Establish a multi-disciplinary working party with the following terms of reference:

- Review and develop requisition and supply systems for use by all Area Health Services and facilities to make them consistent, accurate efficient and failsafe.
- Review on a state-wide basis the professional services supplied by Hospital Pharmacy Departments to Theatres. The Review should address the assessment of the suitability of products used in Theatres. State-wide protocols should be developed after the review.
- Develop a written protocol for all health care facilities for the checking of solutions and other pharmaceuticals before use in Theatres. (The working party should include a representative of Australian Confederation of Operating Room Nurses in respect of the last term of reference).
- Review current department publications, including Circulars, Policies and Protocols, relating to documentation of operative procedures to ensure that all significant data is recorded accurately in medical records and that there is an effective ongoing audit process in each facility so that the quality of records is maintained.
- Establish a working party to review the current practices for developing and disseminating Department Circulars, Area and Hospital Policies and Protocols to ensure they are consistent and implemented.

The Commission is currently liaising with the Director-General of Health in respect of the implementation of these recommendations.

Ministerial Inquiry into Cosmetic Surgery

The Cosmetic Surgery Report was launched by the Hon Craig Knowles, Minister for Health in October 1999. Following is a summary of the Inquiry and its findings.

As reported in the 1998-1999 Annual Report, the NSW Minister for Health appointed a Committee of Inquiry into Cosmetic Surgery in October 1998. The Inquiry was prompted by concerns about the way cosmetic surgery procedures are promoted and the quality and safety of those procedures raised by health professionals, the NSW Health Department, the NSW Medical Board, the Health Care Complaints Commission and professional bodies.

The Inquiry was to investigate the concerns and recommend a way forward. Its terms of reference were:

- to identify the extent and type of problems associated with the promotion of cosmetic surgery;
- to identify and review the adequacy and limitations of existing consumer safeguards including those relating to regulatory and professional registration processes;
- to identify the quality and accessibility of sources of current consumer information on cosmetic processes; and
- to make recommendations to the Minister for Health on the need for and options for additional safeguards for consumers.

The Inquiry defined cosmetic surgery as a procedure performed to reshape normal structures of the body, or to adorn the body, with the aim of improving the consumer's appearance and self-esteem. It excluded gender reassignment and the link between silicone breast implants and connective tissue diseases.

The inquiry commissioned two research projects: A *Review of the published literature* and a *Consumer Survey*.

Some of the recommendations the Inquiry made are as follows:

- A Cosmetic Surgery Credentialling Council (CSCC) be established for all registered providers of cosmetic surgery procedures to provide independent and accountable verification of qualifications and training.
- Amend the Private Hospitals and Day Procedure Centres Act and the Day Procedure Centre Regulation to require licensing for facilities where medical procedures are performed using local anaesthetic and sedation.
- The CSCC collect data on the number and type of cosmetic procedures in NSW, and outcomes (morbidity and mortality), and publish it annually
- United Medical Protection should publish annual statistics on the number and types of cosmetic surgery procedures for which notifications and claims are made, and the basis for the claims.
- Medical practitioners performing invasive cosmetic procedures should have adequate surgical training, being that required for Fellows of the Royal Australasian College of Surgeons, or equivalent.
- Prescribe the use of class 3B and class 4 lasers for health related and cosmetic purposes under the *Radiation Control Act* so that users are required to be licenced and prescribe laser equipment used for those purposes so that it must be registered under the Act.
- The National Health and Medical Research Council fund research on the main adverse outcomes of augmentation mammoplasty in Australia, particularly capsular contracture.
- The relevant medical colleges and professional associations, in conjunction with the Cosmetic Surgery Credentialling Council develop guidelines for liposuction addressing qualifications of medical practitioners, limits on drug use, fluid management and patient selections.
- The CSCC provide information to the public about credentialled providers to address consumer uncertainty about the level of skill and qualifications of cosmetic surgery providers. This should include information about the provider's relevant qualifications, training, experience and clinical outcomes.
- Cosmetic surgery providers should give consumers information regarding their qualifications, credentials and training, their experience in performing the procedures; clinical outcomes and number of adverse events.
- Cosmetic surgery providers should use information brochures and visual aids to help consumers understand the nature of the procedures and the risks of complications.
- The Health Care Complaints Commission and

the NSW Department of Fair Trading prepare consumer information guides to assist consumers to identify factual information about cosmetic surgery.

- Providers of cosmetic surgery give undertakings to consumers as to what they will do if there are complications or the consumer is not satisfied.
- The NSW Medical Board inform cosmetic surgery providers of their obligations to give consumers objective information about the risks and benefits of alternative treatment options, including treatment options for complications.
- The Cosmetic Surgery Credentialling Council develop a Code of Ethics on Appropriate Patient Selection.
- The ACCC and HCCC develop a guide on the application of fair trading laws to the promotion of health services.
- Amend the *Medical Practice Act* 1992 to prohibit doctors from entering into financial arrangement with agents who refer patients.
- The NSW Government not grant permits for competitions offering cosmetic surgery procedures and products as prizes, and amend the *Lotteries and Art Unions Act (NSW)* to prohibit competitions offering cosmetic surgery as a prize.

Parliamentary Joint Committee on the Health Care Complaints Commission Inquiries

The Parliamentary Joint Committee on the Health Care Complaints Commission (PJC) has a range of functions set out in section 65 of the Health Care Complaints Act 1993. One of those functions is to report to both Houses of Parliament any change the Joint Committee considers desirable to the functions, structures and procedures of the Commission.

During the year the PJC commenced two inquiries: one into the function of the Commission to investigate the frequency, type and nature of allegations made in legal proceedings of malpractice by health practitioners; the other into conciliation processes.

Inquiry into s80(1) (j)

Section 80(1)(j) of the Health Care Complaints Act 1993 sets out one of the functions of the Commission: to investigate the frequency, type and nature of allegations made in legal proceedings of malpractice by health practitioners.

The Commission encountered significant practical barriers to accessing court information including the listing categorisation of matters by the courts and the matching of the names of parties to the registers of health practitioners. Despite considerable reforms to court information management systems and the creation of a professional negligence list in the Supreme Court, the obstacles remain. If section 80(1)(j) was to have any practical effect, legislative amendment was seen to be necessary to facilitate the reporting of appropriate information to the Commission.

The PJC commenced its inquiry. The Commission made a submission to the inquiry during the year. The Committee is yet to report to the Minister for Health in relation to its findings.

Inquiry into Conciliation Processes

In April 2000 the PJC announced an inquiry into conciliation processes within the NSW health system.

The Committee's terms of reference are:

(a) the effectiveness and efficiency of the Health Care Complaints Commission and the Health Conciliation Registry within the current legislative and administrative regime governing conciliation;

(b) the effectiveness and efficiency of conciliation done at the local level by health providers;

(c) the effectiveness of the Patient Support Office in assisting the local conciliation process;

(d) client satisfaction with the current conciliation processes;

(e) conciliation schemes in similar agencies and comparative jurisdictions; and

(f) other related issues.

During the year the Commission met with the Chair of the Committee and made a written submission to the inquiry. The Committee is yet to report to Parliament.

Quality Improvement Initiatives

Special Investigation

Section 59 of the Health Care Complaints Act 1993 permits the Commission to investigate the delivery of health services by a health service provider where concerns may arise out of a complaint or more than one complaint if it:

- raises a significant issue of public health or safety;
- raises significant question as to the appropriate care or treatment of clients; or
- provides grounds for disciplinary action against a health practitioner.

The Commission may not carry out such an investigation unless it has notified the Director-General of its intention; requested the Director-General to provide it with a report on the matter; and the Director-General failed to provide such a report or provided an unsatisfactory report.

Upon reviewing 12 complaints about a health service conducting independent health assessments, the Commission identified a number of issues impacting on the outcomes for consumers of that service.

The pattern of issues raised in the complaints included:

- the inadequate information on the powers and conduct of the health service and related appeals mechanisms, including the purpose of any interview and the reasons for any decision;
- apparent weight being given by the person carrying out the medical assessment to any untested allegations contained in the information provided to the health service by the referring agency. Its potential to have a significant impact on the clinical outcome for the patient, particularly if they were a whistleblower, concerned the Commission;
- inadequate assessment, documentation and use of psychiatric diagnoses; and
- lack of transparency and fairness in the processes used by the health service and its appeal mechanism. This included but was not limited to the lack of a clear framework.

As the NSW Ombudsman had similar concerns and complaints about this service, the Commission and the NSW Ombudsman reached an agreement to avoid duplication of investigations. The Commission was of the view that the number of complaints about similar issues about this health service raised a significant question as to the appropriate care or treatment of people. The issues raised in the complaints included inappropriate care arising out of administrative processes used by the health services. The Ombudsman agreed to terminate any complaint it had received on the basis the Commission would commence action under section 59 of the Act as described above. The Commission notified the Director-General of the Department of Health of its intention to conduct an investigation on 1 September 1999.

The Department of Health engaged a consultant to review the health service in light of the Commission's reference. The Commission received a copy of the consultant's report on 14 April 2000.

The report confirmed the concerns raised by complainants. However the recommendations of the report failed to deal with all of the concerns raised by the Commission and it did not provide a detailed action plan. The Commission will continue to work with the Department of Health and the Area Health Service until it is satisfied that sufficient action has been taken to remedy the concerns raised.

Skin Care Improvement and Pressure Ulcer Prevention Group and the Continuity of Care Project

As reported in the 1998-1999 Annual Report, two working parties were established by the NSW Department of Health following recommendations by the Commission to look at issues related to the care and treatment of elderly patients and the issues related to the continuity of care of patients where more than one health care provider is involved with the one patient. Work is continuing on these two matters and the Commission awaits the findings of the working parties. The findings will be reported on in the 2000-2001 Annual Report.

Rural Community Information Session

In 1998-1999, the Commission started a program to visit major rural towns and centres to promote the role and function of the Commission and to explain the complaint process to the community. The Commission also held special information sessions for workers in the health system, to explain about the Commission's work and the complaint process from the provider's perspective.

In July 1999, the Commission held two information sessions in Broken Hill, one for the community and the other for the health providers. These sessions were organised with the assistance of the Far West Area Health Service. In August, the Commission held similar sessions in Armidale, and one session for the community in Tamworth. The sessions were organised with assistance from the New England Area Health Service.

The session scheduled for health providers in Tamworth was subsequently cancelled. The Commission also held two sessions in Port Macquarie, one for the community and the other for the Division of General Practitioners who were gathered in Port Macquarie for a weekend of seminars and training. The trip to Port Macquarie was requested and organised by the Port Macquarie Division of GPs.

The Commission will continue these visits.

Aboriginal Community Visits

In July 1999, the Commission started a program of visits to Aboriginal communities in rural NSW to promote the role and function of the Commission and to hear from the communities about their concerns with the NSW health system. These visits were organised with the Aboriginal Health and Medical Research Council of NSW and the Aboriginal Medical Services based around the State.

The first visit to the Aboriginal communities started in July 1999 to the far west region. This trip was organised by the Far West Ward Aboriginal Health Service and the Coomealla Health Aboriginal Corporation. The Commission visited communities based in Broken Hill, Willcannia, Menindee, Balranald, Dareton and Ivanhoe. The second trip was in August 1999 where the Commission visited Tamworth and Armidale, Inverell, Walcha, Gunnedah, Guyra and Glen Innes. This trip was organised with the assistance of the Armidale and District Services Inc.

The Commission plans on visiting as many communities around NSW as possible, and will continue this program into the next two financial years. The Commission is preparing a report on its findings and consultations and the first such report is expected to be finalised next financial year and presented to the Minister for Health. The findings of the report will be discussed in the 2000-2001 Annual Report.

Web Page

In April 2000, the Commission launched its first homepage on the web. The NSW Health Department assisted the Commission in developing the web page. The web page provides general information to the public as well as health providers in NSW about making complaints, how the Commission handles complaints, the Patient Support Office, complaint resolution methods and what happens when a complaint is investigated. The homepage also provides an electronic version of many brochures as well as the complaint form.

Future developments of the web page will enable people to lodge their complaints electronically and will include a variety of case studies, employment notices and the option to apply for positions vacant electronically. The Commission plans to have all publications such as the brochures, information sheets, past and future editions of the Health Investigator as well as the Annual Reports available on the web.

The Commission is aware of accessibility issues and will endeavour to make the site easily accessible for people with various disabilities.

Distribution of Brochures

In 1999-2000, the Commission distributed over 90,000 copies of the brochure *Your rights and responsibilities as a health consumer*; 16,000 copies of *The Complaint Process* brochure; and around 30,000 copies of the brochure *Making a Complaint* in 17 community languages. These brochures were distributed to the Area Health Services around NSW, to public and private hospitals, community health centres and to multicultural health workers.

The Commission also distributed around 4000 promotional posters targeting Aboriginal communities in NSW.

Expo 50 Plus

In March 2000, the Commission participated in the Expo 50 Plus which was held at Sydney Town Hall during Seniors Week. The Commission's stall was well located and over 2,000 brochures and information sheets were distributed to Expo visitors. Many people who visited Expo took the opportunity to talk to Commission staff to find out more about the work of the Commission, about their rights as health consumers, while others just wanted to share their experiences in the health system. Participating at Expo 50 Plus was a great success and the Commission plans to participate in future Expos.

Special Interest Magazine

In March 2000, the Commission was offered the opportunity to publish articles in Probus magazine which targets the elderly. Probus has a distribution of over 90,000 copies and is published quarterly. The first two articles placed by the Commission covered the topic of rights and responsibilities and making informed consent.

Consultations with Consumer Groups

The Commission has continued its formal consultation process with peak consumer groups through the Consumer Consultative Committee. The Commission held three meetings in 1999-2000.

The Consumer Consultative Committee discussed issues related to general Commission business, the formulation of a Disability Action Plan, the review of the Medical Practice Act and the Health Care Complaints Act and promotional activities targeting health consumers. The Commission finds these meetings valuable and has put plans in place to make them more rigorous and effective for both the consumer groups as well as the Commission. In May 2000 the Commission initiated a review of membership and asked Consumer Groups to renominate themselves as members if they wished to participate for another three year term. Before the end of the financial year, the Commission received one resignation from the Public Interest Advocacy Centre on the basis that it did not perceive itself as a peak health consumer body as is required for membership of the Commission, but an advocacy group for consumers. The Commission accepted their resignation with regret.

The remaining members of the Committee are:

- Aboriginal Health and Medical Research Council;
- Australian Association for Welfare of Child Health Inc;
- Combined Pensioners and Superannuants Association;
- Mental Health Coordinating Council;
- NSW Council for Intellectual Disability Ltd;
- NSW Council on the Ageing;
- People Living with HIV/AIDS NSW;
- People with Disabilities NSW; and
- Women's Health Resource and Crisis Centres Association.

Consultations with the Health Registration Boards, Professional and Industrial Organisations and other Key Stakeholders

Under the Health Care Complaints Act 1993, a complaint to a registration board is also a complaint to the Commission and vice versa. The Commission has a statutory obligation to consult with the relevant board in relation to how a complaint against a registered health practitioner should be handled and as to what action the Commission will take at the end of each investigation. As most complaints against individuals concern medical practitioners, a representative of the NSW Medical Board attends an Assessment Committee meeting held at the Commission each week. Consultations occur with the other registration boards on a monthly basis, with senior Commission officers attending the complaints committees of the boards.

The Commission is a member of the Ad Hoc Committee - Complaints/Disciplinary Process - which meets quarterly and includes the following members:

- the Health Care Complaints Commission;
- the NSW Medical Board;
- the Health Conciliation Registry;
- the Health Professionals Registration Boards;
- the Australian Medical Association (NSW); and
- United Medical Protection.

The Commission holds regular meetings with the NSW Nurses' Association in order to discuss matters of common concern regarding the regulation of the nursing profession. The Commission meets with representatives of the professional colleges, private health insurance agencies and other professional organisations on a needs basis.

The Staff

Establishment and staff profile - snapshot

(EFT* positions as at 30 June each year)

Titles of Positions	1997	1998	1999	at 1.7.1999	at 30.6.2000
Establishment - Permanent Positions - EFT					
Director/Commissioner (SES)	1	1	1	1	1
Deputy Commissioner (SES)	1	0	0	0	0
Directors (Senior Officers)	0	2	2	2	2
Directors (Graded Officers)	0	2	2	2	2
Heads of Teams/Managers	6	5	5	5	5
Legal Officers, various titles	5	5	5	5	5
Hearing Officers	0	1	2	2	2
Senior Investigation Officers	14	14	13	13	15
Preliminary Investigation Officers/ Resolution Officers	4	3	3	3	3
Complainant Liaison Officer	0	0	1	1	0
Patient Support Officers	8	8	8	8	10
Telephone Inquiry Officers	2	2	2	2	2
Clerks, various titles	8	8	9	9	9
Clerical Officers, various titles	11	12	11	11	11
Sub Total	*60*	*63*	*64*	*64*	*67*
Temporary Positions - EFT					
Medical Advisers (part-time)	1.2	1.2	1.2	1.2	0
Clerk - IT Manager	1	1	0	0	0
Investigations Advisor	0	0	0	0	1
Special Projects Officer	0	0	1	1	1
Total Positions - EFT	**62.2**	**65.2**	**66.2**	**66.2**	**69**

**EFT is an abbreviation for Equivalent Full-Time*

Equal Employment Opportunity

The distribution of staff by level and employment basis as at 30 June 2000 is shown on the following two tables:

Percent of total staff by level

Level	Total Staff #	Respondents %	Men %	Women %	A %	B %	C %	D %
< $26,276								
$26,276 - $34,512	1	100	100					
$34,513 - $38,582	11	55	9	91		17	50	17
$38,583 - $48,823	4	100	50	50				
$48,824 - $63,137	35	94	26	74	3	24	15	12
$63,138 - $78,921	9	89	44	56		25	25	
> $78,921 (non-SES)	3	100	67	33				
> $78,921 (SES)	1	100		100				
TOTAL	**64**	**88**	**30**	**70**	**1.7**	**20**	**20**	**9**

A: Aboriginal peoples & Torres Strait Islanders

B: People from racial, ethnic, ethno-religious minority groups

C: People whose language first spoken as a child was not English

D: People with a disability

Percent of total staff by employment basis

	Subgroup as % of Total Staff in each Category				Subgroup as Estimated % of Total Staff in each Employment Category			
Level	**Total Staff #**	**Respondents %**	**Men %**	**Women %**	**A %**	**B %**	**C %**	**D %**
Permanent								
Full-Time	*50*	90	28	72	2.2	20	22	11
Part-Time	*4*	75	25	75				
Temporary								
Full-Time	*6*	83	67	33		20		
Part-Time	*3*	67		100		50		
Contract								
SES	*1*	100		100				
Non SES								
Casual								
TOTAL	***64***	***88***	***30***	***70***	***1.7***	***20***	***17***	***9***
SUBTOTALS								
Permanent	54	48	15	39	1	10	11	6
Temporary	9	7	4	5		3		
Contract	1	1		1				
Full-Time	56	50	18	38	1	11	11	6
Part-Time	7	5	1	6		2		

Executive remuneration

There was one position in the Commission with remuneration at level 5 of the Senior Executive Service during the financial year 1999-2000.

Position Title	Occupant	Period	Remuneration	Performance Pay
Commissioner	Merrilyn Walton	1.7.1999-28.1.2000	$207,205	Nil
Commissioner	Julie Kinross (Acting)	29.1.2000- 25.6.2000	$152,670	Nil
Commissioner	Amanda Adrian	26.6.2000-present	$152,670	Nil

Appointments 1999-2000

Position Classification	P	T
Commissioner	1	0
Manager, Complaints Assessment & Resolution	1	0
Manager, Team 2	0	1
Senior Investigation Officers	0	5
Patient Support Officer	0	1
Legal Officer	1	0
Executive Assistant	1	0
Telephone Inquiry Officer	0	1

P = Permanent *T = Temporary*

Terminations 1999-2000

Position Classification	P	T
Commissioner	1	0
Director Executive Support Group	1	0
Medical Advisors	0	4
Legal Officers	2	0
Senior Investigation Officers	2	1
Resolution Officer	1	1
Telephone Inquiry Officer	1	1
Clerical Support officer	0	2
Executive Assistant	1	0
Information Technology Manager	0	1

P = Permanent *T = Temporary*

SES POSITIONS

The number and levels of SES positions over the past 3 years are as follows:

		1997/98	1998/99	1998/99			1999/00
Band	**Range**	**Number**		**Level**		**Number**	
Band 1	Lower Upper	- 1	- -	1	Lower Upper	- -	- -
Band 2	Lower Upper	- -	- -	2	Lower Upper	- -	- -
Band 3	Lower Upper	1 -	1 -	3	Lower Upper	- -	- -
Band 4	Lower Upper	- -	- -	4	Lower Upper	- -	- -
				5	Lower Upper	- 1	- 1
				6	Lower Upper	- -	- -
				7	Lower Upper	- -	- -
				8	Lower Upper	- -	- -
Totals		2	1			1	1

a) Four band structure was replaced by eight level structure from 1/10/97.
b) All positions were filled by women.

Grievances

One formal grievance was lodged during the year and an investigation took place. The grievance lapsed when one of the parties ceased duty with the Commission.

Enterprise Bargaining

The Commission and the Public Service Association of NSW entered into a Workplace Agreement. The agreement provides for consultative and communication mechanisms, review of workplace policies and practices such as performance management, training and development and employment and recruitment. A key element is a more flexible working hours scheme.

Occupation Health and Safety

The OH&S Committee met regularly and continued its program of workplace inspections. The committee reviewed 34 reported incidents and there were no particular trends and few serious injuries. Not all incidents involved injuries and the most serious injury occurred outside the workplace. Most injuries to staff were minor sprains, bruises, cuts or burns stemming from equipment defects or other users not keeping equipment safe. As a result reminders to staff about workplace safety were issued on several occasions.

Fire safety training was conducted for fire wardens and other interested staff during the year.

The employee assistance program continues to be available to staff.

Risk Management

The Commission's workers' compensation, motor vehicle, public liability, property and miscellaneous items insurance are provided by the NSW Treasury Managed Fund, managed by GIO. There have been no significant changes to risks or risk management during the year.

Consultants

Two consultancy projects costing $5,000 were let during the year to assist the Commission to develop its disability action plan.

Information Technology - Y2K Issues

The Commission's preparation, contingency plans and necessary changes were in place in time. The Commission replaced its central computer server, some cabling and network equipment. Relatively minor modifications were made to the in-house complaints database and a new time sheet was developed. There were no problems either with the arrival of the new year or associated with the leap year. The Commission was originally allocated $98,000 for Y2K and drew down and spent $30,000 of this during 1998-99. Expenditure during 1999-2000 was $9,000 (excluding staff time) from the Commission's ongoing recurrent appropriation.

Energy Management

The Commission is committed to the Government's Energy Management Policy, Reducing Greenhouse Emissions. The Director, Corporate Support has been appointed as the Commission's Energy Manager.

The Commission has prepared an energy management plan which may be summarised as follows:

- Building energy savings measures will be considered.
- The Commission will consider energy efficiency ratings when replacing computers, other office machines and equipment.

The Commission has not set specific goals in addition to the public sector wide goals. Mechanisms to collect data and monitor energy usage are in place.

During the year the Commission replaced two photocopy machines with models with energy saving features. The machines however needed to be high capacity machines for operational reasons and this may limit actual savings being achieved. The Commission replaced one motor vehicle with a small fuel efficient model. Contrary to initial intentions, operational and occupational and health and safety issues have meant that another vehicle to be replaced will be a larger, less economical model.

Vehicle Fuel Use	1998-99	1999-2000
Litres	4,092	2,996
Distance travelled	41,400	30,015
Litres per 100km	9.88	9.98

The total amount of vehicle fuel used has reduced. This is attributed to vehicle use pattern related to operational needs rather than energy savings measures.

Electricity use	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000
Annual Kilowatt hours (kWh)	121,572	128,343	131,331	138,976	144,234
kWh per person	2,210	2,252	2.304	2,396	2,364

Electricity use overall has increased and this may at least in part be related to the number of people occupying the premises increasing from 55 to 61. Electricity use per person has generally increased over the years with a small reduction in 1999-2000 over the previous year.

A more detailed analysis of energy used by building facilities and office equipment is necessary so that further measures can be introduced in order to meet the Government's energy savings targets.

Workers' Compensation Claims

The Commission continued its low level of claims made on the fund. This result further reflects both the focus that management has placed on minimising risk and creating a safe workplace as well as the efforts of an active occupational health and safety committee within the Commission.

	1996-1997	1997-1998	1998-1999	1999-2000
Number of Claims:	7	5	5	8
Claim Payments ($000):	19	5	6	6
Total Cost ($000):	25	6	10	11

Motor Vehicle Claims

In 1999-2000 there were no claims against the managed fund for motor vehicle repairs.

	1996-1997	1997-1998	1998-1999	1999-2000
Number of Claims:	1	4	2	0
Total Cost ($000):	1	8	5	0

The Commission maintains a fleet of three motor vehicles i.e. one SES and two pool vehicles.

All three vehicles are leased.

Account Payment Performance

A total of 1,490 invoices were received during the year and were processed as follows.

< 31 days after receipt = 87%

< 60 days after receipt = 8%

> 60 days after receipt = 5%

Overseas Travel

During the reporting year, overseas travel was undertaken by the Acting Commission, Ms Julie Kinross, to New Zealand to attend the Council of Health Care Complaints Commissioners meeting which was held from 4-10 February 2000.

Training and Development Awareness

Details of the various course/seminars attended by staff members during the year are as follows:

Seminars/Courses	No. of Staff Attended
Aboriginal Mental Health Conference	1
Australian Bioethics Association	1
College of Law - Autumn Intensive CLE	1
Crime in the Professions	1
Discriminatory Conduct	1
Front Foot Consultation	2
Giving and Receiving Feedback	6
Health Information Management Update	2
HTML authoring for the Web	2
Innovation in Alternative Dispute Resolution	2
Justice Awards Presentation	1
Law Society - Government Lawyers Convention	2
Legal Sites on Internet	4
Management for Senior Managers	1
Managing Outsourced Legal Services	1
Microsoft Excel	1
New Legal Profession Amendment Regulation	1
Non Judicial Process	1
NSW Fire Brigade - First Attack Firefighting	12
NSW Treasury - GST - Modelling the impact	1
NSW Treasury GST Seminar	1
Professional Ethics	1
Spokeswomen's Network	1
Step by Step Guide to Disciplinary Process	4
The Judges Series	1
Web Accessibility Workshop	2
Workshop for AHS Representatives	2
TOTAL	**56**

Financial Reports

Appendix A: Equity

Ethnic Affairs Priorities

The Commission revised its Ethnic Affairs Priority Statement for the period 1999-2000 which forms the basis of this report.

Goal 1

Promote consumer input into Commission decision making, including convening regular Consumer Consultative Committee meetings (CCC) with specific ethnic representation, communicating with ethnic groups and the media and conducting consumer satisfaction surveys.

Performance

- The Ethnic Communities Council nominated a person to represent it on the CCC. Although the representative did not attend all CCC meetings he provided input into the Commission's Ethnic Affairs Priority Statement and provided guidance on staff training in cultural diversity.
- The Commission regularly provided speakers for ethnic and other community groups
- The Commission conducted a consumer satisfaction survey with over 500 responses. It could not however link survey responses to voluntary ethnicity data held and this will need to be addressed.

Goal 2

Provide access to information for people from culturally diverse backgrounds.

Performance

- Thirty thousand brochures in seventeen languages other than English were distributed to multicultural health workers, Area Health Services, migrant resource centres, public hospitals and individuals.
- The Commission's website became operational in April 2000 and has been developed in plain English. Copies of brochures in languages other than English will progressively be put on the website.
- A communications strategy for the Commission is currently being developed and this will include the ethnic community.
- Patient Support Officers continued to liaise with and make presentations to local ethnic community groups. During the reporting period four presentations occurred.

Goal 3

Ensure cultural diversity is addressed in all areas of service delivery.

Performance

- Ethnic affairs initiatives have been incorporated or cross referenced in the Commission's corporate plan.
- Ethnicity data is being captured in the Commission's complaints database and ethnicity reports have been developed; data is yet to be analysed.
- Cultural diversity training, including the use of interpreters, has been arranged for all staff with training to occur during August and September.
- Interpreters were used on sixty occasions in 1999-2000.

Goal 4

Staff management and recruitment practices incorporate cultural diversity issues.

Performance

- All job advertisements have been reviewed to ensure appropriate wording to target people from culturally diverse backgrounds. The Commission could not reliably ascertain from job applications what proportion of applicants were from culturally diverse backgrounds.
- Two or 18 % of appointments to Commission vacancies were from people from culturally diverse backgrounds bringing the proportion of such staff employed in the Commission to 15%.

Disability

The Commission submitted its Disability Action Plan (DAP) to the Ageing and Disability Department (ADD) on 28 February 2000. The plan has been further refined in consultation with the ADD. The main strategy for the reporting year was to develop a framework and identify a series of actions to make Commission services, information and premises more accessible to people with disabilities, their families and carers. The DAP does this but only a small number of those actions as outlined below were achieved in the reporting year.

Goal 1: Physical Access

People with disabilities can access Commission offices, services and information.

Performance

The Commission has prepared a detailed action plan to facilitate physical access to the Commission's Foveaux Street premises. Significant items could not progress until a decision was taken (by July 2000) to extend the lease in those premises. Some actions have commenced including some improved signage and access to toilet facilities for people with disabilities.

Goal 2: Promoting Positive Community Attitudes

People with a disability are recognised as consumers of the services provided by the Commission and are included in promotional material and activities.

Performance

The Commission's Disability Action Plan includes modifications to publications to help achieve this goal. It is proposed to do this as new and revised publications are issued.

Goal 3: Staff Training

Increase disability awareness by staff of the Health Care Complaints Commission.

Performance

Training for staff is yet to occur. The Commission prepared an investigations training package during the year and this refers to the needs of people with disabilities.

Goal 4: Information Services

Equitable access for people with disabilities, their families and carers to information about Health Care Commission services.

Performance

The Commission has developed a communications strategy which incorporates people with disabilities. Brochures are in plain English and some use pictures to convey messages.

Goal 5: Access to Employment

Equitable access to work areas of the Health Care Complaints Commission.

Performance

The Commission's Disability Action Plan identifies a series of actions to facilitate employment. Special equipment and furniture has been provided to staff as required.

Goal 6: Complaint Procedures

A complaints mechanism that is accessible to people with disabilities, their families and carers.

Performance

Complaints procedures are included in Commission publications.

Goal 7: Other

Organisational practice promotes disability access.

Performance

The Commission arranges visits either at home or other suitable premises when requested by people with disabilities, older people or people with special circumstances who are involved in complaints being handled by the Commission.

Ageing

The Commission is a key agency and has contributed to the development of the NSW Healthy Ageing Framework.

Goal 1

Improve older people's access to HCCC services and information.

Performance

- Conducted over 12 seminars and information sessions for aged groups to promote the role and function of the Commission and the Patient Support Office
- Participated in Expo 50 Plus and distributed over 2000 brochure to participants and visitors
- The Commission's Consumer Consultative Committee has members who represent the Combined Pensioners and Superannuants Association, Council on the Ageing and others. These peak consumer organisations promote the work of the Commission to their members.
- Future Patient Support Office business plans will include special information sessions to be held at nursing homes and aged residential care to promote the Commission and the Patient Support Office.

Goal 2

To report on complaints relating to ageing issues.

Performance

The Commission categorised 23 complaints in 1999-2000 as being related to ageing issues.

Appendix B: Freedom of Information

Section A - Numbers of new FOI requests

Information relating to numbers of new FOI requests received, those processed and those incomplete from the previous period.

	FOI requests	Personal	Other	Total
A1	New	52	1	53
A2	Brought forward	-	-	-
A3	Total to be processed	52	1	53
A4	Completed	52	1	53
A5	Transferred out	-	-	-
A6	Withdrawn	-	-	-
A7	**Total processed**	**52**	**1**	**53**
A8	Unfinished (carried forward)	-	-	-

Section B -What happened to completed requests

	Results of FOI	Personal	Other
B1	Granted in Full	12	-
B2	Granted in Part	40	-
B3	Refused (Declined)	-	1
B4	Deferred	-	-
B5	**Completed**	**52**	**1**

Section C - Ministerial certificates - number issued during the period

C1	Ministerial Certificates issued	-

Section D - Formal consultations -

Number of requests requiring consultations (issued) and total number of formal consultations for the period

		Issued	Total
D1	Number of requests requiring formal consultations	-	-

Section E - Amendment of personal records

Number of requests for amendment processed during the period

	Results of requests	Total
E1	Agreed	-
E2	Refused	-
E3	**Total**	**-**

Section F - Notation of personal records

Number of requests for notation processed during period

F3	Number of requests	2

Section G - FOI requests granted in part or refused

Basis of disallowing access - number of times each reason cited in relation to completed requests which were granted in part or refused

	Basis of disallowing or restricting access	Personal	Other
G1	Section 19 (application incomplete, wrongly directed)	-	-
G2	Section 22 (deposit not paid)	-	-
G3	Section 25 (1)(a1) (diversion of resources)	-	-
G4	Section 25 (1)(a) (exempt)	39	1
G5	Section 25 (1)(b), (c), (d) (otherwise available)	-	-
G6	Section 28 (1)(b) (documents not held)	-	-
G7	Section 24 (2) (deemed refused, over 21 days)	-	-
G8	Section 31 (4) (released to Medical Practitioner)	-	-
G9	**Totals**	**39**	**1**

Section H - Costs and fees

Costs and fees for requests processed during period, not including costs and fees for unfinished requests

		Assessed Costs	FOI Fees Received
H1	All completed requests	$15,000	$1,445

Section I - Discounts allowed

Number of FOI requests processed during the period where discounts were allowed

	Type of Discount Allowed	Personal	Other
I1	Public Interest	-	-
I2	Financial hardship - Pensioner/Child	10	-
I3	Financial hardship - non-profit organisation	-	-
I4	**Totals**	**10**	**-**
I5	Significant correction of personal records	-	-

Section J - Days to process

Number of completed requests by calendar days (elapsed time) taken to process

	Elapsed Time	Personal	Other
J1	0 - 21 days	49	-
J2	22 - 35 days	2	-
J3	Over 35 days	1	1
J4	**Totals**	**52**	**1**

Section K - Processing time

Number of completed requests by hours taken to process

	Processing Hours	Personal	Other
K1	0 - 10 hours	43	1
K2	11 - 20 hours	6	-
K3	21 - 40 hours	3	-
K4	Over 40 hours	-	-
K5	**Totals**	**52**	**1**

Section L - Reviews and appeals

Number finalised during period

L1	Number of internal reviews finalised	2
L2	Number of Ombudsman reviews finalised	1
L3	Number of District Court appeals finalised	-

Appendix C: Legislation

The following is a list of some of the legislation, including registration Acts, relevant to the work of the Commission:

- Chiropractors and Osteopaths Act 1991
- Dental Technicians Registration Act 1975
- Dentists Act 1989
- Health Services Act 1997
- Health Care Complaints Act 1993
- Health Administration Act 1982
- Medical Practice Act 1992
- Mental Health Act 1990
- Nurses Act 1991
- Nursing Homes Act 1988
- Optical Dispensers Licencing Act 1963
- Optometrists Act 1930
- Pharmacy Act 1964
- Physiotherapy Registration Act 1945
- Podiatrists Act 1989
- Poisons and Therapeutic Goods Act 1966
- Private Hospitals and Day Procedures Centres Act 1988
- Psychologists Act 1989
- Public Hospitals Act 1929
- Public Health Act 1991

Appendix D: Committees & Taskforces

The Commission has representation on significant statutory bodies and interdepartmental committees including:

Chief Executives Committee - Commissioner

Chiropractors and Osteopaths Registration Board Complaints Screening Committee - Director, Complaint Resolution

Consumer Focus Collaboration - Director, Complaint Resolution

Dental Board Complaints Screening Committee - Director, Complaint Resolution

Dental Technicians and Prosthetists Registration Complaints Screening Committee - Director, Complaint Resolution

Department of Health Information Management Committee - Commissioner

Medical Board Conduct Committee - Commissioner

Medical Board Medico-Legal sub-committee - Commissioner

Methadone Liaison Group - Manager, PSO

Ministerial Advisory Committee on Privacy and Health Information - Commissioner

National Council of Health Care Commissioners - Commissioner

National Health Complaints Information System Project Steering Committee - Commissioner

Nurses Registration Board Conduct Committee - Commissioner

Optical Dispensers Registration Complaints Screening Committee - Director, Investigations and Prosecutions

Optometrists Board Complaints Screening Committee - Director, Investigations and Prosecutions

Pharmacy Board Complaints Screening Committee - Director, Complaint Resolution

Physiotherapists Registration Complaints Screening Committee - Director, Investigations and Prosecutions

Processes of Review in Mental Health Services - Director, Patient Support Office

Psychologists Registration Complaints Screening Committee - Commissioner

Skin Care Improvement and Pressure Ulcer Prevention Group - Director, Patient Support Office

Statewide Complaints Data Project Management Committee - Director, Complaint Resolution

Watchdog Agencies - Commissioner

Apendix E: Staff of the Commission

(At 30 June 2000)

Commissioner
Amanda Adrian, *BA, LLB, FRCNA, FNSWCN, RN*

Director, Investigations & Prosecutions
Tom Galloway, *LLM*

Director, Complaints Assessments & Resolutions
Julie Kinross, *MSW, Post Grad Dip Soc Planning, BA (Psych), PG Dip Ad Finance & Investment*

Director, Corporate Support
Tom McKnight

Director, Patient Support Office
Bruce Greetham, *MM*

Manager, Prosecutions & Legal Advisings
David Swain, *LLM, DipCrim*

Manager, Complaint Assessments & Resolution
Sharlene Weibenga, *B App Sc (Health)*

Manager, Investigation Team 1
Elizabeth Wing, *LLB*

A/Manager, Investigation Team 2
Ian Crosbie, *Grad Cert Man, MNIA, JP*

A/Manager, Patient Support Office
Brian McMahon

Legal Officers
Robyn Clark, *BA, LLB*
Kanagasabai Vasan, *MA Attorney-at-Law (USA)*
Sarah Connors, *BA, LLB*
Lynne Organ, *LLB*

Hearing Officers
Michael Wade, *BCom*
Zoe Bowman, *BA, LLB*

Senior Investigation Officers
Christina Hart, *BA(Hons), BSocStud(Hons)*
Rosemary Pendlebury, *RN, RMN, DNE, RN (NCUSA), MM, JP*
Moira Kelly, *MAASW, BA (SocWk), MSW, GradDip Rel Ed, BTh, MTh, JP*
Giles Yates, *BA, MA, PhD(Bioethics)*
Elizabeth van Ekert, *BA, DipEd*
Antoinette Younes, *BA, MA, LLB, GDLP, JP*
Vivienne Flynn, *RN, GradDip (Health Science) (HIV Studies)*
Eva Crisp, *BSc (Hons), JP*
Maureen Holt, *LLB*
David Moss, *BN, RN*

Resolution Officers
Amanda Hadley, *BSc PMC*
Jenny Brown
Sonia Belen, MD, BS, FACBS, FPOGS

Patient Support Officers
Bernadette Liston, *BA*
Teresita Indolos, *Grad DipHP,(BA, BSw - Philipines)*
Mark Hodges, *BSocSc (Psy)*
Irene Sullivan
Ellen Palmer, *BSW(Hons)*
Kate Ryder, *MPH, BA (Hons)*
Valerie Keen, *BSocStud*
Ruth Robinson, *BA(Leisure), GradDipLaw, ADRec*

Administrative Officer
Trevor Covell, *PAC*

Publications/Policy Officer
Maida Talhami, *BBA (USA)*

Commissioner's Executive Assistant
Virginia Westerson

Executive Assistant to Directors
Sara Coutinho

Administrative and Clerical Staff
Robin Parsons, David Cornish, Rod Dalziel, Estella Fanella JP, Mirella Jennings, Jackie Liong JP, Carmen Sitta, Carole Song, Sue Russell, Linda Calver, Kelly Ann Davies, Loryn Bird

Telephone Inquiry Officers
Janette Campbell (Acting), *BSocSc*

Temporary Staff

Senior Investigation Officers
Vicki Dendtler, *(P/T), BSc (App Psych)*
Jacqueline Dahl, *(P/T), BA, LLB*
Timothy Rochford
Chris Waters, *RN, DHSc(N), BSocSci (Justice Studies)*
Angela O'Gorman, *BA*
Rochelle Dunlop, (P/T), *LLB*

Investigations Advisor
Chris Williams, *Assoc Dip Ed , BTh, BTheol.*

Clerical Trainee
Melinda Murray

Staff who had been employed for part of the year, on extended leave or secondment from the Commission: Catherine Maxwell, Silvana Manno, Vera Orr, Karrie Pattingale, Sally Anne Forsstrom, David Harris, Eric Fisher, Glenda Peel, Julie Gottlieb, Wal Grigor, Bran M'Cithech, Arlene Chattakar-Aitkins, Christina King, Diane Veness, Merrilyn Walton, Winsome Ely, Peta Kava, Gretel O'Toole, Nasrin Schonberger, Kirstin Thomas, Noelle Taoube, Paul Conroy.

Appendix F: Access

Office Address

Level 4, 28-36 Foveaux Street

Surry Hills NSW 2010

(Wheelchair access via Belmore Lane)

Postal Address

Locked Mail Bag 18

Strawberry Hills NSW 2012

Hours of Business

9.00am to 5.00pm Monday to Friday

Telephone and Fax

Telephone: (02) 9219 7444

Fax: (02) 9281 4585

TTY service for hearing impaired:
(02) 9219 7555

Toll Free in NSW: 1800 043 159

Website

www.hccc.nsw.gov.au

E-mail

hccc@hccc.nsw.gov.au

Interpreters

Interpreters can be arranged to discuss a complaint.

Patient Support Office

It is best to contact Patient Support Officers by telephone:

Penrith/BlueMountains (02)4734 3870

Western Sydney (02) 9881 1506

South Eastern Sydney (02) 9382 8129

South Western Sydney (02) 9828 5710

Central Sydney (02) 9395 2028

Northern Sydney (02) 9926 8184

Newcastle/Hunter (02) 4985 3143

For people in rural or remote areas, ring the Commission on 1800 043 159.

Patient Support Officer's phone numbers change from time to time. If you are having difficulty getting in touch with any of them, please ring the Commission.

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HEALTH CARE COMPLAINTS COMMISSION

investigate

public interest

monitor

care

resolve

IN THE PUBLIC INTEREST