Health and Community Services
COMPLAINTS COMMISSION

Annual Report
2013-2014

DRIVING
improvement

Sixteenth Annual Report (2013/14)

The Honourable Robyn Lambley MLA
Minister for Health
Parliament House
DARWIN NT 0800

Dear Minister

In accordance with the requirements of section 19(1) of the *Health and Community Services Complaints Act*, I am pleased to present the Annual Report of the Health and Community Services Complaints Commission for the year ending 30 June 2014.

Yours sincerely

Lisa Coffey
Commissioner

7 October 2014

The HCSCC

The Health and Community Services Complaints Commission (HCSCC) was established in 1998 with the passage of the *Health and Community Services Complaints Act*. The HCSCC initially sat with the Ombudsman's Office, with the Ombudsman also holding the position of Commissioner. Since 2010 the HCSCC has been a stand-alone entity with an independent Commissioner. Lisa Coffey is the current Commissioner, having been appointed in August 2010. This is the sixteenth annual report of the HCSCC and the fourth since its establishment as a separate office.

The HCSCC was set up to provide an independent, just, fair and accessible mechanism for the resolution of complaints between users and providers of health, disability and aged services. The focus of the *Health and Community Services Complaints Act* is on the resolution of complaints, the improvement of services and the promotion of the rights and responsibilities of both service users and providers.

To achieve these aims, the Commissioner's powers and functions include:

- Making enquiries into any complaints;
- Encouraging and assisting users and providers to resolve complaints directly;
- Conciliation and investigation of complaints;
- Suggesting ways of improving services and promoting rights and responsibilities;
- Reviewing and identifying the causes of complaints;
- Providing information, advice and reports to Boards, service users, the Minister and the Legislative Assembly; and
- Consulting with providers, organisations and users of health and community services.

Table of Contents

Message from the Commissioner 2

Performance Overview for 2013/14 3

Resolution of Complaints 4

Enquiries / Informal Complaints 5

Complaints 9

Website 14

Investigations 15

Public Awareness & Engagement 19

Planning, Development and Review 20

Case Studies 23

- Enquiries 23
- Assessments 26
- Conciliations 29

Appendix 1: Breakdown of Complaint Issues 31

Appendix 2: Organisation 35

Vision 36

Mission 36

Our Values 36

Message from the Commissioner

I am pleased to present the Northern Territory Health and Community Services Complaints Commission (HCSCC) Annual Report for 2013/14.

As will be seen throughout this report, this year has been a busy one for the HCSCC. The number of people accessing our services has increased, but the most remarkable statistic is the significant increase in matters handled as formal complaints, an increase of 35% for direct complaints, and 66% overall.

This does not mean that we are electing to handle complaints more formally; in fact we are working to assist providers to deal directly with complainants to resolve concerns with minimal involvement from the HCSCC. But it does appear to mean that we are being approached with more serious concerns, an apparent trend that will be monitored more closely in the new financial year.

Our resolution focus has continued as we encourage parties to engage in conciliation to discuss and resolve complaints. This is an option that parties are increasingly willing to consider and one that meets the aims of the Act in terms of resolution, improvement and promotion of rights.

We have also continued to work with the disability sector and providers in particular in 2013/14, playing a part in preparing services for the roll-out of the NDIS. We visited Tennant Creek on a number of occasions and continue to work to promote the need to have systems in place that safeguard rights of people with disabilities, now and in the future. In addition to an independent complaints mechanism such as the HCSCC, one of the most important safeguards is a robust internal complaint handling system that people are able to use without fear, confident that they will be able to have their say in how their services are delivered. The HCSCC is proud to have delivered training on National Standards in this area 2013/14 and developed a best practice system that will be the subject of consultation in the year ahead.

In terms of disability safeguards, as I have stated in past reports, urgent reform is still required to the Northern Territory Guardianship system. We are the only Australian jurisdiction without an independent guardian/advocate, a protection that is particularly important in remote NT with the advent of the NDIS.

Finally, I would like to sincerely thank my team at the HCSCC for their hard work and commitment in 2013/14. I also extend my thanks and admiration to the many people who have engaged with us openly and honestly, making and addressing complaints in the past year. Complaints are not easy to make or to have made about you. As can be seen throughout this report however, they are a valuable vehicle for reflection and improvement, leading to better services for all.

Lisa Coffey

Commissioner

Performance Overview for 2013/14

Some of the key performance outcomes and achievements for 2013/14 are set out below. More detail on all of these can be found later in this report.

Complaints and Enquiries Up

- Approaches to the HCSCC reached an all-time high (623), an increase of 30% on the previous year;
- Overall number of complaints increased by 66%, with complaints made direct to the HCSCC increasing by 35%;
- Enquiries increased from 393 in 2012/13 to 463 in 2013/14.

Improved Processes

- Streamlining of initial complaint processes contributed to the improvement in assessment timelines in 2013/14 with 68% completed within the 60 day timeframe;
- Our Systemic Issues Register has been put in place to ensure that we are able to monitor the incidents of potential systems based issues even where we take no further action in specific complaints;
- Our new electronic survey is attracting more feedback about our services that will allow us to make improvements in years ahead.

Resolution Focus

- New strategies were introduced to encourage and facilitate direct resolution of informal complaints between the service users and providers, resulting in more enquiries being closed in 2013/14;
- There was an increase in matters dealt with through conciliation;
- Team skills in this area have developed through ongoing training focus in 2013/14.

Continued Engagement

- We continued work with service providers and users in the disability sector in preparation for the roll out of the NDIS;
- To accompany our recent focus on reviewing and improving the accessibility of our resources, work has begun to update our website.

Table 1: Key Deliverables 2012/13 – 2013/14

Key Deliverables	2012/13	2013/14
Enquiries & complaints received	522	667
Enquiries & complaints closed	460	598
Complaints resolved within 180 days of receipt	80%	74%

Resolution of Complaints

How We Assist to Resolve Complaints

Anyone can approach the HCSCC to discuss a complaint or possible complaint about a health, disability, or aged service. We will give you advice about who can complain; what you can complain about; what to do if a complaint is made about you; and assist you to resolve your complaint.

The most informal way of dealing with complaints is through our **enquiry**, or informal complaint, system. The aim of the enquiry system is to assist parties to resolve their concerns in the most timely and informal way possible. Not all complaints can be dealt with informally but in many cases we are able to assist the service user to raise their concerns directly with the service provider without further involvement from us. In other cases, we may make contact with the provider and facilitate the resolution in that way.

If a concern cannot be resolved via our enquiry system, we will deal with it via our **complaint** system. This is a more formal process in which we will gather information that may assist to resolve the complaint, and ultimately decide whether further action is necessary in relation to the concerns raised. In many cases the answers to relevant questions or outcomes that the person making the complaint wants can be obtained during this initial process and no further action is required.

If further, more formal action needs to be taken to resolve a complaint because it raises important questions of health or safety, the HCSCC may decide to conduct a formal **investigation**. An investigation is a longer process during which the HCSCC may call witnesses and seize information. Findings are made at the end of an investigation and a formal report prepared.

Another option for the HCSCC is **conciliation**. Conciliation is a form of alternate dispute resolution in which parties come together to discuss the issues of complaint in a confidential environment, with the aim of settling the dispute. It is a voluntary, flexible process in which parties are encouraged to discuss issues frankly and openly. It can be used as an alternative to medico-legal processes, or a forum for communication resulting often in explanations being provided to parties, along with apologies where appropriate. In some cases agreements reached through conciliation can lead to improvements in services.

If the HCSCC decides that it is not the best body to deal with a complaint, it may **refer** it to another complaint handling organisation, such as Consumer Affairs or the Information Commissioner.

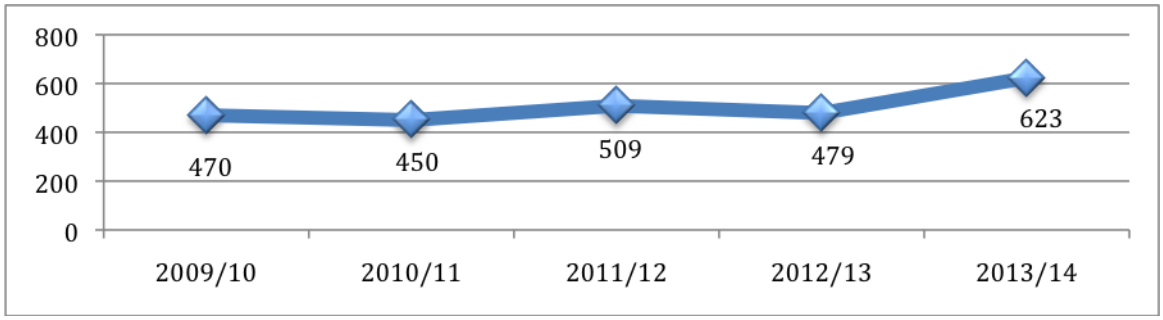
The HCSCC may also decide to refer complaints about Registered Practitioners (such as doctors, nurses, dentists and physiotherapists) to the relevant **Registration Board**. The decision to refer is made in consultation with the Board concerned, which is notified about every complaint concerning registered members of their profession.

New Approaches 2013/14

A total of 452 enquiries and 215 complaints were received during 2013/14. As 44 enquiries became complaints, the number of people who approached the HCSCC with concerns about services in 2013/14 was 623.

A comparison of approaches over the past five financial years follows, demonstrating a significant rise in approaches to the HCSCC in the past year.

Figure 1: Approaches 2009/10 - 2013/14

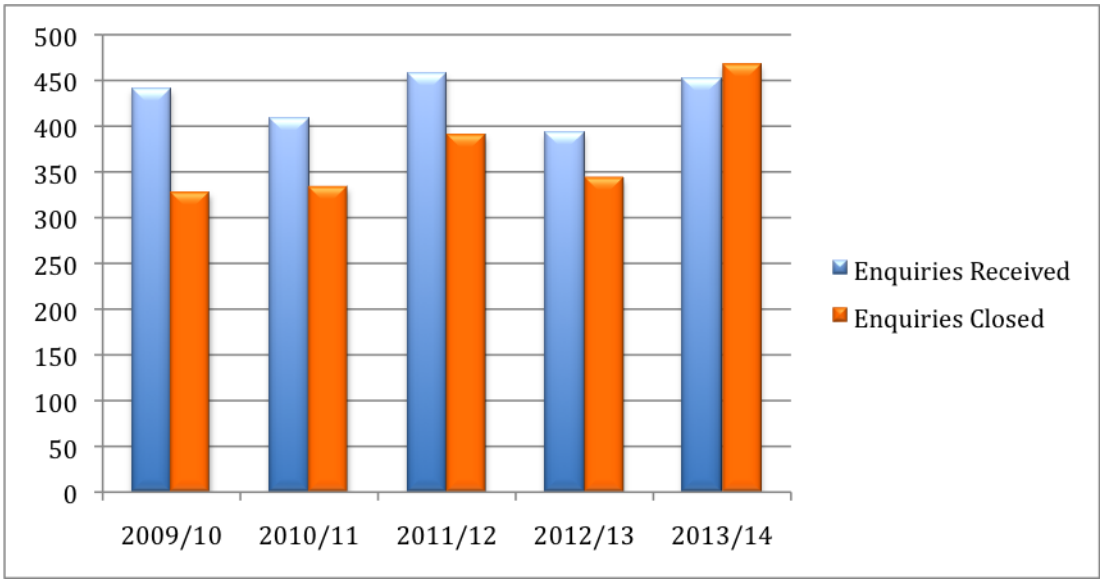


Enquiries / Informal Complaints

As stated above, the aim of our enquiry process is to assist parties to resolve concerns about services as informally as possible.

In 2013/14, we dealt with 463 enquiries. For the first time, the number of enquiries closed was slightly higher than those received, meaning that a number of matters carried over from the previous year were closed.

Figure 2: Enquiries Received and Enquiries Closed 2009/10 - 2013/14



Although the majority of enquiries do not become formal complaints (10% this financial year, consistent with previous years) they represent a substantial proportion of the HCSCC's workload. Importantly many potential complaints to the HCSCC were resolved or referred back to the provider of the service at this early stage.

Public providers accounted for 64% of the enquiries received in 2013/14, up from 50% last year. Of the enquiries about public providers, 51% related to Corrections medical services, and 26% related to acute hospitals.

Eight percent (38) enquiries related to disability services.

Table 2: Providers Subject of Enquiries 2009/10 – 2013/14

	2009/10	2010/11	2011/12	2012/13	2013/14
Private	173	178	232	198	163
Public	268	230	226	195	289
Total	**441**	**408**	**458**	**393**	**452**

Prisoner Enquiries

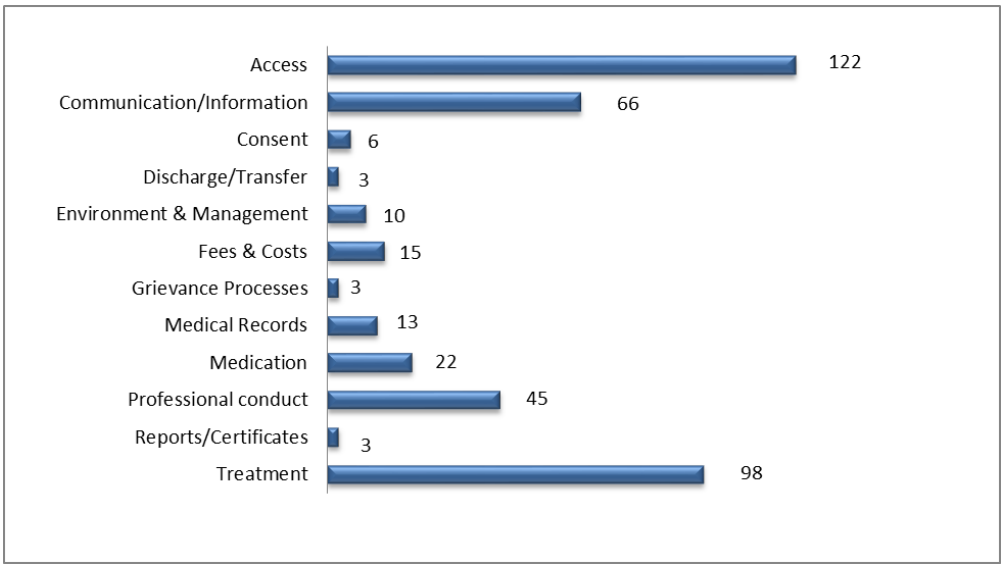
Prisoners at Darwin and Alice Springs Correctional Centres are able to contact the HCSCC to raise concerns about services via a dedicated, secure phone line. The majority of the issues raised by prisoners are referred back to the Corrections medical service to be resolved in accordance with agreed protocols.

There was a significant increase in enquiries from the Correctional Centres in 2013/14, with 146 enquiries (32%) up from 89 the year prior. It appears that this increase may reflect resourcing issues in prison medical services as 39% of these enquiries related to access to services, and 40% related to treatment.

Issues & Outcomes from Enquiries

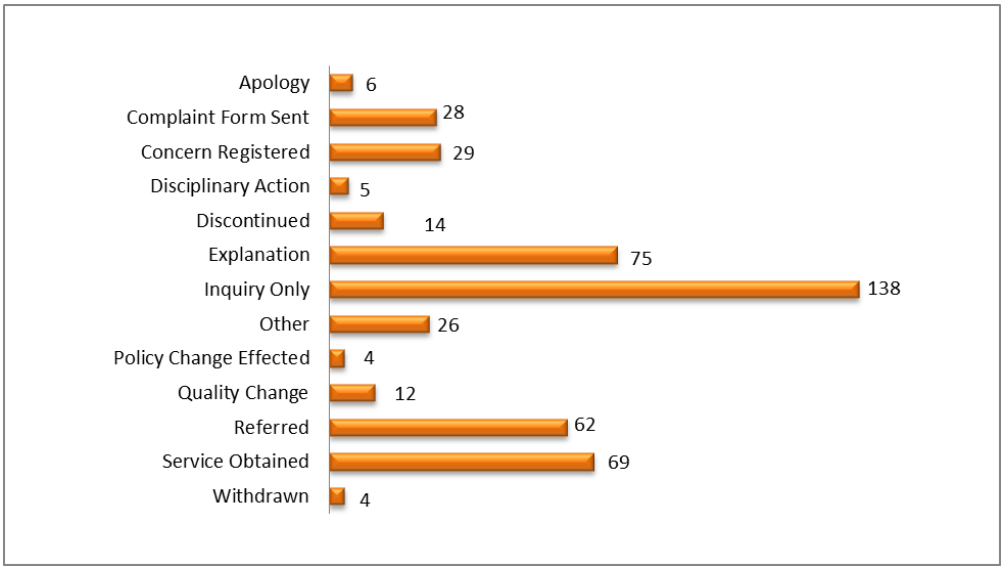
As with previous years, the most common issues raised and dealt through our enquiry process were access to services, standard of treatment and communication. Sixty-two enquiries were considered and found to be out of jurisdiction.

Figure 3: Issues Raised in Enquiries Closed 2012/13



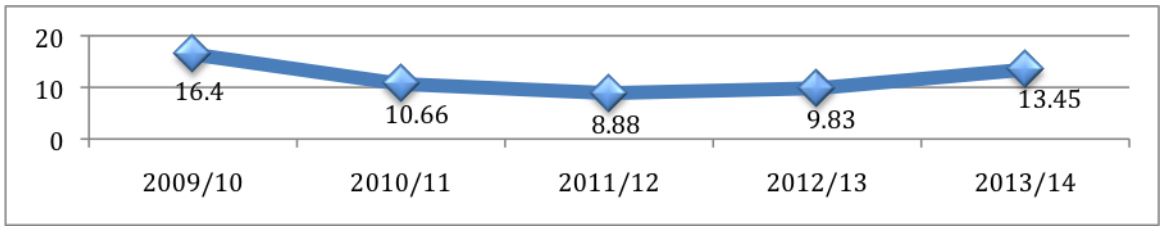
Pleasingly, 30% of callers to the HCSCC reported being able to follow up on their own enquiries after seeking initial advice from HCSCC officers. Seventy-five enquiries (16%) resulted in the person receiving an explanation related to their concern, and in 69 cases (15%) a service was obtained following involvement by the HCSCC.

Figure 4: Outcome of Enquiries Closed 2013/14



As seen in Figure 5 below, the average time taken to finalise enquiries has increased during the reporting period, from just under 10 days to more than 13 days.

Figure 5: Time Taken to Finalise Enquiries (Days) 2012/13

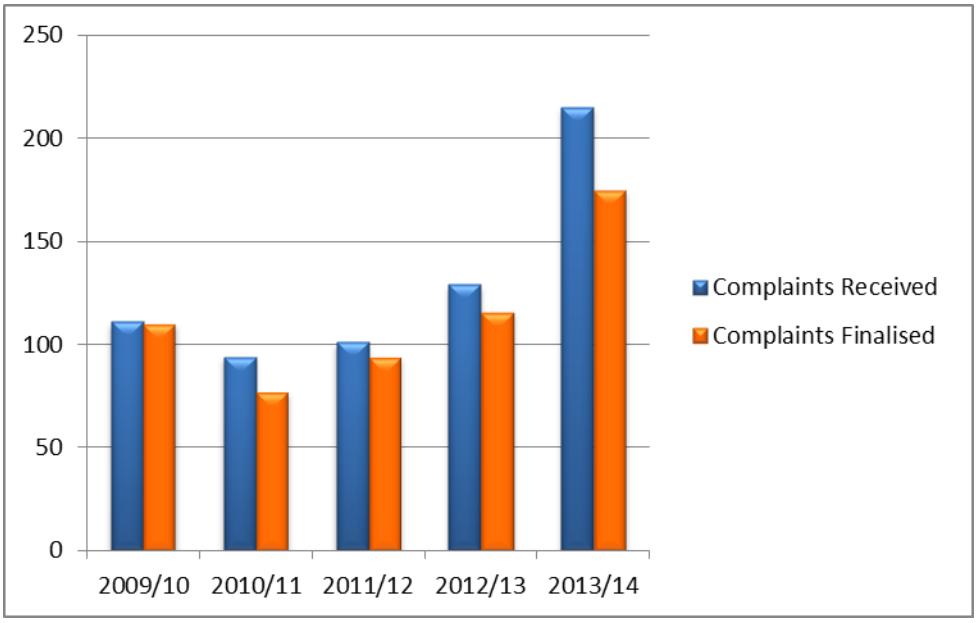


The benchmark set for finalisation of enquiries is 10 days. This year is the first time that this benchmark has not been reached in the past four years, a reflection on increasing workloads.

Complaints

In 2013/14, staff of the HCSCC handled 271 complaints, 56 of which were already open at the beginning of the financial year. 215 new complaints were received in 2013/14, a significant increase on previous years.

Figure 6: Complaints Received and Finalised 2009/10 – 20013/14

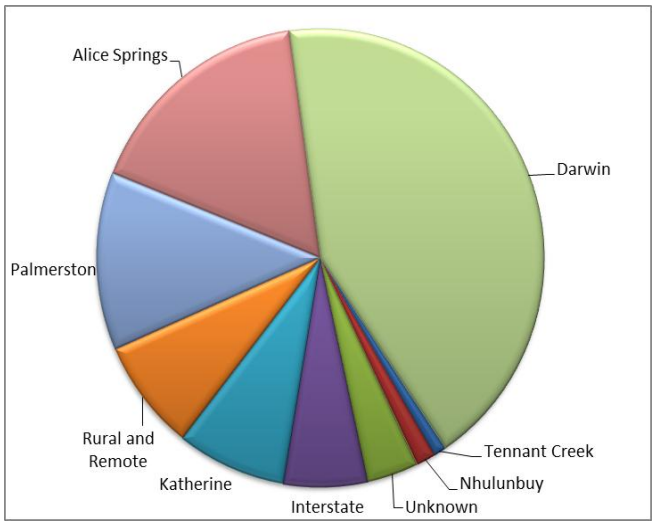


Who Complains & How?

Of the complaints with residential details recorded in 2013/14, 43% came from Darwin, 27% from Palmerston, 17% from Alice Springs, 10% from remote NT (including Nhulunbuy and Tennant Creek), 8% from Katherine, and 6% from interstate.

In 2013/14 72% of complaints came from the main urban centres (Darwin, Palmerston and Alice Springs), and 18% from other areas of the NT. This is down slightly from last year (29%) but reflects an increase in actual numbers of complaints from these regions.

Figure 7: Geographic Source of Complaints 2013/14



Where the complaint is made by phone the complainant is asked to confirm it in writing. Where a complainant is unable to confirm a complaint in writing themselves, the HCSCC will reduce it to writing and provide a copy to the complainant as required under the Act.

In 2013/14, of complaints made directly to the HCSCC, 31% of complainants approached the HCSCC by phone, 2% in person and 27% in writing. 26% of all complaints were received electronically. The remaining complaints were referred to the HCSCC by a legal practitioner (7%), a Registration Board (4%) or the Community Visitor Program (1%).

Ninety-one complaints (42%) of complaints originated with the relevant Practitioner Registration Board and were the subject of consultation between HCSCC and AHPRA. This is an increase from 29% of complaints in 2012/13.

What Services are Complained About?

Table 3 provides a breakdown of providers, both individual and institutional, subject to complaints during the reporting year.

Table 3: Providers Subject to Complaints 2008/09 – 2013/14

	2009/10	2010/11	2011/12	2012/13	2013/14
Private	49	47	61	67	119
Public	62	47	40	62	96
Total	**111**	**94**	**101**	**129**	**215**

Figure 8 gives a breakdown of public sector complaints, with Medical Practitioners the most commonly complained about (31%), followed by Nurses and Midwives (28%), and Hospitals (21%).

Figure 9 shows that Medical Practitioners were subject to the greatest number of complaints in the private sector (37%), followed by Nurses and Midwives and Physiotherapists (8%).

Figure 8: Public Providers

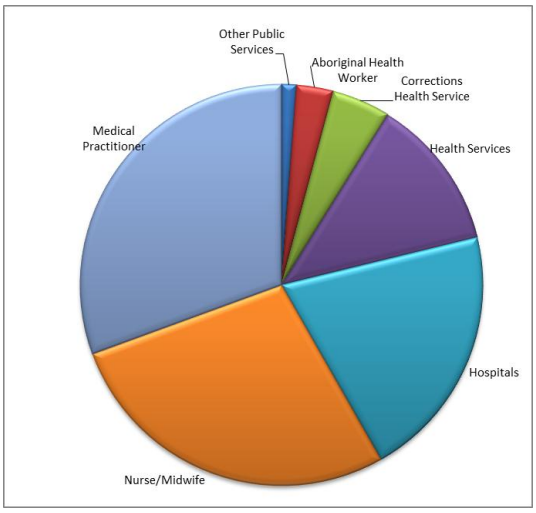
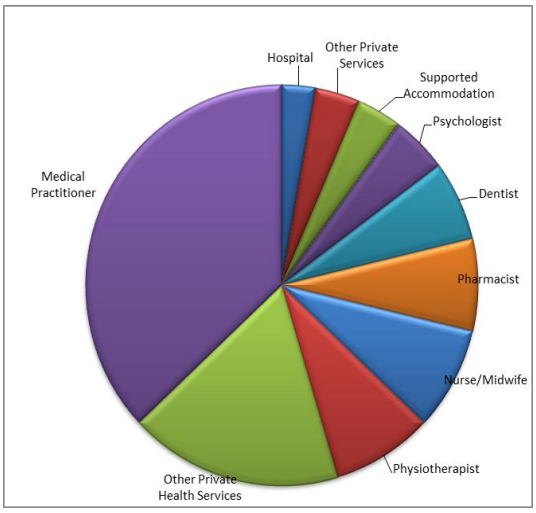


Figure 9: Private Providers



A further breakdown of complaints about services for aged people, mental health services and services for people with a disability is set out in Table 4 below. As can be seen from the table, the number of formal complaints about aged and disability services is slowly increasing. This was also reflected in an increase in enquiries about disability services, which were up again this year to 38.

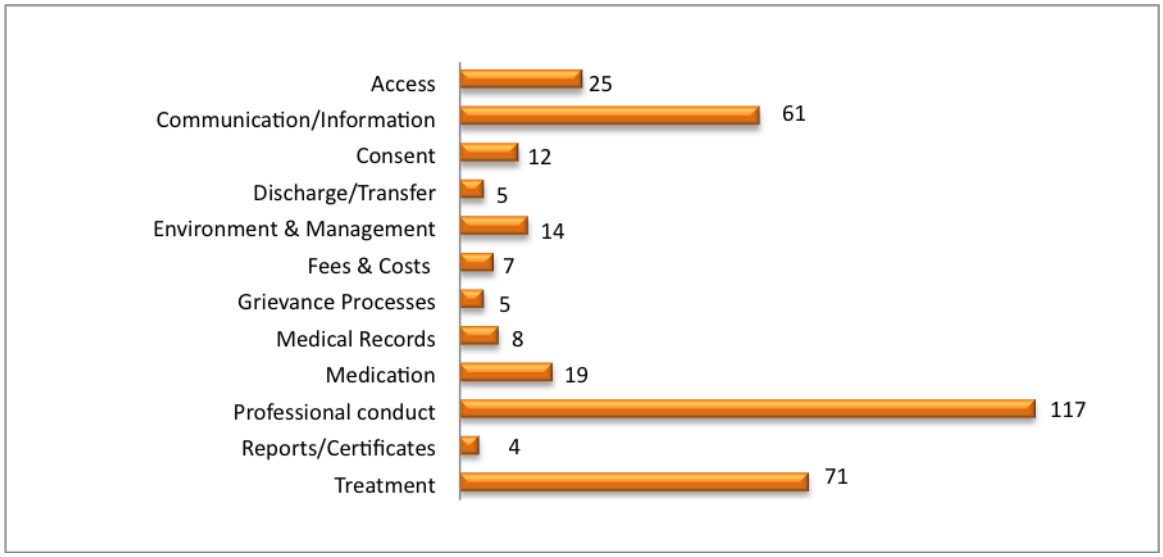
Table 4: Aged and Disability Services Complaints 2010/11 – 2013/14

Provider Type	2010/11	2011/12	2012/13	2013/14
Disability Services	2	4	6	8
Mental Health Services	3	1	1	14
Aged Services	0	1	1	1
Total	**5**	**6**	**8**	**23**

What Issues are Complained About?

Each issue described in each complaint received by the HCSCC is recorded for reporting purposes, with some complaints raising more than one issue. Issue categories are used consistently across Australia to allow for comparison.

Figure 10: Issues Raised in Complaints Closed 2013/14



In 2013/14 issues were recorded against all complaints received by HCSCC, including AHPRA notifications. This method of reporting allows for a more complete picture of the types of issues complained about in the Northern Territory, and is consistent with practice in most other Australian jurisdictions.

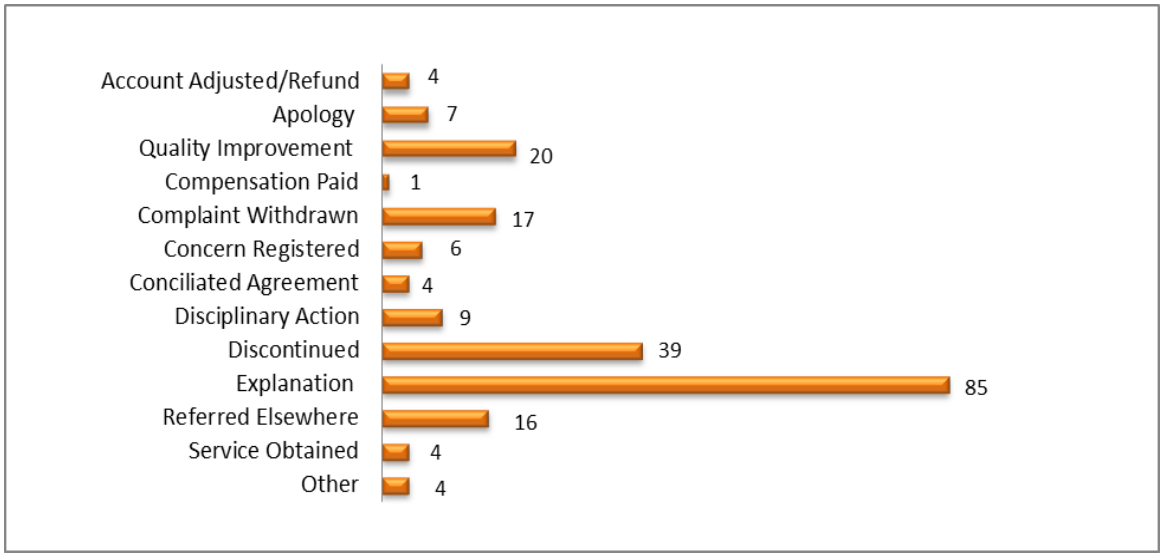
While the top three issues, conduct, treatment and communication, remain consistent year on year, most conduct matters are dealt with by the National Health Practitioner Boards.

A further breakdown of each of the categories of complaint issue and a comparison with previous years can be found at Appendix 1.

Outcomes of Issues Complained About

When complaints are finalised the outcome of each issue identified in the complaint is recorded.

Figure 11: Outcomes of Issues Raised in Complaints Closed 2013/14



The most common outcome from complaints closed by the HCSCC was an explanation (39%). This is consistent with previous years. Eighteen percent of matters were discontinued without further outcome in 2013/14, and 9% resulted in a quality improvement of some kind.

Note: These figures do not include outcomes of Board processes unless the matter was referred to the HCSCC.

What Happens to our Complaints

The HCSCC finalised 175 complaints in 2013/14.

Table 5: Reasons for Closure: Complaints Closed 2013/14

Reasons for Closure	
Investigation complete	5
Conciliation complete	9
No further action	66
Referred to Board	16
Referred to other entity	1
Dealt with by Board pursuant to MOU	78
Total Complaints Closed 13/14	**175**

It is not unusual for the HCSCC to take no further action in relation to a complaint (see above), however that may be for a variety of reasons, including the fact that a complaint has resolved through the process. A breakdown of the reasons for no further action can be seen in Table 6.

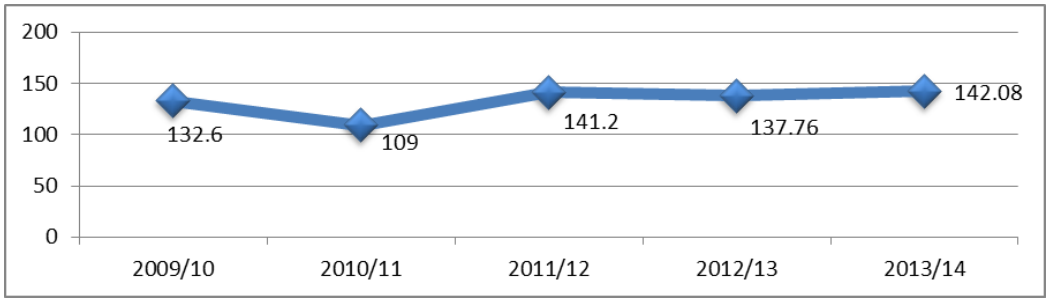
Table 6: Reason for No Further Action Complaints Closed 2013/14

Reason for No Further Action	
No basis for complaint to HCSCC	2
Complaint over 2 years old	1
Failure to reasonably resolve with provider	0
Further investigation unnecessary &/or unjustified	32
Complaint lacks substance	3
Complaint is resolved	17
Complaint determined by a court, tribunal or board	1
Required information not received	3
Complaint has been withdrawn	7
Total	**66**

Time taken to Finalise Complaints

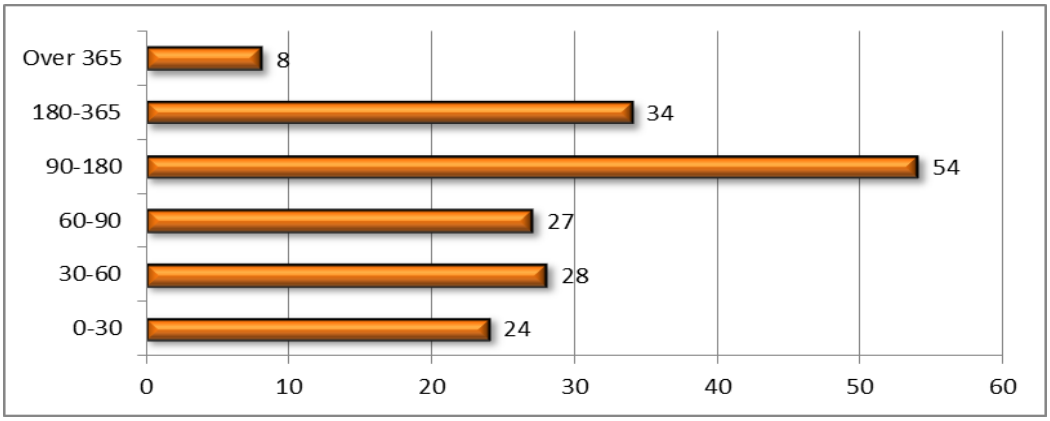
The average time taken to finalise complaints in 2013/14 remained reasonably consistent with previous years despite the increase in complaint numbers. Again in 2013/14 the mandatory consultation between the Boards and HCSCC has added to the time taken to finalise complaints that involve a registered provider.

Figure 12: Time Taken to Finalise Complaints 2013/14 (Average Days)



In 2013/14 74% of complaints were closed within 180 days. The benchmark for closure within 180 days is 80%.

Figure 13: Time Taken to Finalise Complaints 2013/14 (Total Days)



Website

Anyone can access the HCSCC through our website at www.hcscc.nt.gov.au. Our site has links to our complaint form, information (including the latest Annual Report and brochures), and our legislation, and aims to allow people to find answers to questions without the need to contact the HCSCC directly. The number of visits to our website over the past year is set out below.

Table 7: Website Access 2010/11 – 2013/14

Year	2010/11	2011/12	2012/13	2013/14
Total Visits	2017[1]	3157	2956	3802

Fifteen percent (15%) of complaints were received electronically in 2013/14, the same percentage as 2012/13. This compares with 13% in 2011/12 and 6% in 2010/11.

[1] There were no figures available for a number of months in 2010/11 and therefore this number is unreliable.

Investigations

The Commissioner may decide to investigate a complaint where it is complex or raises significant issues of public health or safety, or public interest. Investigation is a formal process during which the Commissioner may interview people involved and seize documents.

One of the main aims of an investigation is to look into systemic issues and identify areas for service improvement. At the conclusion of an investigation the Commissioner will make findings and may make recommendations for action or change.

Where a recommendation is made, the party concerned will be advised of the recommendations and reasons for the decision and required to advise the Commissioner of action that has been, or will be, taken to comply with the recommendation. If the Commissioner is not satisfied that appropriate steps have been taken in relation to a recommendation, the Commissioner may provide the Minister with a copy of the report and it will then be tabled in the Legislative Assembly.

Where recommendations are accepted and action plans put in place to address them, the HCSCC regularly monitors implementation of the recommendations to ensure that undertakings are met and improvements made.

Five investigations were completed in 2013/14, some of which are detailed below. Thirty one recommendations were made as a result of these investigations.

Fifty-nine recommendations arising from 11 separate investigations were subject to implementation monitoring in 2013/14, with 40 of those closed in the reporting period.

Overview of Investigations

Electronic Prescriptions in Remote Communities

A complaint was received in late 2011 alleging that there had been a failure in the electronic medication management systems in remote NT, resulting in many people not receiving their regular medications. It was suggested that there had been significant adverse outcomes for a number of patients as the result of this, including the possible death of two people. The complaint further alleged that the issues were ignored when initially raised, and that action taken to address the issues was inadequate.

The investigation was completed in 2013 and made a number of findings and recommendations.

In summary the investigation concluded that the system itself did not “fail” as it was operating exactly as intended. Instead the investigation found that the system, designed for an acute hospital setting, was not immediately suitable for the remote, primary care services in the NT as it did not meet the needs and expectations of practitioners in remote communities.

In a hospital environment patients are prescribed medications for a short time as people generally do not stay there for lengthy periods. In a primary care setting, patients often stay on the same medications for long periods of time, requiring repeated prescriptions. The system, designed for hospital settings, encouraged doctors to enter an end date for the prescription. Once that end date was reached, the prescription disappeared from the main

view and moved instead to the medication history screen. This behaviour, combined with the fact that many practitioners were not considering full medication history screen when seeing patients or reviewing files, meant that in many cases prescriptions were not renewed and so patients did not get their medications.

Having identified the problem, the impact was considered. While there were therapeutic gaps found in a number of cases, with deterioration proven in 15, none were identified as "sentinel" events. No evidence was found to demonstrate that there were any deaths directly related to the medication management issue. Despite this, it is clear that the outcomes in this matter could have been much worse, with more harm and more serious consequences.

The HCSCC found that the issue described above was first raised in 2009 but that concerns raised at that time were simply not taken seriously enough. No effective remedies were put in place until this matter was raised again in 2011. In addition to concerns regarding responsiveness, the investigation identified additional issues with evaluation of risk and lack of clinical involvement in system development and oversight.

Despite finding that there was no evidence of ongoing risk to public safety in this matter, the HCSCC identified a need to ensure continuous, systematic evaluation of electronic systems to ensure quality can been guaranteed and incidents such as this not repeated. Staff must be encouraged to raise concerns, and have confidence that their concerns will be heard and acted upon; with any required modifications made in a timely manner and accompanied by training where required.

Finally the investigation considered communication. The HCSCC found that frank and open discussions with affected patients about what had happened did not always occur in a timely manner. This was due in part to the lack of a relevant policy on Open Disclosure, and the perceived need for training before discussions could occur. The delayed, disorganised approach to Open Disclosure is of great concern and indicative of issues seen more broadly in health care settings.

Following the conclusion of the investigation a number of recommendations were made regarding the future selection of systems that are fit for purpose with focus on safety; integration of clinical leadership in all strategic decision making regarding clinical information systems; review of contractual arrangements to ensure safety issues are addressed as a priority; development and updating of Open Disclosure policies, including a policies specific to large scale events and remote communities; improved training on Open Disclosure; legislative amendment; and implementation of clinical safety management systems. Implementation of these recommendations is now being monitored.

Admission to Mental Health Facility

Concerns had been raised about the mental health of a woman when she appeared to unreasonably refuse treatment for herself and her baby soon after giving birth. The woman was subsequently evicted from hospital and agreed to admission to a mental health inpatient ward, stating that she did so on the basis that this would allow her to continue to breastfeed and bond with her baby. The woman complained to the HCSCC that she had not consented to a voluntary admission under the Mental Health and Related Services Act (MHRS Act).

The HCSCC found that the woman was admitted to the inpatient ward for two reasons: to allow for further observation to properly diagnose any mental health condition that might be present; and to allow her to remain in close proximity to the hospital to breastfeed her baby. The HCSCC found however that the admission was not a voluntary admission in accordance with the requirements of the MHRS Act.

In order to admit a person as a voluntary patient to a psychiatric inpatient unit, a number of conditions must be met, chief amongst which is the need for the person to give informed consent to admission and treatment. Section 7 of the MHRS Act outlines conditions which must be met in order for informed consent to be given. These conditions include the requirement that consent must be freely and voluntary given without any inducements being offered. The person must be able to understand the effect of giving consent and communicate this by signing the required form. Before admission, the person must be given a clear explanation about the assessment, possible diagnosis and nature of proposed treatment; an adequate description of its risks and benefits; and advice about the risks and benefits of alternative treatments. The person must be advised that treatment may be refused or consent withdrawn at any time; be provided with information about rights of review and appeal under the MHRS Act; and given adequate time to consider the information being given.

The HCSCC found that the first condition required to give informed consent to admission and treatment was not met and that the woman was therefore induced into transferring to the psychiatric inpatient unit. The basis for this finding was that the woman agreed to admission only so she could be close to, and continue to breastfeed her baby. She did not agree that she had a mental illness which required assessment and treatment and her agreement to admission was not for the purposes set out in the MHRS Act.

The Department of Health did not agree with the HCSCC finding in this regard, however recommendations regarding the need for training regarding legal implications of instructions in medical records, requirements for informed consent, and pathways for voluntary and involuntary admission in accordance with the MHRS Act were accepted.

Complaint Handling in Community Organisation

The complainant alleged that a community organisation stopped providing respite service after he complained about the quality of that service. The complaint assessment indicated that there may be systemic issues with respect to the organisation's complaints handling policy, procedures and practices, and the matter was referred to investigation.

Complaint files held by the organisation were audited and compared with the relevant organisational complaint policy and procedures. In order to rate the quality of complaints practice, the HCSCC developed a model best practice complaint system by researching current Australian literature on complaints handling in human service organisations and combining that with HCSCC knowledge and experience.

The HCSCC found that in the past, the organisation had not followed its own policy and procedures; complaints practice was not impartial, objective or fair; documentation was poor; and staff at all levels in the organisation lacked complaint management skills. Complaint files indicated that practice had improved over the past 18 months, however there were still problems with fairness and transparency of process.

In comparing the organisation's current policy and procedures to a best practice complaints system, the HCSCC found that many of the required elements of a best practice complaints handling system were captured in policy and procedures, but that this needed to be embedded in practice.

The organisation agreed to HCSCC recommendations which included updating current policy and procedures to place a service quality framework at the front of the complaints policy; and include fairness and confidentiality principles in the complaints handling policy and procedures as stand-alone principles. Further, it was recommended that parties to the complaint be actively and transparently involved in the complaint process; and on closing the complaint, be informed of the right to have the handling of the complaint reviewed by an external organisation. Finally, it was recommended that all staff receive training in the importance of complaints to quality services as well as in how to properly manage complaints.

Ongoing Investigations

Investigations currently underway at the HCSCC and expected to be completed in 2014/15 cover topics including:

- Discharge processes;
- Choice and control in selection and oversight of disability services;
- Use of restraint in correctional services and acute settings;
- Management of high risk pregnancies;
- Access to medical services for women in prison;
- Management of mental health client in community.

Public Awareness & Engagement

Aside from complaint handling and resolution, other key functions of the HCSCC include promotion of the rights and responsibilities of both service users and providers, promotion of effective complaints systems, and provision of information, education and advice about the *Health and Community Services Complaints Act*, the Code and complaint resolution.

In 2013/14 the HCSCC continued to work closely with a number of different organisations, providing training, information sessions, and workshops, and delivering presentations. Our efforts included:

- participation in **six public education events**, including Seniors' Month (Alice Springs) and Disability Awareness Week stalls;
- **delivery of training** in complaints resolution to nursing and clinical management teams, as well as other independent offices;
- **fifteen information sessions** in a variety of legal, council, health and disability settings; and
- presentations to health and disability **conferences** in the NT and interstate, including the NDS National Conference in Darwin, and the 4th annual Healthcare Complaints Conference in Sydney.

In addition team members from the HCSCC met with a variety of organisations one-on-one to promote our services and complaints resolution generally. These organisations included remote health providers, legal organisations, disability providers, NT Medicare Local, local councils, Integrated DisAbility Action, Disability Advocacy Service, Community Visitor Program, National Disability Insurance Agency, Medical Board, Nursing and Midwifery Board, AMSANT, and National Disability Services (NDS).

Through the bi-annual Disability and Health Commissioners' meetings, the Commissioner met with representatives from the Productivity Commission, Medical Defence Association, AHPRA, the Australian Commission on Safety and Quality in Healthcare (ACSQHC), Aged Care Complaints Scheme, and experts on the use of psychotropic drugs in nursing homes.

In May 2014 the Deputy Commissioner hosted the annual Complaint Managers' meeting in Darwin. The agenda focussed on issues referred to Complaint Managers from Commissioners' meetings and complaint management topics common to all jurisdictions.

In addition to the face-to-face work that was undertaken by the HCSCC, we have also distributed over 400 brochures and posters to a range of health and disability organisations in the NT.

Planning, Development and Review

Planning

The 2013 – 2015 HCSCC Strategic Plan focuses on three main objectives of the HCSCC, being resolution of complaints, improvement of services and promotion of rights, as well as the governance or internal workings of the Commission. We continued to work towards the goals set out in that plan in 2013/14, as well as updating the plan through our regular review process. Some of our achievements from 2013/14 are set out below:

Resolution

- Completed a review of the informal complaint handling system resulting in guidelines and consistency in reporting;
- Conducted a review of the way we conduct assessments, including file allocation and report writing, which should result in a more streamlined process;
- Completed further training in resolution skills.

Improvement

- Utilised the systemic issues register to assist in identification of issues requiring investigation;
- Our new electronic feedback tool commenced;
- Training on complaint resolution skills and processes delivered to service providers.

Rights

- Continued to work on increased engagement with remote NT;
- Delivered training on National Disability Standards (Rights and Feedback and Complaints) in Tennant Creek and Katherine in conjunction with NDS;
- Delivered key note address on Preventing and Responding to Abuse and Neglect in Disability Services at NDS Zero Tolerance Forum in Darwin;
- Presentation on Dignity of Risk at NDS National Conference in Darwin.

Governance

- Training in areas of complaint resolution, procedural fairness, preparation for conciliation, active listening completed;
- Consistent data entry rules developed and implemented;
- Template letters reviewed and improved;
- Security review completed and recommendations implemented;
- Work on the development of new electronic complaints management system commenced.

Quality

The best way to know about the quality of the service to the HCSCC is to ask the people who use HCSCC services: people who make complaints, their representatives and the people who provide the services that are complained about.

All parties to a formal complaint are provided with a survey asking whether they agree with a series of statements. They are given five options – Strongly Disagree with the statement, Disagree, No Opinion, Agree, Strongly Agree. When measuring responses, 5 points are awarded for Strongly Agree, 4 points for Agree and so on. Statements are framed so that 5 points indicates a positive response, and 1 point (Strongly Disagree) indicates a negative response. In tables 8, 9 and 10 below, average scores out of 5 are expressed as a percentage.

Commencing mid-March 2014, we trialled an on-line survey format, sent to parties who had their contact with the HCSCC resolved as an enquiry as well as to parties to formal complaints. People without an e-mail contact are still sent a hard copy survey in the mail.

When introducing the new survey, the HCSCC took the opportunity to review the survey questions. For this reason, outcomes from the survey are reported below as outcomes before the new survey (up to March 2014) and outcomes after the new survey was introduced.

Table 8: Survey Responses 1 July 2013 – March 2014 (Average Scores).

Measure	Complainants (5 responses)	Providers (4 responses)
Accessibility	92%	83%
Timeliness	89%	85%
Fairness	90%	90%
Independence	86%	90%

Table 9: Survey Responses Complaints: March 2014 – 30 June 2014 (Average Scores)

Measure	Complainants (8 Responses)	Providers (5 Responses)
Staff	97%	92%
Complaint Process	96%	90%
Complaint Outcome	94%	86%
Overall Satisfaction	93%	84%

Table 10: Survey Responses Enquiries: March 2014 – 30 June 2014 (Average Scores)

Measure	Complainants and Providers (6 Responses)
Staff	89%
Enquiry Process/Outcome	84%
Overall Satisfaction	88%

In response to a new survey question which asks: "Did the complaint/enquiry lead to an improvement in service?", 73% of people involved in complaints, and 67% of those involved in enquiries stated that there had been a service improvement as a result of the complaint/enquiry.

The increase in responses to the electronic survey appears to show that this is a more effective way of obtaining feedback. For the first time, the HCSCC is also able to report on people's experience of the enquiry process.

In addition, those people who prefer to provide feedback in writing, or who wish to provide feedback in addition to completing the survey are able to do so via a new feedback email address: hcsccfeedback@nt.gov.au.

Case Studies

The case studies detailed below represent a cross section of the types of matters that were finalised in 2013/14. The examples have been modified to remove identifying features.

Enquiries

Staff Turnover Affecting Disability Service Provider

Shirley and her husband receive home help services from a disability provider. Shirley contacted HCSCC as she was not satisfied with their services.

Shirley said that the service is okay when the permanent staff attend her home to carry out the tasks as they are aware of what needs to be done, however, when new staff are sent out, they do not know what jobs they need to do and she needs to instruct them.

Shirley had contacted the service provider to voice her concerns but said that they seemed uninterested and unwilling to help.

The complaint was resolved when the HCSCC contacted the provider to discuss Shirley's issues. The provider stated that there had been high staff turnover which was the reason some of the new staff were unaware of tasks required by them. This information was passed onto Shirley and it was suggested that she wrote out a list of how she wanted the staff to complete the jobs.

Shirley was very glad that her concerns had been addressed and was willing to try being patient with the new staff.

This matter was resolved.

Refund for Patient after Poor Treatment Coordination

Maureen was unhappy with the level of service and professionalism she had experienced from a medical service provider.

Maureen was required to have some tests done and was given a number to call to receive the results.

After calling this number and leaving a voicemail regarding her medical information, it came to her attention that this was in fact a residential number. Maureen rang the provider and expressed her concerns that her confidentiality had been breached as she had left a message on the answering machine. She reported that the staff member did not appear concerned about the issue and reported that that was the number that was always given.

Maureen decided to make an informal complaint to HCSCC to ensure that her matter was resolved and that other patients did not experience the same poor co-ordination.

The HCSCC contacted the service provider and they undertook to look into the issue to ensure that the correct phone number was given in the future. The service provider issued a gift card to Maureen as an apology and the complaint was resolved.

Attitude and Manner at the Dentist

Sandra took her father to the dentist to have some dental work done. Sandra was unimpressed with the dentist's attitude and manner toward her father and contacted HCSCC to raise her concerns.

As Sandra's father is old and frail, he could be hard to understand at times and when he was explaining to the dentist what was wrong with his tooth she became annoyed and rudely told him to tell his daughter so she could understand what he was saying.

The HCSCC contacted the dental surgery via email to raise Sandra's concerns. The dentist who had been working on Sandra's father identified that she needed to work on her communication skills and she apologised to her patient.

Sandra was happy with the outcome and the matter was closed.

Patient Information

Sarah took her son to the doctors for a possible sprained ankle and was referred for x-rays to ensure it was not broken. Sarah was concerned that the x-ray results were not given to her over the phone and that she was advised by a new staff member that she was required to book an appointment to discuss the results and treatment, which she believed was an unnecessary cost.

Sarah went ahead and booked the appointment as directed, however when she attended with her son, she was told that he had been confused with another patient, there was no break and therefore no reason for the consultation as no treatment plan was needed.

Upon consulting HCSCC with her concerns, Sarah opted for a resolution that enabled her to gain an explanation and understanding of why this issue had risen.

The SIO contacted the practice manager and was advised that Sarah had not received the results over the phone due to the clinic's privacy policy. It was also discussed that patients are only to be contacted if there are any concerns with results and are able to discuss at their next consultation. The practice manager apologised for the inconvenience and stated that the policy will be reinforced so this does not occur again.

Billing Awareness

Paul attended an appointment at the podiatrist for some orthotics to be made. The consultation and cost of the orthotics left him $350 out of pocket. When Paul was notified that they were ready, he was required to book yet another appointment costing him a further $60.

Paul contacted HCSCC and advised that he was unaware of the additional costs and the requirement of having to make an appointment as he believed he should be able to just pick them up. He simply could not afford the additional consultation.

The SIO contacted the podiatrist and was advised that the appointment was necessary to have the orthotics fitted and to ensure there were no issues. Paul would also be able to receive Medicare assistance.

Paul was thankful that the matter was resolved and suggested that customers should be made aware of all costs.

Limited Access to Facilities

Margaret tried to place an order over the phone for some medical aids but the supplier was reluctant to take the order. They informed Margaret that she was required to place the order either in-store or via the internet. As Margaret had a mobility impairment and did not have the internet at her home, neither of these options were suitable.

The HCSCC contacted the supplier and was informed that they were aware of the situation. They explained that they prefer written requests in order to prevent errors and that they maintain a list of customers who are able to place orders over the phone. Margaret was on this list, however the staff member who took Margaret's call was a trainee and not aware of the process.

Margaret was able to place her order over the phone, the training was reviewed and special needs were accommodated. Margaret was happy with the outcome and the explanation.

Physical Environment of Facility

Liz was sent to hospital requiring treatment, however, when she arrived she was told they were too busy to look after her. She had to wait for hours before being put in a shared cubicle.

Liz felt both her privacy and her confidentiality had been breached as the doctor conducting an examination and discussed her personal medical records in the shared cubicle.

The HCSCC made enquiries about why Liz, as well as other patients, had been put in this situation. The hospital explained that it was overcrowded that day and the only way to manage all patients was to have more than one in each cubicle. The provider agreed that this caused concerns for patient privacy and confidentiality but stated that this did not happen often.

Liz's enquiry raised awareness of privacy concerns and staff were reminded to take more care in situations such as this in the future.

Service Availability

Jane and her husband live in a remote area of the NT. Jane's husband has a heart condition and she is concerned that the ECG machine at their local medical clinic has broken down. Jane approached the clinic to find out when the machine would be repaired or replaced but they told her they did not know.

The HCSCC contacted the clinic manager to discuss the issue. The general manager stated that remote areas are priority for replacement machines, however it would take 3 months for it to arrive. Arrangements were being made for a temporary machine to be loaned to the clinic, and it was expected to arrive within a fortnight.

Jane was very happy to know what was happening. The enquiry was closed.

Assessments

Timing of Diagnosis - No Further Action

Albert complained that he had recently been admitted to hospital for treatment of a serious infection which he says should have been diagnosed earlier by his GP. He said he went to see the GP about his concerns but the GP did not listen to him and did not make a diagnosis.

HCSCC obtained medical records of GP presentation and a response from the GP. Advice was also sought from a clinical advisor in relation to the timing of diagnosis.

The advice received indicated that when Albert saw his GP the wound was in the early stages of infection and there was no danger to the patient at that point. According to the advisor, the treatment and original diagnosis did not raise any concerns.

In relation to the complaint that the GP did not listen to Albert's concerns, the Commissioner noted that there were differing views about the tone and content of the discussion between the doctor and the complainant. The doctor apologised to Albert for the misunderstanding and as nothing further would be gained from further investigation, no further action was taken.

Incorrect Prescription – Referral to the Board

Ms Brown lodged a complaint with the HCSCC after she visited the chemist to have a prescription filled. Mrs Brown had been taking 250mg tablets however the pharmacist dispensed a box of 500mg tablets, with a printed label stating that the tablets were 250mgs stuck to the box. Fortunately Ms Brown recognised the error prior to taking any of the tablets.

As the complaint presented a potential public safety risk, the apparent error and conduct of the pharmacist who dispensed the medication was referred to the Pharmacy Board for investigation.

Waiting Time for Child – Concerns Registered

Claire took her young child to the Emergency Department after she cut herself in a fall at home. Claire lodged a complaint with the HCSCC as she had to wait four hours for attention, during which time the wound was not washed or assessed. When the child was seen, they were sent away again as she was told that a general anaesthetic would be required to stitch the wound and this would not be possible until the next day.

Enquiries into the complaint indicated that the waiting time was within the expected parameters, but that as the family had private health insurance, they could have been sent to a private practice for attention at a much earlier stage. The provider conceded that this was the case and undertook to reinforce the need to seek this information from people attending ED.

Concerns about lengthy waiting times for young children was raised with the provider for consideration and placed on the systemic issues register.

Inadequate Monitoring – Referral to the Board

A complaint was lodged on behalf of Didi who was admitted to hospital for treatment of an abscess. Didi underwent surgery to treat the abscess, however post-surgery she experienced a severe drop in blood pressure, resulting in adverse outcomes for her.

Enquiries were made into the complaint, with records appearing to show that Didi was not properly monitored for a period of 45 minutes after the surgery finished. As a result it appeared that the drop in her blood pressure was not recognised in a timely manner and she had a heart attack.

The conduct of the practitioner who is ultimately responsible for the patient after surgery was referred to the relevant Board for further investigation. That investigation is still underway.

The assessment of the complaint also identified concerns with the information provided to Didi and her family about the incident. Records from discussions between the hospital and Didi's family do not appear to demonstrate that appropriate open disclosure processes were followed: no explanation of the event is recorded; the records do not note any apology and do not indicate that this was an avoidable event. In addition it appears that appropriate incident reporting did not occur in this case.

This information was provided to the family who are now seeking further discussions with the hospital and legal advice.

Communication Concerns – Resolved

Mr Edgar was an elderly man who was admitted to hospital with a serious infection. While in hospital Mr Edgar had a stroke and later died. Mr Edgar's family lodged a complaint as they believed that the stroke was caused by a medication error. They were also upset that they were not contacted by the hospital as soon as the stroke occurred, meaning that Mr Edgar passed away without his family by his side.

A review of the medical files and other documentation indicated that Mr Edgar did have a stroke and that no medication error had occurred. The records also indicated that attempts had been made to contact family members as soon as Mr Edgar had a stroke, without success. The hospital staff assured the family that in their view Mr Edgar was not in pain at the time of his death.

The family accepted the explanation and the complaint was resolved. The family's suggestion that an Aboriginal Liaison Officer should have been available to Mr Edgar during his stay in hospital was raised with the hospital for consideration.

Clinic Procedures – Improvements Made

In 2013 the Medical Board referred concerns about the referral processes at a NT GP clinic to the HCSCC for assessment. The two issues raised were the adequacy of follow up procedures when a patient is referred to a specialist for urgent assessment; and the sharing of information between GPs at the clinic.

As part of the assessment, the HCSCC discussed the concerns with the clinic manager. In light of the concerns the clinic put new procedures in place to ensure that referrals are followed up in the future. In relation to information sharing, the HCSCC noted that the clinic used an electronic records system which should be sufficient to ensure that information is

accessible to all practitioners. To ensure that the doctors were using the system effectively, this issue was placed on the agenda for discussion at the next practice management meeting.

The Commissioner determined to take no further action on the matter as the issues were addressed by the clinic.

Communication during Delivery – Referral and Orientation

Fran gave birth at a NT hospital and made a number of complaints about her experience. She complained that the doctor who attended her birth did not pay any attention to her birth plan or preferences and made decisions about how the birth would proceed without involving her. Fran said that this had made her experience a difficult and distressing one, instead of the happy experience she had hoped it would be.

Enquiries into the complaint were made and revealed that proper consent was not sought or obtained during the birth, and communication between the practitioner and the patient was not adequate. The enquiries also showed that the doctor was new at the hospital and that the hospital's orientation processes were not sufficient to support him.

The conduct of the practitioner was referred to the Board for investigation. The concerns about the hospital's orientation procedures were raised and improvements are being monitored.

Repeated Concern – Direct Resolution

George's niece lives in supported accommodation in the NT. George has previously made a complaint to the HCSCC about services delivered by the disability provider, including lack of social and other activities. The previous complaint was resolved with an agreement between the provider and George. He contacted the HCSCC again this year with concerns that the agreement was not being implemented.

Enquiries were undertaken and found that there had been a change in staff at the accommodation in recent times and they were not aware of the previous agreement. This was raised with management who agreed to discuss the matter directly with George. The complaint was closed on the understanding that George could come back to the HCSCC if he has further concerns in the future.

Access to Treatment - Monitoring

Harry, an inmate at a NT Correctional Centre, complained that he has a chronic medical condition and has not been able to see a doctor to have his condition assessed. Harry says that he has submitted numerous medical request forms, and while he saw a doctor once, there was no follow up or discussion about ongoing management.

The issue was raised with the Corrections Medical Centre and a response sought. In the meantime, Harry was seen by a doctor again and his concerns resolved.

The complaint was closed, but the issue of delay in accessing medical treatment was placed on the systemic issues register for further monitoring.

Conciliations

The Real Issue was not the Complaint

A man complained that there was a problem with the equipment used for IV fluids given to him during and after surgery, stating that as a result he experienced considerable pain in his arm after discharge from hospital. It was determined that the matter would be referred to conciliation, so that the complainant could be given an explanation about the problems with equipment, and staff from the hospital could understand the effect the equipment failure had on the complainant.

During the conciliation, it became apparent that the reason for the man's complaint to the HCSCC was that he had heard staff talking soon after his surgery, and believed that there had been an incident during his surgery which might have been catastrophic for him. As a result, he had not been able to sleep, and had become quite anxious since his discharge from hospital. While the issue with the pain in his arm was a real one, it was not the main cause of concern for him.

The anaesthetist explained that there was an incident, but that it was not unusual and not dangerous. However, it was agreed that a checklist used by surgeons to discuss what happened during surgery would be updated to ensure that any anaesthetic incident would be discussed with the patient after surgery so that other people would not have this experience. An apology was also provided to the complainant and accepted by him.

Admission to Residential Facility

A complaint was received from a woman whose brother needed to move into supported accommodation but was not accepted by the residential facility. The facility had a rule that all new residents must have a GP who was willing to visit them there. The man's GP had refused to agree to provide this service.

The complaint was referred to early conciliation after the HCSCC assessment indicated that the complaint could be quickly and satisfactorily resolved. The conciliation conference was held at the residential facility with the manager of the facility, the complainant and the GP in attendance. Following discussion of the issues, it was agreed that the GP would attend the facility, and arrangements were made that day to allow relationship between the facility and the GP to be maintained. The woman's brother was moved to the residential facility the following day.

Consumer Voice Contributes to Holistic Care

The complainant, who is living with a life threatening illness, contacted the HCSCC because she wanted to receive a higher quality, more personal service from her provider.

The woman acknowledged the high quality clinical service provided to her, but stated that because she suffers from a rare disease, pathways of care were not well established. In particular, she complained that co-ordination of care was poor, there was minimal communication between the treatment service and her GP, and her personal needs arising from the diagnosis and treatment of her disease had not been well catered for over time.

This complaint was referred to conciliation after assessment. The complaint was deemed suitable for early conciliation because the complainant's focus was on service improvements to ensure others did not share her experience.

One outcome from the conciliation was the inclusion of the complainant as a consumer representative on a number of advisory committees to ensure that a consumer voice is heard in provision of services for people living with diseases similar to her own. Improved pathways of care were established, meaning that the complainant was now aware of the steps in her ongoing treatment, and her GP was more involved. A commitment was also made by the service to increase focus on the mental health needs of people with the complainant's illness.

Service User Control in the Choice of Disability Services

A woman with profound physical disability contacted the HCSCC complaining that she was dissatisfied with the services she was receiving from her disability provider. She also complained that she wanted to be able to control her own funding package; that is she thought she should be able to make her own decisions about what agency would provide the services she needs to live independently, and what those services would be. She stated that the Office of Disability, who are responsible for tendering out her services, would not allow her to choose her disability service provider.

The complaint was referred to conciliation so that the issues raised by the complainant could be fully discussed. As she had no disability provider at the time, the woman was in hospital, and the conciliation, attended by the complainant, her support person and staff from the Office of Disability was conducted in the hospital.

It was agreed at conciliation that the Office of Disability would keep the HCSCC informed of progress in negotiating a new package for the complainant. Monthly updates were provided to the HCSCC and contact was maintained with the complainant. The complainant has now been discharged from hospital with the provider of her choice providing her care.

Maintaining Relationships with Disability Providers

An elderly woman is cared for by her daughter in her own home, with respite services provided by the local disability provider. The daughter complained that it was not unusual for the carer not to turn up to take her mother out, and when this happened, no one let her know. As a result her mother, who looked forward to the outings, was often disappointed, and the complainant could not make plans her own plans.

The complaint was referred to early conciliation so that relationships between the client and provider could be maintained. Each issue was resolved at conciliation, with the provider agreeing to pay for additional staff to attend to the complainant's mother and for processes to be put in place to increase reliability of carers and agency communication with the family.

Appendix 1: Breakdown of Complaint Issues

Tables 10-21 provide further breakdown of the content of each of the major issue categories. Four issues were determined to be out of jurisdiction, and are not detailed in the tables below.

Table 11: Access Category

ACCESS	2010/11	2011/12	2012/13	2013/14
Access to facility	0	0	1	0
Access to subsidies	0	0	1	0
Refusal to admit or treat	3	4	5	8
Service availability	7	1	6	12
Waiting list delay	1	2	3	5
Total	**11**	**7**	**16**	**25**

Issues relating to access made up 7% of all issues raised in complaints in 2013/14.

Table 12: Communication & Information Category

COMMUNICATION & INFORMATION	2010/11	2011/12	2012/13	2013/14
Attitude and manner	18	12	20	38
Inadequate information provided	4	7	12	16
Incorrect/misleading information provided	1	1	2	4
Special needs not accommodated	2	0	4	3
Total	**25**	**20**	**38**	**61**

Issues relating to communication and information made up 18% of all issues complained about. This is consistent with last year's figures.

Table 13: Consent Category

CONSENT	2010/11	2011/12	2012/13	2013/14
Consent not obtained or inadequate	2	4	3	9
Involuntary admission or treatment	3	2	0	2
Uninformed consent	0	0	1	1
Total	**5**	**6**	**4**	**12**

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

Table 14: Discharge & Transfer Arrangements Category

DISCHARGE & TRANSFERS	2010/11	2011/12	2012/13	2013/14
Delay	1	0	0	1
Inadequate discharge	5	0	6	3
Patient not reviewed	1	0	1	1
Total	**7**	**0**	**7**	**5**

One per cent of issues raised in 2013/14 related to discharge and transfer arrangements.

Table 15: Environment & Management of Facility Category

ENVIRONMENT & MANAGEMENT	2010/11	2011/12	2012/13	2013/14
Administrative processes	2	1	4	3
Cleanliness/hygiene of facility	1	2	2	0
Physical environment of facility	0	1	0	2
Staffing and rostering	1	1	2	6
Statutory obligations/accreditation	1	1	2	3
Total	**5**	**6**	**10**	**14**

Complaints in this category relate to administration rather than the care/treatment component of the service. These issues made up 4% of all issues raised in complaints.

Table 16: Fees, Cost & Rebate Issues Category

FEES, COSTS & REBATES	2010/11	2011/12	2012/13	2013/14
Billing practices	3	0	1	7
Cost of treatment	2	1	0	0
Financial consent	0	0	1	0
Total	**5**	**1**	**2**	**7**

Issues relating to cost of service constituted 2% of issues in complaints finalised.

Table 17: Grievance Category

GRIEVANCE	2010/11	2011/12	2012/13	2013/14
Inadequate or no response	2	2	6	5
Complaint information not provided	0	1	1	0
Reprisal/retaliation as a result of complaint lodged	0	0	2	0
Total	**2**	**3**	**9**	**5**

Issues of grievance and complaint handling made up 1% of all issues complained about, a decrease from 4% last year.

Table 18: Medical Record Category

MEDICAL RECORDS	2010/11	2011/12	2012/13	2013/14
Access to/transfer of records	2	0	0	2
Record keeping	1	2	6	5
Record Management	0	0	1	1
Total	**3**	**2**	**6**	**8**

The medical record category includes complaints about errors and inadequacies in medical records. They accounted for 2% of all issues complained about in 2013/14.

Table 19: Medication Category

MEDICATION	2010/11	2011/12	2012/13	2013/14
Administering medication	2	2	5	7
Dispensing medication	2	0	4	3
Prescribing medication	4	6	6	6
Supply/security/storage of medication	1	2	2	3
Total	**9**	**10**	**17**	**19**

Medication related concerns made up 5% of all issues in 2013/14, down from 8% last year.

Table 20: Professional Conduct Category

PROFESSIONAL CONDUCT	2010/11	2011/12	2012/13	2013/14
Assault	1	1	2	12
Boundary violation	1	7	4	5
Breach of Condition	0	0	0	2
Competence	17	21	20	60
Discriminatory conduct	0	0	2	5
Emergency treatment not provided	1	0	0	0
Financial fraud	1	1	0	1
Illegal practice	0	5	6	14
Impairment	0	1	3	1
Inappropriate disclosure of information	1	1	8	12
Misrepresentation of qualifications	2	0	1	4
Sexual misconduct	0	0	4	1
Total	**24**	**37**	**50**	**117**

Issues relating to professional conduct made up 34% of all issues complained about. As noted above, the majority of these matters were dealt with in conjunction with AHPRA in accordance with the consultation requirements under the National Law. More than half of the complaints in this category relate to concerns regarding the competence of the provider. Where these allegations relate to the conduct of a registered provider, they are likely to be referred to the relevant National Health Practitioner Board for consideration.

Table 21: Reports/Certificates Category

REPORTS/CERTIFICATES	2010/11	2011/12	2012/13	2013/14
Accuracy of report/certificate	1	0	2	3
Inadequate/no consultation	0	0	0	1
Timeliness of report/certificate	1	0	0	0
Total	**2**	**0**	**2**	**4**

Complaints about reports and certificates made up 1% of issues in complaints closed in 2013/14. It should be noted that the HCSCC has no jurisdiction over the process of writing, or the content of, a health status report.

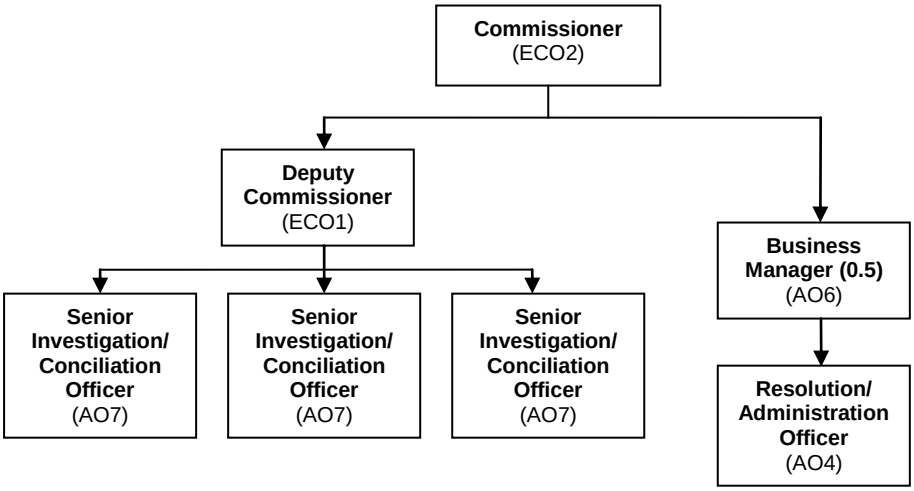
Table 22: Treatment Category

TREATMENT	2010/11	2011/12	2012/13	2013/14
Attendance	0	0	0	1
Coordination of treatment	2	3	1	11
Delay in treatment	3	2	1	9
Diagnosis	7	12	8	12
Excessive treatment	0	0	3	0
Inadequate consultation	0	1	0	4
Inadequate treatment	12	9	7	17
Infection control	0	0	2	2
No/inappropriate referral	1	2	4	0
Public/Private election	0	0	2	0
Rough & painful treatment	4	0	0	1
Unexpected treatment outcome	4	8	8	4
Withdrawal of treatment	2	2	3	1
Wrong/inappropriate treatment	5	5	2	9
Total	**40**	**44**	**41**	**71**

Issues relating to treatment constituted 20% of all issues in complaints closed in 2013/14, with inadequate treatment identified as the primary concern within this category.

Appendix 2: Organisation

The HCSCC receives support from the Department of Attorney-General and Justice in areas such as human resources, finance, procurement, record management and information technology. The HCSCC is co-located with the Office of the Children's Commissioner. The organisational structure of the HCSCC is as follows:



The HCSCC has 6.5 full time equivalent staff. The HCSCC shares a Business Manager (AO6) with the Office of the Children's Commissioner.

Table 1: Staffing Profile as at 30 June 2014

Position Level	Male	Female	Total
Commissioner (ECO2)	0	1	1
Deputy Commissioner (ECO1)	0	1	1
Administrative Officer 7 (AO7)	0	3	3
Administrative Officer 6 (AO6)	0.5	0	0.5
Administrative Officer 4 (AO4)	0	1	1
Total	**0.5**	**6**	**6.5**

Vision

Quality health, disability and aged care services delivered equitably to all Territorians.

Mission

Drive improvement by providing accessible, impartial, independent, quality advice, education and complaints resolution.

Our Values

Integrity	impartial, transparent and accountable at all times; fair, ethical, respecting confidentiality.
Respect	person centred, listen, act in a caring manner, value diversity, be reasoned and reasonable.
Professional Excellence	expert, hard working, committed to learning; demonstrating leadership & building relationships.
Responsiveness	accessible, timely, appropriate to need, culturally aware, inclusive, flexible, leading to practical outcomes.
Courage	rights based; act independently and in accordance with the Act; make and communicate decisions.

Contact:

GPO Box 4409
Darwin NT 0801

Level 5, NT House
22 Mitchell Street
Darwin NT 0800

Phone: 08 8999 1969
Freecall: 1800 004 474
Fax: 08 8999 6067

Email: hcscc@nt.gov.au
www.hcscc.nt.gov.au