



hcsc  
health & community services  
complaints commissioner

# Health & Community Services Complaints Commissioner

South Australia

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**Annual Report**

**2014 - 15**

**Annual Report 2014-15**  
Health and Community Services  
Complaints Commissioner

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# Commissioner's Statement

9 September 2015

The Honourable Jack Snelling MP  
Minister for Health  
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Dear Minister

It is my duty and privilege to submit the annual report of the Health and Community Services Complaints Commissioner for the year ended 30 June 2015, in accordance with the requirements of Section 16(1) of the *Health and Community Services Complaints Act 2004*.

This report provides a summary of the activities and achievements for the 2014-15 financial year.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Steve Tully', is written over a light grey rectangular background.

Steve Tully  
**Health and Community Services Complaints Commissioner**

# About this Report

This report records the Health and Community Services Complaints Commissioner's (HCSCC) achievements in contributing to the improvement of the safety and quality of health and community services in South Australia during 2014-15. The report also includes information about HCSCCs statutory obligations and financial position for the year.

The report is a key accountability document and the principle way in which the Health and Community Services Complaints Commissioner reports on HCSCC activities to the Parliament and the South Australian community.

## Case studies

The case studies have been included to demonstrate HCSCC services. The details of some case studies have been changed and all case studies have been de-identified to protect the privacy of HCSCC complainants.

## Making HCSCC accessible

HCSCC is committed to being accessible to South Australians who need assistance with communication and to people from culturally and linguistically diverse backgrounds. HCSCC utilises a variety of support services to enable effective communication with people and the new website, launched in 2014, has enhanced accessibility features.

If you need assistance to access this annual report, please contact our Enquiry Service on 08 8226 8666 or toll free 1800 232 007 (from a Country SA landline) and HCSCC will arrange the appropriate assistance to share this report with you.

If you are deaf, have a hearing impairment or speech impairment, contact us through the National Relay Service:

- TTY users phone 133 677 then ask for 08 8226 8666
- Speak and Listen (speech-to-speech relay) users phone 1300 555 727 then ask for 08 8226 8666
- Internet relay users connect to the National Relay Service (<http://www.relayservice.com.au/> for details) then ask for 08 8226 8666
- SMS relay for mobile phone users dial 0423 677 767

## Feedback

HCSCC welcomes your feedback on this annual report. Please contact the HCSCC Enquiry Service on 08 8226 8666 or toll free 1800 232 007 (from a Country SA landline), fax 08 8226 8620, email [info@hcsc.sa.gov.au](mailto:info@hcsc.sa.gov.au) or complete the online contact form at [www.hcsc.sa.gov.au](http://www.hcsc.sa.gov.au).

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# 1. Snapshot of the HCSCC

## Our Challenge

To optimise our efforts in responding to complaints across HCSCCs broad jurisdiction with particular effort to support and encourage those who would otherwise be unlikely to complain.

## Our Vision

A complaint is an opportunity to:

- get information about what happened
- redress individual grievance and harm
- uphold the HCSCC Charter of Health and Community Services Rights
- ensure action to improve services and systems.

## Our Values

HCSCC is guided by the following values:

- independence and impartiality
- integrity and professionalism
- accessibility
- a rights based and public interest focus to HCSCC work
- excellence in customer service
- responsiveness to criticism about HCSCC performance.

## Our History

The office of the Health and Community Services Complaints Commissioner is an independent statutory office established by the *Health and Community Services Complaints Act 2004* (the Act). HCSCC opened on 4 October 2005.

HCSCC provides free information and assistance to resolve complaints about public, private and non-government health and community services, including disability and child protection services. HCSCC encourages direct resolution with the service provider first. HCSCC may assist when direct resolution with the service provider would be unreasonable or has not succeeded.

## Our Functions

Section 3 of the Act requires HCSCC:

- (a) to improve the quality and safety of health and community services in South Australia through the provision of a fair and independent means for the assessment, conciliation, investigation and resolution of complaints
- (b) to provide effective alternative dispute resolution mechanisms for users and providers of health or community services to resolve complaints
- (c) to promote the development and application of principles and practices of the highest standard in the handling of complaints concerning health or community services
- (d) to provide a scheme which can be used to monitor trends in complaints concerning health or community services
- (e) to identify, investigate and report on systemic issues concerning the delivery of health or community services.

## HCSCC also:

- promotes and upholds the statutory HCSCC Charter of Health and Community Services Rights
- investigates serious complaints about issues of public interest or safety
- conducts outreach with people who have special needs and their advocates
- provides training to improve the capacity to raise and resolve complaints locally
- promotes and upholds the statutory HCSCC Code of Conduct for Unregistered Health Practitioners.

## 2. History

Some of the key milestones in HCSCCs recent history are listed below.

### June 2015

Completed the two year Supported Decision Making Project and supported an application for further funding from National Disability Insurance Scheme to continue the project.

### June 2015

Successfully completed the project to design and build the new complaints database to go live 3 July 2015.

### April 2015

The Council of Australian Governments' Health Council agreed to implement a National Code of Conduct for Health Care Workers, estimated for implementation in late 2015/early 2016.

### August 2014

Entered into a contract to develop a new complaints database to improve HCSCC reporting on complaints. Expected to 'go live' in July 2015.

### May 2014

Commenced Phase 2 of the Supported Decision Making Project.

### April 2014

Commenced follow up on Coroner's recommendations.

### December 2013

Launched the new HCSCC website.

### December 2013

Established a partnership with Poche (Flinders University of South Australia) to develop an audit tool to assess racism in public health services.

### November 2013

Issued the first public order under the Code of Conduct for Unregistered Health Practitioners.

### August 2013

Commenced the two year Supported Decision Making Project.

### August 2013

Signed a Memorandum of Understanding with the National Disability Insurance Agency.

### August 2013

Reviewed the Memorandum of Understanding with the Aged Care Complaints and Investigation Scheme.

### June 2013

Steve Tully appointed as Health and Community Services Complaints Commissioner for a term of seven years.

### March 2013

The Code of Conduct for Unregistered Health Practitioners came into effect.

### March 2013

HCSCC published public reports on individual service providers and issues of public interest.

### February 2013

Since opening in October 2005, HCSCC has received 10,000 complaints.

### October 2012

HCSCC published an academic paper and undertook other project work focussed on safeguarding of vulnerable people who have a disability.

### July 2012

HCSCC undertook Aboriginal and Torres Strait Islander project work aimed at addressing racism and service coordination in country and remote areas.

### June 2012

Action commenced with regard to the implementation of section 76 of the Act - Returns by prescribed providers and the development of a Code of Conduct for Unregistered Health Practitioners.

### **March 2012**

Leena Sudano completed her contract as the first Health and Community Services Complaints Commissioner.

### **October 2011**

HCSCC was awarded the 2011 South Australian Regional Award Runner Up for Project of the Year at the IAP2 Australasian Core Values Awards. This recognised HCSCCs effort in involving public participation in the development of the HCSCC Charter of Health and Community Services Rights.

### **June 2011**

The HCSCC Charter of Health and Community Services Rights officially came into effect.

### **May 2011**

Statutory review recommendations that required changes to the *Health and Community Services Complaints Act 2004* came into effect in the *Health and Community Services (Miscellaneous) Amendment Act 2011*.

### **December 2010**

Established the statutory Health and Community Services Advisory Council.

### **September 2010**

The HCSCC Charter Consultation Report, including the proposed HCSCC Charter of Health and Community Services Rights was provided to the Minister for Health.

### **August 2010**

HCSCC established a protocol with the Aged Care Complaints Investigations Scheme (ACCIS) about a new complaints scheme for Commonwealth funded aged care services.

### **July 2010**

The *Health Practitioner Regulation National Law (South Australia) Act 2010* came into effect creating a single national registration and accreditation scheme for health practitioners. This created a co-regulatory role for AHPRA and HCSCC.

### **July 2010**

Undertook public consultation on the draft HCSCC Charter of Health and Community Services Rights. HCSCC received a total of 148 written submissions from a range of individuals, groups and organisations.

### **June 2010**

Secured once-off funding from SA Health to undertake a collaborative pilot project with the Council on the Ageing SA (COTA SA) and Health Consumers Alliance SA (HCA) to promote advance care planning and directives in the community.

### **January 2010**

Enabled a Complaint Resolution Officer to work half time on progressing the recommendations of the Ever Felt Like Complaining? Aboriginal and/or Torres Strait Islander Outreach project.

### **December 2009**

Publicly released the Ever Felt Like Complaining? Aboriginal and/or Torres Strait Islander Outreach Project Report.

### **December 2009**

Amendments were made to the *Health and Community Services Complaints Act 2004* including enabling HCSCC to accept complaints directly from a child about a health or community service.

## 3. Commissioner's Overview

### Introduction

This year there have been major developments at national, state and local levels that have impacted on health and community services in South Australia.

### National Level

#### National Disability Insurance Agency

At a national level, plans for the full roll out of the National Disability Insurance Scheme (NDIS) are being developed which complement and supplement South Australia's Disability Plan that clearly indicates ongoing responsibilities for agencies. The notion that the NDIS will take care of all matters associated with the disability sector is clearly incorrect and its context needs to constantly be reinforced.

The role of the state disability agency, the Department for Communities and Social Inclusion is being internally analysed and its services costed and compared with indicative pricing schedules. South Australia has a relatively high level of direct government disability service provision when compared to other states and this adds a special dimension for South Australia in the roll out of services. With the doubling of clients at full roll out, however, clearly workforce development issues for the whole sector remain a most challenging factor.

HCSCC takes a particular interest in matters involving safety and quality and believes that both aspects are inextricably linked. With the transition to the national scheme, there has been significant effort directed towards determining effective safety and quality imperatives. The major points of discussion include the level of incident reporting, the checking of potential staff for suitability to work in the sector, independent complaints handling, advocacy and broader community engagement with scheme participants. Such matters are currently incorporated into state programs and there are Memorandums of Understanding with the National Disability Insurance Agency (NDIA) that provide varied safeguarding and quality arrangements with each state and territory for each pilot site. These programs can stay in place and be evaluated in a timely fashion during

transition. There is no need to rush consideration of these important matters in favour of an immediate consistent national approach.

#### National Code of Conduct for Health Care Workers

Also at a national level, state and territory Ministers have agreed that there is to be a national code that applies to all health practitioners not registered by the Australian Health Practitioner Regulation Agency (AHPRA). Such codes currently exist only in South Australia and New South Wales.

The new national code, which will require some minor legislative amendment in South Australia, will allow for conditions that have been imposed on a health practitioner in one state, by a complaints entity, to apply throughout Australia. The national code is remarkably similar to the one currently applying in South Australia.

#### Independent Review of the Australian Health Practitioner Regulation Agency

Health Ministers also commissioned an independent review of AHPRA and the national law it administers. The review was completed for the April 2015 Minister's meeting and will be considered at the October 2015 meeting. In the meantime the SA State Manager of AHPRA and I have agreed to review our responsibilities in terms of the full agreement under the Memorandum of Understanding and to identify improvements that can be made to inform complainants and notifiers of arrangements that apply and how their matters can move from one jurisdiction to another. The review will also consider matters of timelines and transparency of process.

### State Level

#### Transforming Health

At the state health level, the Minister for Health and Ageing announced major reforms to the state's health system, Transforming Health. The reforms are accompanied by public consultation processes at key milestones and the reform process is seeking efficiencies in order to combat the increasing pressures on the state's

metropolitan hospitals. There is no doubt that the need for reform is urgent and the need to tackle inefficiency has been well articulated.

HCSCC will continue to push the need for a balanced health system that has due regard to primary and preventative health. The need to involve health consumers and consumer organisations will also continue to be reinforced as will the need to provide coordinated care for people with multiple and complex health needs who possibly could be compromised in a system based on speciality.

### **Review of the Mental Health Act**

Of major significance is the fact that the current state Mental Health Act is being reviewed and will involve a further round of public consultation. This piece of legislation provides the framework for treatment, consent and practice for caring for people living with mental illness. HCSCC will monitor in particular how community teams can be strengthened, how services can be strengthened for people (and their carers) living with borderline personality disorder and what measures will be implemented to reduce chemical and mechanical restraint (and other trauma).

### **Child Protection**

In terms of Child Protection, HCSCC has made contributions to the Parliamentary Select Committee on Child Protection and Care and the Child Protection Systems Royal Commission.

HCSCC has also carefully considered the Coroner's report into the death of Chloe Valentine and the implications for the design of Families SA programs.

HCSCC acknowledges the difficult task that faces the child protection workforce and the even more difficult task of children living within families who are dealing with multiple and complex needs.

In such circumstances HCSCC urges that a fundamental revisiting of the social determinants of health and wellbeing is required to consider the factors that lead to children at risk. It is all very well for our community to look at those trying to deal with child abuse and criticise their efforts,

but in HCSCCs view, an effort that balances preventative strategies, intensive support and maintenance support along with broader community involvement is required. HCSCC takes an active interest in Families SA program redesign and notes that it has admirable aims and objectives.

HCSCC also acknowledges the SA Child Protection Systems Royal Commission and notes that Commissioner Nyland will report on her findings in May 2016.

### **Partnering with Consumers**

The Safety and Quality Unit of SA Health has worked hard throughout the year to develop policies, practices and implementation schedules to implement Standards 1 and 2 of the National Safety and Quality Health Service (NSQHS) Standards. These standards relate to governance and partnering with consumers in the widest sense from design of systems to evaluation of systems and the right of individual consumers to be involved in the management of their own treatment and care plans.

The Charter of Health and Community Services Rights is also a key plank in consumer partnering. HCSCC has been pleased to play an active role with SA Health and has great optimism that the efforts will deliver benefits including financial benefits to the public health system.

### **Local Level**

At the local level service providers and service users continue to work within the framework set at federal and state levels. Complaints indicate that the major thrusts in policy toward consumer centred care are still very much in the implementation phase and that a significant gulf between policy settings still exists. This does not in any way mean that the policy settings are not well constructed. Indeed on the contrary it simply means that greater effort in implementation is required, most often in the form of staff training in communication, partnering and cultural sensitivity. As one consumer put it to me, 'we are part of the solution, we are not the problem', in regard to how they felt about their role in human services program design, delivery and evaluation. Complaint handling is the primary function of

the office and the statistics demonstrate that the number of complaints for the year is consistent with previous years.

Handling of a complaint most often, but not always, deals with an issue after the event. However, true to its beliefs, HCSCC allocates resources to proactive programs such as the Supported Decision Making Project, which will be evaluated in the early part of the next financial year. From my perspective, the program has already demonstrated the significant improvements that can be made for vulnerable people living with disability in terms of both safety and quality.

### **Supported Decision Making**

The Supported Decision Making Project, when fully evaluated, will provide special insight as to how establishing good communication channels with patience can lead to profound improvement in vulnerable consumers' lives. Such outcomes have not been delivered by traditional service models.

### **Health and Community Services Advisory Committee**

Following a review of all government boards and committees in October 2014, the expiring terms of the Health and Community Services Advisory Committee were not extended. As a result, the Advisory Committee has not met since that time. Legislation relevant to abolition of the Committee is currently being considered by Parliament. I wish to express my appreciation for the efforts of all members and the contribution they made to establishing priorities and providing unique insights.

### **Charter Champions**

Efforts to continue to build the Charter Champions network will continue to accelerate and former Advisory Committee members are significantly represented in the network.

### **New Complaints Management System**

Staff have worked on the development of a customised and modern complaints management system throughout the year and the new system will be implemented from 3 July 2015. The

development has been staged over three years to accommodate the office's budget and its ease of operation and reliable reporting facilities are eagerly awaited. It will replace the old system along with its various manual work-arounds. Records from the previous system which has been utilised over the past ten years will be archived and remain accessible.

The office ended the year with less open investigation files than it commenced with and accordingly, demonstrated a productivity improvement.

### **Code of Conduct for Unregistered Health Practitioners**

The Code of Conduct for Unregistered Health Practitioners proved to be useful in assessing a number of complaints against providers whose credentials are not within the scope of AHPRA. Seven interim (non-public) orders were made, placing conditions on practitioners and some other practitioners chose to cease their roles in the health or community services sectors. The work of the Crown Solicitor's Office deserves special recognition for their assistance and legal advice.

### **Administrative Support**

Administratively the office is assisted by SA Health in terms of financial, budgetary, office leasing, information technology and human resources support. The assistance from those areas is much appreciated.

### **Stakeholder Recognition**

I also record my support to all the consumers, consumer agencies and service providers that the office has dealt with throughout the year. By far and away the dominant feature of complaints handling has been to work toward information, explanation and improvement.

Finally I thank all the staff of the office for their continued efforts and work in an area that is often very challenging and requires persistence, patience and goodwill.

Steve Tully  
**Health and Community Services Complaints Commissioner**

## 4. Highlights of 2014 -15

### Our Aims

- to promote and protect the rights of service users
- to improve the safety and quality of health and community services in South Australia through the provision of a fair and independent means for the assessment, conciliation, investigation and resolution of complaints
- to further improve HCSCC complaint resolution processes using service improvement tools
- to help build the capacity and skill of service providers in the direct resolution of complaints
- actively encourage and support the benefits of consumer centred care.

### Our Achievements

- responded to a total of 2200 complaint contacts, of which 2015 were new complaints
- closed over 89% of complaints within 21 days
- had a presence in various community forums and expos
- maintained working arrangements for relevant matters concerning the National Disability Insurance Agency (NDIA)
- contributed to major work being undertaken in mental health and the safeguarding of vulnerable people living with disability
- provided an opportunity for all service users and service providers to offer feedback
- continued to strengthen engagement with service users, carers and service providers including the non-government and private sectors
- had a major presence and influence on significant consumer centred care procedures and policies including the Families SA redesign program
- completed the second stage of the two year Supported Decision Making Project.

- implemented a set of arrangements in consultation with the Coroner's office to ensure report-back on Coroner's recommendations
- maintained an ongoing positive relationship with the Australian Health Practitioner Regulation Agency (AHPRA) and met regulatory obligations in relation to exchanging information with AHPRA.

### Continuing Challenges

- maximising HCSCCs contribution to safety and quality of health and community services with reduced resources
- strengthening HCSCCs public reporting about HCSCC work, encouraging people to speak up and encouraging service providers to improve complaints handling processes.

## 5. Future Directions

**For the year 2015-16 HCSCC anticipates directing resources to the following:**

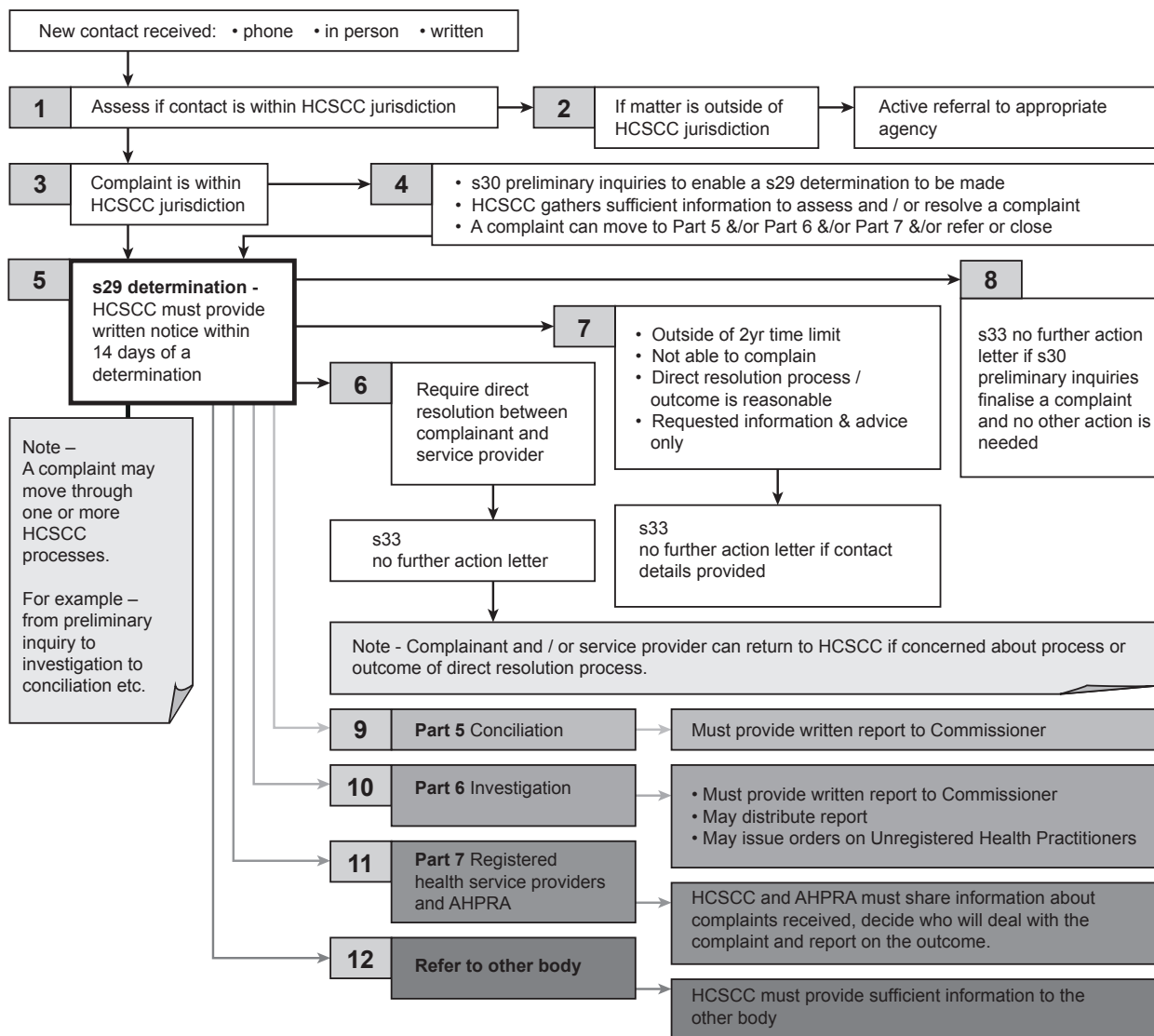
- provide capacity for dealing with around 2000 complaints
- continue to refine the use of experts in considering more complex complaints
- increase the potency of Charter Champions by leveraging service wide effort to increase consumer involvement
- work with the customised complaint database scheduled to commence in July 2015
- monitor complaint trends in prison health, restraint and seclusion in health settings, child protection and disability services and inform program leaders of those trends
- contribute to national efforts with regard to:
  - o unregistered health practitioners
  - o safeguarding for people living with a disability
  - o the Australian Health Practitioner Regulation Agency (AHPRA)
- promote the benefits identified in the independent evaluation of the Supported Decision Making Project as a major rights based safeguarding strategy for vulnerable people living with disability
- implement the National Code of Conduct for Health Care Workers not registered by AHPRA
- optimise benefits of working with the Health Performance Council.

# 6. Complaint Resolution Service

The actions of the South Australian Health and Community Services Complaints Commissioner (HCSCC) are governed by the provisions of the *Health and Community Services Complaints Act 2004* (the Act).

In compliance with the Act, the flowchart below provides a pictorial overview of HCSCCs complaint resolution process. The following explanatory notes supplement the details of the flowchart.

## Flowchart: HCSCC complaint resolution process



### Note:

- **Split complaints** – HCSCC can split a complaint. For example, deal with one aspect in an investigation and refer another aspect to AHPRA.
- **AHPRA** – HCSCC has a legal relationship with AHPRA.
- **Review of HCSCC actions and decisions** – 1. Parties can request reviews by the Commissioner and / or the State Ombudsman. 2. Some Part 6 investigation reports can be reviewed by the District Court.
- **HCSCC recommendations and monitoring of safety and quality improvements** – HCSCC tracks progress and outcomes of recommendations and agreed improvement strategies.
- **Withdrawal of complaints** – HCSCC can decide to investigate a complaint in the public interest if a complaint is withdrawn. Written notice of withdrawal and decision to investigate is required.
- **Annual report** – the *Health and Community Services Complaints Act 2004* requires HCSCC to report on all HCSCC complaints activities.

## Flowchart Explanatory Notes – HCSCC Complaint Resolution Process

1	<p>Assess if the contact is within HCSCC jurisdiction</p> <p>(a) Is it about an SA health, community or child protection service?</p> <p>(b) Is the person entitled to complain?</p> <p>(c) Is the person complaining about a ground under the Act?</p>
2	<p>If the contact does <u>not</u> fall within the Act it is assessed as being 'outside jurisdiction'.</p> <p>(a) HCSCC will explain the reasons HCSCC cannot deal with their complaint and make every attempt to refer them to the appropriate place.</p>
3	<p>If the contact <u>does</u> fall within the Act then one or more of the following actions can occur.</p>
4	<p>Section 30 of the Act allows HCSCC to make preliminary inquiries into a complaint in order to gather sufficient information to make a determination about what action to take. Some complaints are only dealt with in this part while others can move to investigation and/or conciliation and/or referral to another agency. HCSCC preliminary inquiries can include requiring service providers to provide written information and responses, attend meetings, review policies etc. Some complaints are closed in this section when the complaint is finalised and no further action is needed.</p>
5	<p>The Act requires HCSCC to make an s29 determination about how a complaint will be dealt with. The following actions can be determined:</p> <p>(a) s 33 take no further action - such as in 4. 6. 7. &amp; 8.</p> <p>(b) Pt 5 conciliation and/or - see 9.</p> <p>(c) Pt 6 investigation and/or - see 10.</p> <p>(d) refer to another agency - see 11.</p>
	<p>Sometimes HCSCC will assess a new complaint and decide to take no further action for the following reasons:</p>
6	<p>The Act requires, where it is reasonable, that people first make their complaint to the service provider before asking HCSCC to consider it. HCSCC calls this direct resolution and deals with it in two ways:</p> <ol style="list-style-type: none"> <li>1. HCSCC will provide the complainant with detailed information about how to complain and will provide accurate information about who to complain to in the service. <ul style="list-style-type: none"> <li>o Both the complainant and the service provider are able to return to HCSCC at any time.</li> </ul> </li> <li>2. HCSCC will facilitate direct resolution by sending a copy of the complaint to the service provider asking them to respond to the complainant and provide a copy of their response to HCSCC. HCSCC will review the service provider's response and assess if further action is needed. <ul style="list-style-type: none"> <li>o Both the complainant and the service provider are able to return to HCSCC at any time.</li> </ul> </li> </ol>
7	<p>HCSCC will not take action on a new complaint when:</p> <ol style="list-style-type: none"> <li>1. The complaint is over two years old and the Commissioner assesses there would be no benefit in taking action.</li> <li>2. The complainant provides HCSCC with information about the outcome of direct resolution with the service provider and HCSCC assesses that the response is reasonable and that there would be no benefit in taking action.</li> <li>3. The complainant is not entitled to complain under the Act - e.g. they were not the service user and/or do not have the service user's authority to represent them.</li> </ol>
8	<p>Section 30 preliminary inquiries reveal information which allows a complaint to be finalised with no further action needed - see 4.</p>
9	<p>HCSCC can invite the complainant and service provider to conciliate a matter. This is a voluntary process and the issues addressed and decisions reached are private between the parties.</p>
10	<p>HCSCC can investigate matters arising from an individual complaint and/or systemic matters that are identified and/or as a Commissioner's own motion. Investigations can include requiring service providers to provide written information and responses, attend meetings, review policies, HCSCC seeking expert opinion etc. HCSCC can impose conditions or orders relating to Code of Conduct for Unregistered Health Practitioners.</p>
11	<p>HCSCC has a legal relationship with the Australian Health Practitioner Regulation Agency (AHPRA) in relation to individual registered health practitioners such as doctors, dentists, psychologists etc. HCSCC and AHPRA must decide which agency will deal with the complaint and share information about relevant complaints received and the outcome of those complaints.</p>
12	<p>Where appropriate, HCSCC can refer a complaint to relevant agencies such as the federal Aged Care Complaints Scheme, State Ombudsman etc.</p>

## 6.1 Complaint Resolution Data

The following HCSCC complaint resolution data for 2014-15 fulfils HCSCCs annual statutory reporting requirements. As reported previously, the HCSCC complaints management system, Proactive, has had significant limitations and will be replaced with a customised complaints management system, Resolve. Much of the following information has been made available due to the dedication and commitment of the HCSCC staff team, some of whom were involved in extensive manual data collection and analysis.

HCSCC complaint handling performance standards include:

- 80% closed within 26 weeks
- 95% closed within one year
- No files open more than two years
- 1% of complaints reviewed by the State Ombudsman.

Of all new complaints received in 2014-15:

- 89.09% were closed within 21 days
- 9.37% were closed within 22-44 days
- 1.54% were open more than 45 days.

No systemic files have been open more than two years.

HCSCC was notified of six HCSCC decisions being reviewed by the State Ombudsman. This equates to 0.01% of the total complaints received by HCSCC.

### Number and type of complaint contacts

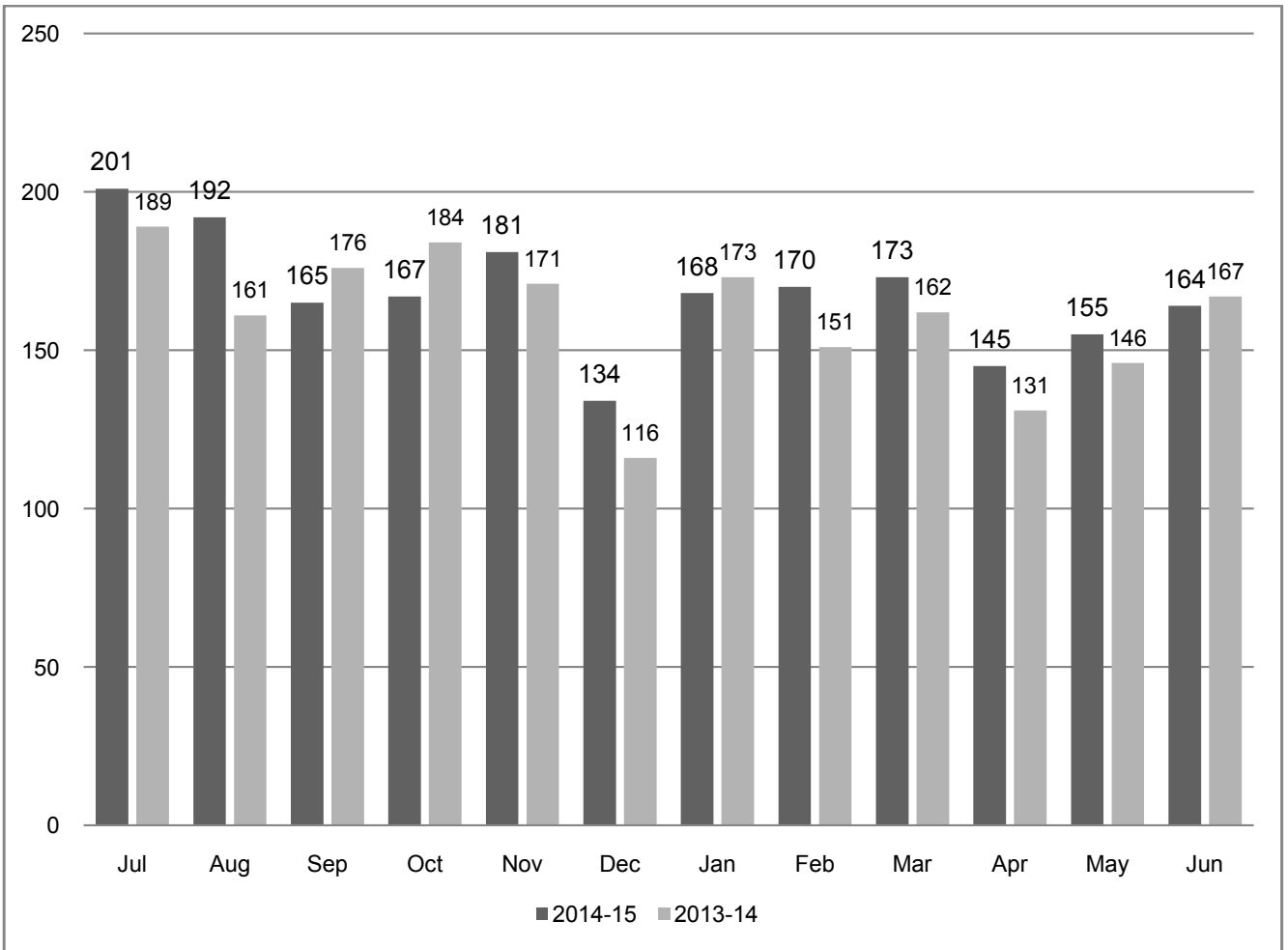
Service Provider Type	Health	Community Services	Child Protection	2014-15 Total
Public	1126	36	99	1261
Private	676	15	3	694
Non-Government Organisation	6	51	3	60
Out of Jurisdiction Contacts	0	0	0	185
Total	1808	102	105	2200

A total of 1808 complaints, equivalent to 82% of all new complaints received in 2014-15, related directly to health services.

### Complaints not finally dealt with

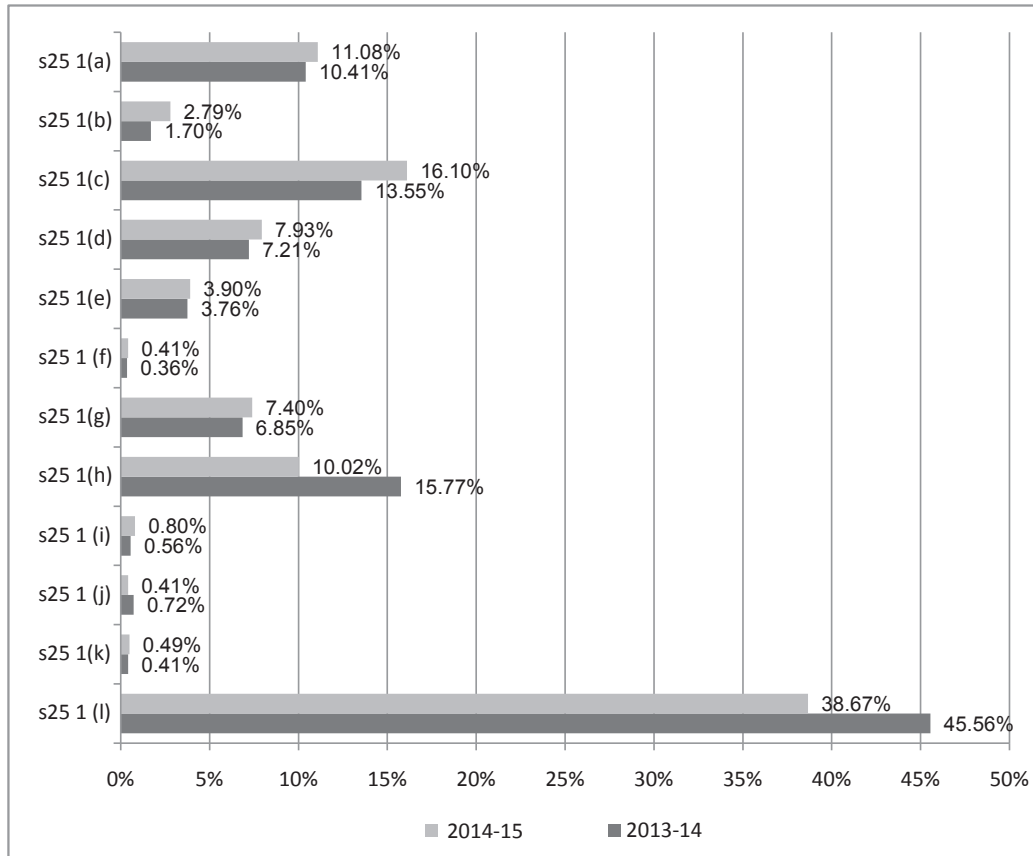
As at 30 June 2015 HCSCC had a total of 86 open files.

**Complaints opened by month (does not include out of jurisdiction contacts)**



**Average new complaints per month: 168**

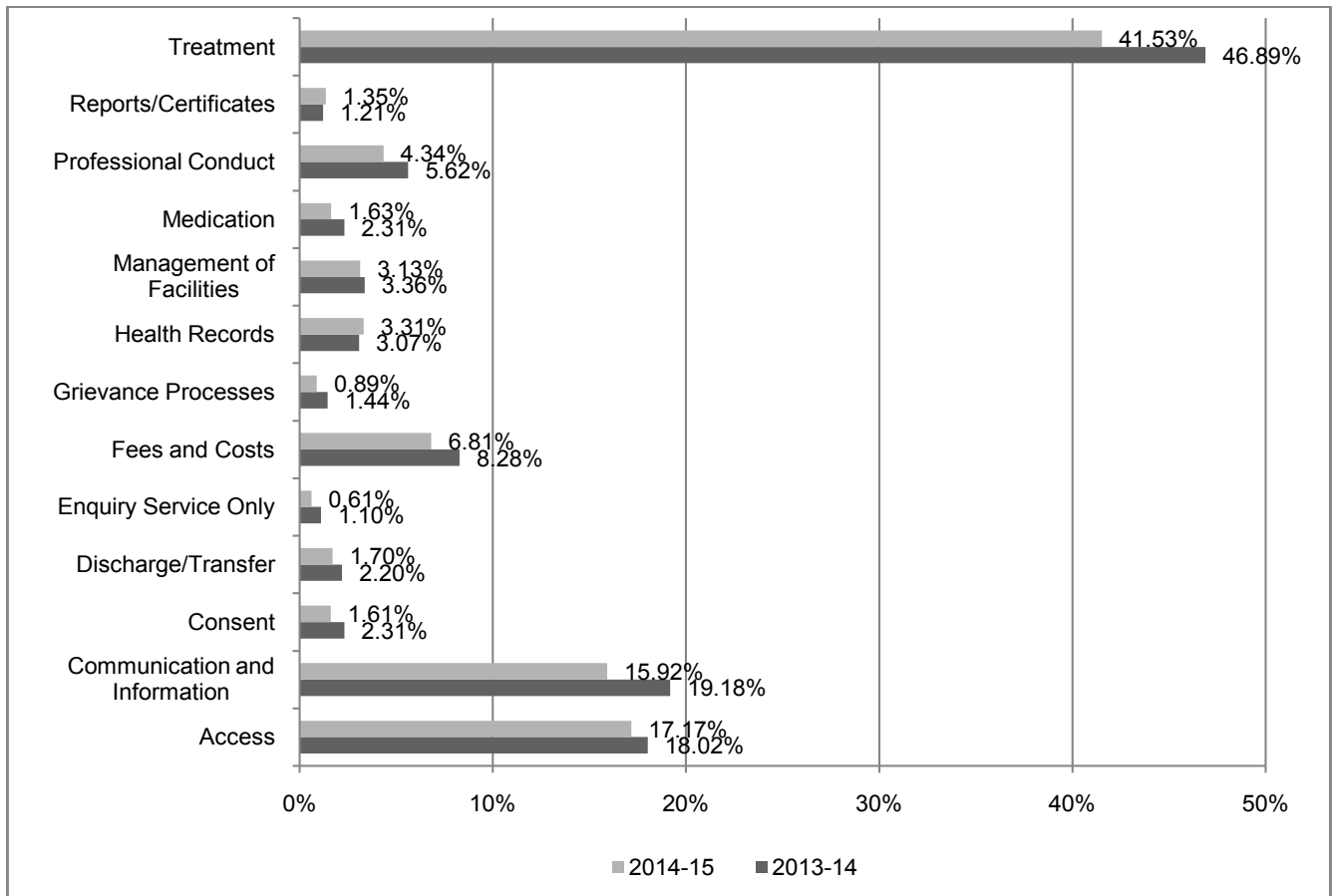
## Grounds for complaint (section 25)



Note: a single complaint may raise more than one ground

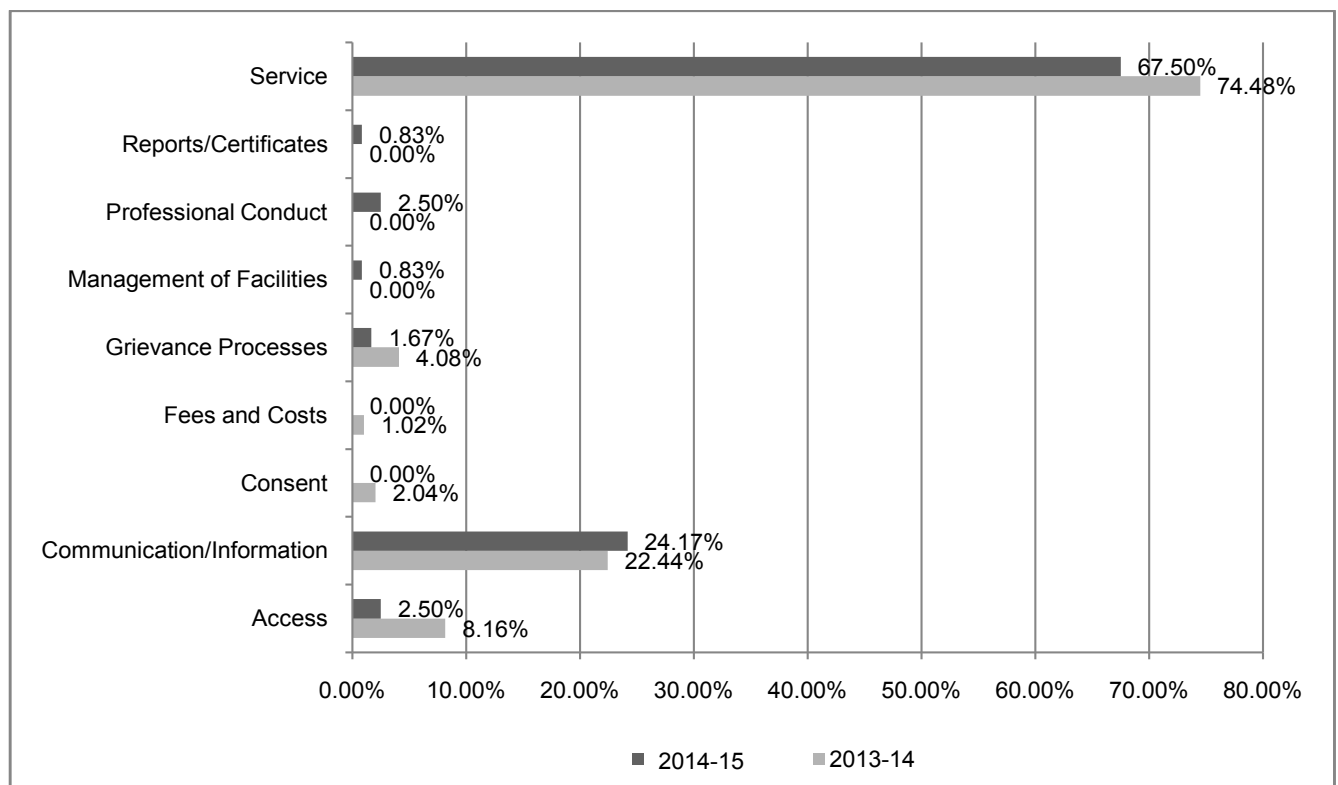
- s25 1 (a) service not provided
- s25 1 (b) service not necessary or inappropriate
- s25 1 (c) unreasonable manner in providing service
- s25 1 (d) lacked due skill
- s25 1 (e) unprofessional manner
- s25 1 (f) failure to respect privacy or dignity of service user
- s25 1 (g) quality of information
- s25 1 (h) access to records denied or information from records not provided
- s25 1 (i) unreasonable disclosure of information
- s25 1 (j) action on complaint not taken by provider
- s25 1 (k) acted in a manner inconsistent with the HCSCC Charter of Health and Community Services Rights
- s25 1 (l) didn't meet expected standard of service delivery.

### Issues complained about - Health complaints



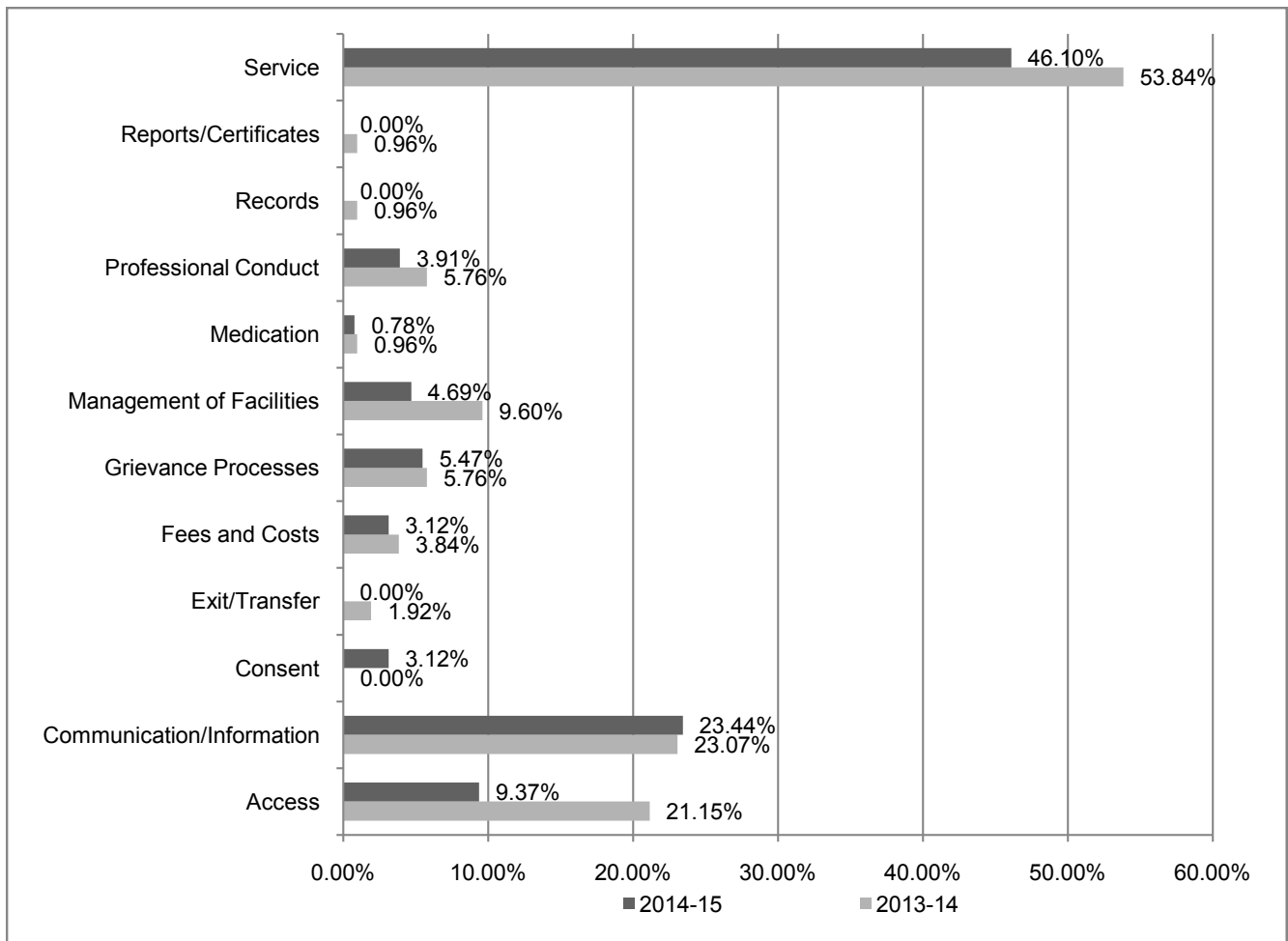
Note: a single complaint may raise more than one issue.

### Issues complained about - Child protection complaints



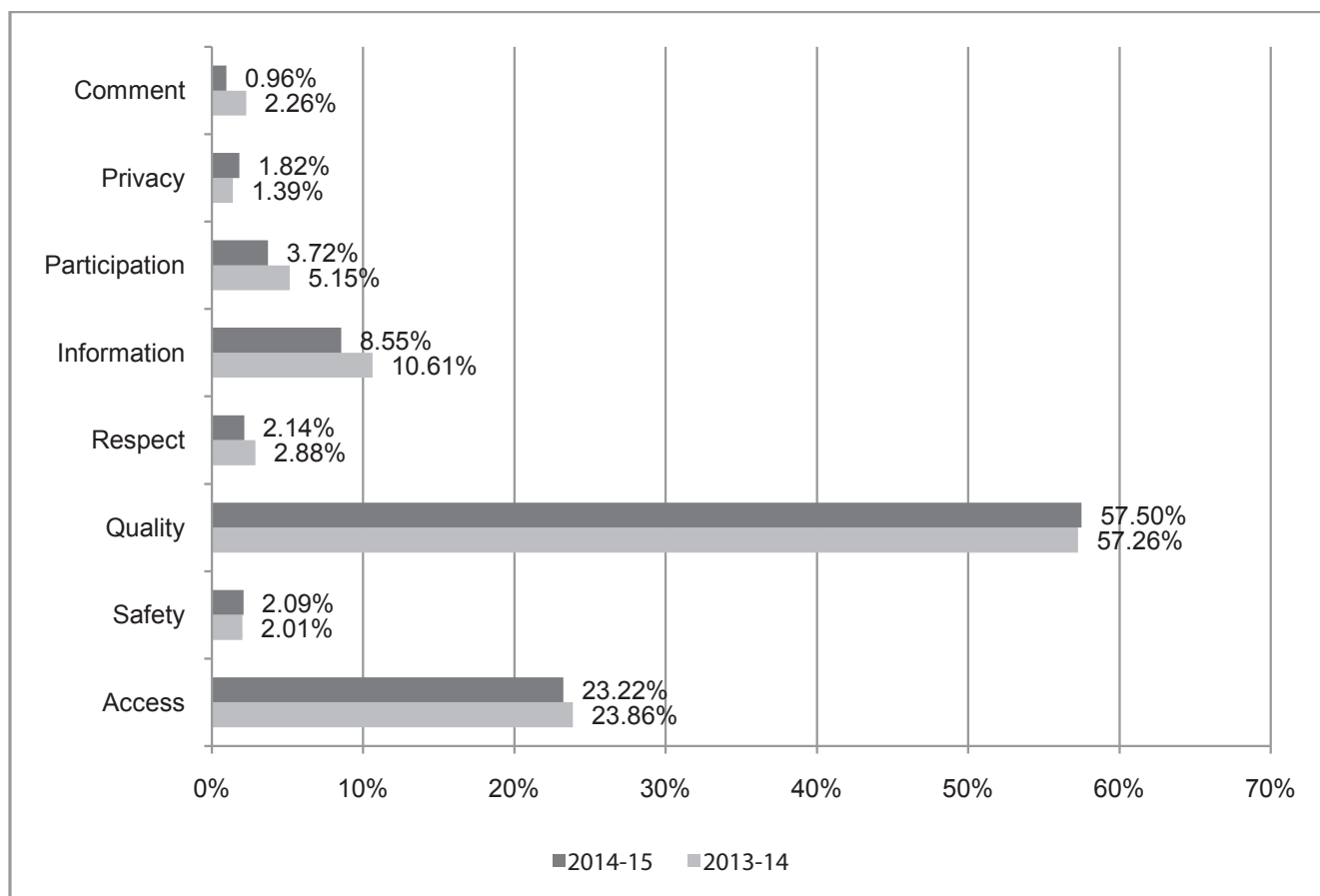
Note: a single complaint may raise more than one issue.

## Issues complained about - Community service complaints



Note: a single complaint may raise more than one issue.

## Complaints received aligned to the HCSCC Charter of Health and Community Services Rights



Note: a single complaint may relate to more than one right.

### HCSCC Charter of Health and Community Services Rights

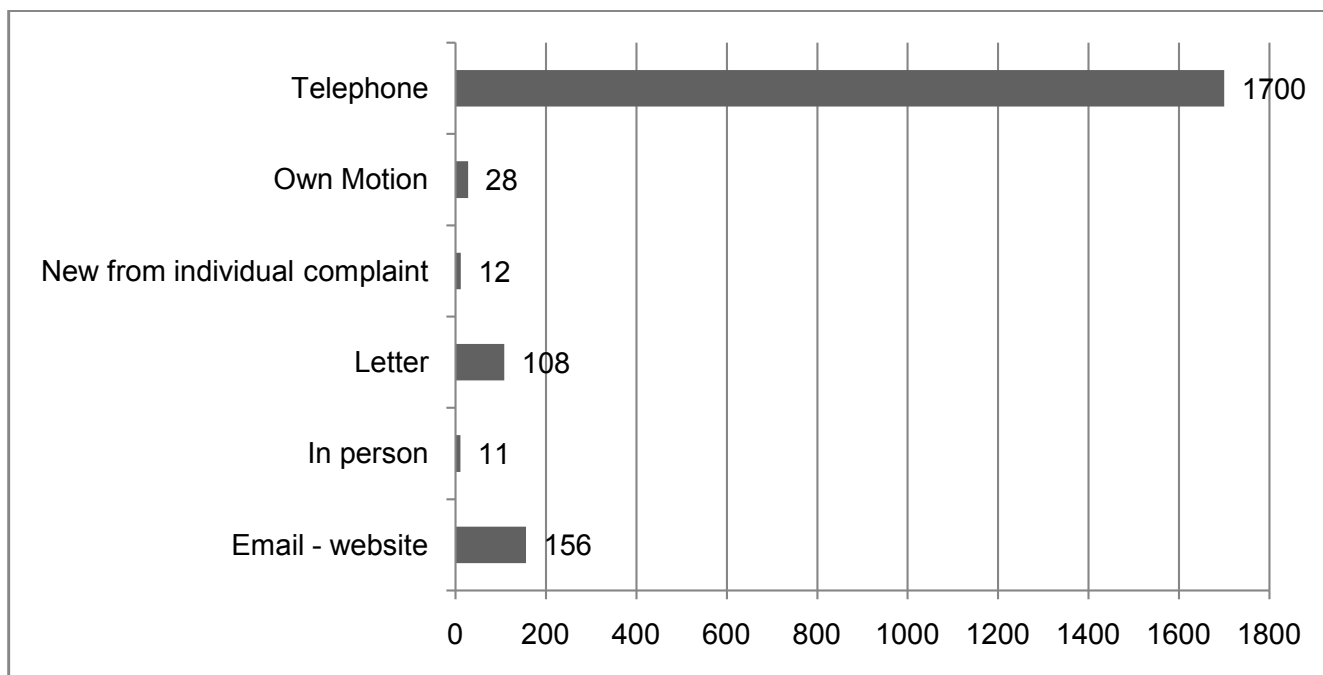
The HCSCC Charter came into effect on 23 June 2011.

1. ACCESS - Right to access health and community services.
2. SAFETY - Right to be safe from abuse.
3. QUALITY - Right to high quality services.
4. RESPECT - Right to be treated with respect.
5. INFORMATION - Right to be informed.
6. PARTICIPATION - Right to actively participate.
7. PRIVACY - Right to privacy and confidentiality.
8. COMMENT - Right to comment and/or complain.

Almost 90% of all complaints align to three of the HCSCC Charter Rights:

- the right to quality (57.5%)
- the right to access (23.22%) and
- the right to information (8.55%).

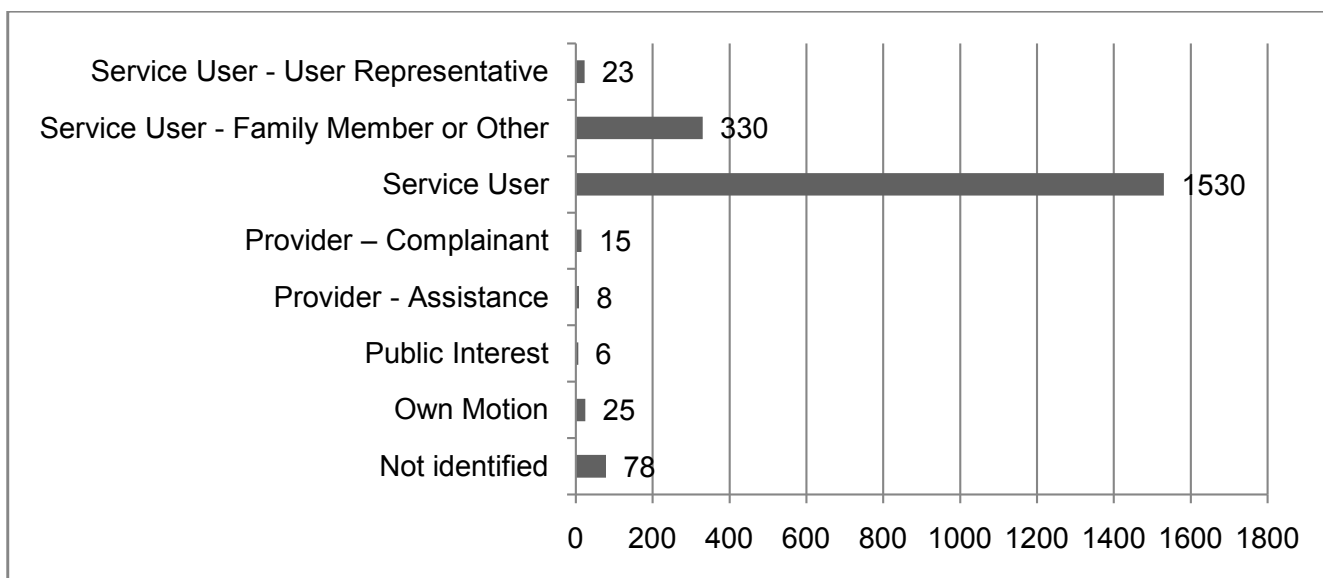
## Method of contact with HCSCC



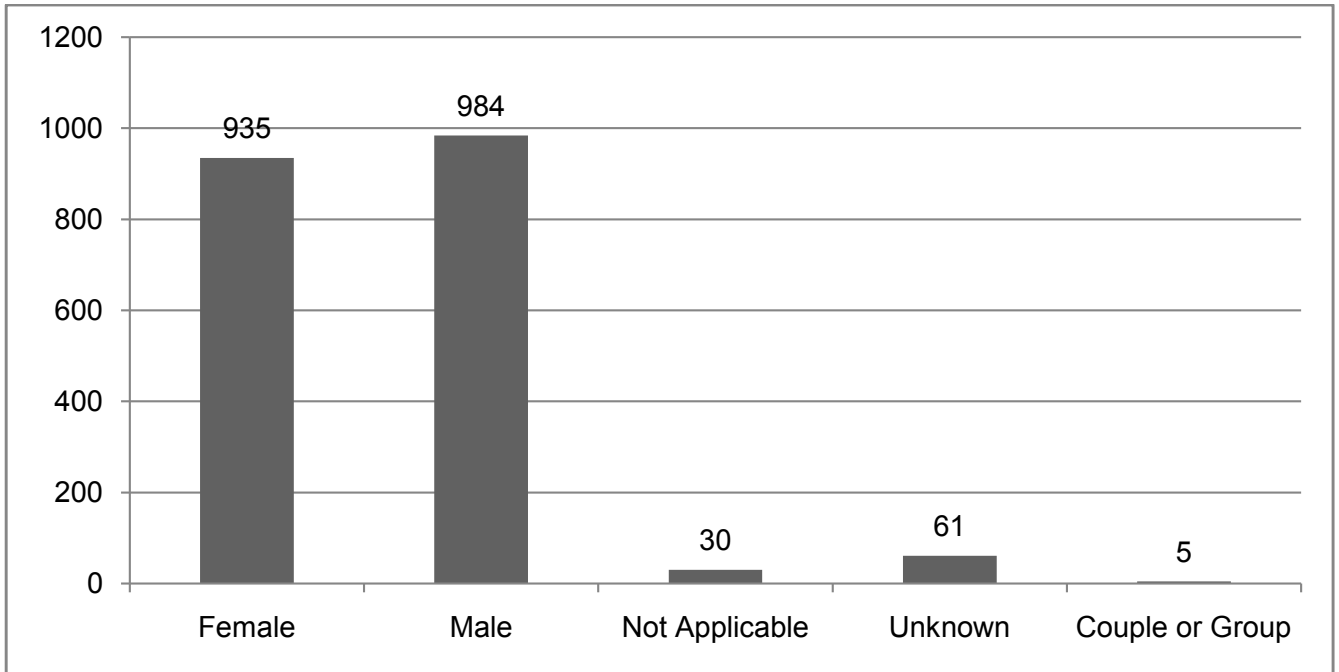
Statistics show that 77% of contacts with HCSCC regarding a complaint are made by telephone. HCSCC acknowledges that for many people telephone contact is often easily accessible and enables the immediate provision of information, advice or action.

Note: this figure does not take into account those matters assessed as outside jurisdiction.

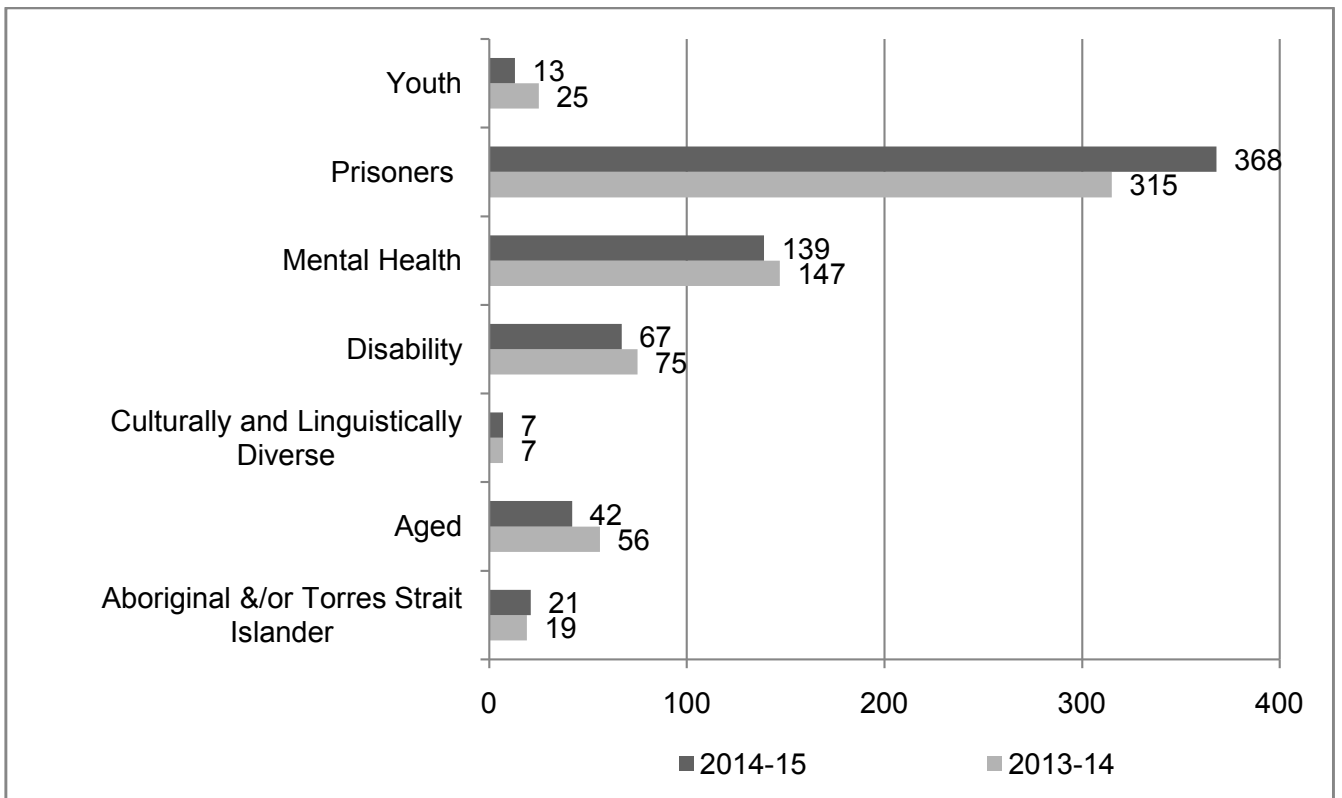
## Role of contact person



### Gender of contact person



### Complaints about people who identify as having special needs



The Act uses the term, special needs groups, as ‘particular classes of persons who because of the classes to which they belong, may suffer disadvantage in the provision of services unless their needs are recognised’.

Consumers of health services are not always comfortable with the term, special needs, as some consumer groups advocate that all complainants by definition have special needs.

A total of 657 special needs were identified in complaints received in 2014-15 (note: the service user may have had multiple special needs).

## 6.2 Assessment (section 29 of the Act)

During 2014-15, HCSCC made a total of 2039 assessments and determinations under section 29 of the Act. A summary of the determinations are as listed below:

Section 29 Determinations	
s29 (2) (b) investigate the complaint under Part 6	109
s29 (2) (c) deal with the complaint under Part 7	53
s29 (2) (d) refer the complaint to another person or body	23
s29 (2) (e) determine to take no further action on the complaint	1162
s29 (3) (b) referred to ACCS	4
s29 (5) direct resolution required	673
s3 (b) referred to another authority	15
Total	2039

### Case study - Assessment outside of HCSCCs jurisdiction

Jake contacted HCSCC complaining about the actions of the police. HCSCC explained that this was not within HCSCCs jurisdiction. HCSCC provided him with detailed information about the appropriate agency to contact.

### Direct resolution

HCSCC encourages people to resolve their complaint directly with the service provider if this is reasonable. Callers to the Enquiry Service receive tailored information and advice about how to take appropriate steps to try and resolve their complaint with the service in the first instance. Each telephone call is an opportunity to build the capacity and confidence of individuals to deal with their current concerns and any future complaints, without the intervention of HCSCC.

People who visit the HCSCC website looking for advice about how to deal with complaints are directed to a HCSCC brochure - Guide for Consumers and other information that outlines step-by-step guidance about how to make a complaint directly to the service.

HCSCC provides further assistance to people who need help to resolve their complaint directly. For example, if it would be unreasonable to expect the person to approach the service if the person has tried to resolve a complaint directly but this has not worked; or if a complaint is serious enough to warrant HCSCCs consideration in the public interest. In these situations HCSCC can take action immediately, if necessary and this often results in the prompt resolution of matters.

### Facilitated direct resolution

In some situations HCSCC is able to facilitate direct resolution of a complaint; for example, when a complainant has identified they have special needs that make it more difficult for them to make a complaint without HCSCC assistance. This usually involves HCSCC forwarding a copy of the complaint to the service provider with a cover letter from HCSCC. The cover letter explains HCSCCs expectations in relation to the service provider's response. This has proven to be a very effective way of addressing a relatively large number of complaints that do not involve serious safety or quality issues but warrant follow up.

In general HCSCC has found that service providers are receptive to this approach and mostly provide good quality responses to the complainant.

### **Case study - Facilitated direct resolution**

Mrs Fitzpatrick suffered a stroke and spent some time in a rehabilitation hospital. After leaving hospital she was informed by the Department of Transport that her doctor had notified the Department that her fitness to drive would need to be assessed following her stroke.

Mrs Fitzpatrick was very upset about this because she had recovered well and gone home quickly. She lived alone and maintained her independence by driving.

HCSCC initially consulted with the Australian Health Practitioner Regulation Agency (AHPRA) about whether HCSCC or AHPRA should deal with the complaint. It was agreed that HCSCC would undertake facilitated direct resolution. With direct resolution, HCSCC sent a copy of the complaint to the doctor and asked for a response to be sent directly to Mrs Fitzpatrick, with a copy to HCSCC. HCSCC gives service providers guidelines about what is expected when they respond.

The service provider wrote to Mrs Fitzpatrick with a thorough response. The doctor explained that it was a legal requirement for him to contact the Department of Transport. The doctor sensitively explained that it was his intention to provide Mrs Fitzpatrick with safe and appropriate care and to ensure the safety of other drivers on the road. The doctor acknowledged it was likely to cause Mrs Fitzpatrick inconvenience.

The response provided by the doctor included an explanation and offered for Mrs Fitzpatrick to contact him again with any other queries. HCSCC assessed this as an appropriate and reasonable response to the concerns that had been raised by Mrs Fitzpatrick.

### **Case study - Refer to other body**

Sonia contacted HCSCC with some concerns she had following a visit to a relative at a private drug and alcohol treatment centre. In particular, Sonia noticed that the facility was run down, had broken windows, smoke alarms without batteries and expired fire extinguishers.

Although HCSCC does deal with complaints about drug and alcohol treatment centres in relation to the health or community services they provide, the agency to assess building safety is the local council. HCSCC referred the complaint to the local council.

### **Case study - Outside the 2 year time limit**

Nathan told HCSCC he had been hit by a car in 1980 and sustained a broken leg. He was adamant that at the time, the doctor undertook surgery on the leg that had not been damaged. Nathan stated that he thought the doctor may have passed away at some point in the last 35 years. Although this was clearly an issue that remained of concern to Nathan, this event was well outside of HCSCCs two year timeframe, and along with the likelihood the doctor was no longer alive, HCSCC decided to take no action on the complaint.

## 6.3 Preliminary Inquiries (section 30 of the Act)

After the basics have been established, such as who is making the complaint, what are their grounds for making a complaint and when did the complaint happen, there is generally a need to find out more. This is where section 30 of the Act, Preliminary Inquiries, fits into the HCSCC complaints process.

Section 30 of the Act provides HCSCC with the legal authority to ask questions about the complaint and seek information and/or documents from service users, service providers and others. With a clearer picture of a complaint, HCSCC is able to put together a plan to deal with the complaint and make the appropriate (section 29) decision on how to proceed. The section 29 decision may be a decision to investigate or conciliate a complaint; to refer the complaint to another authority for their investigation; or to close the complaint and take no further action on it. A section 29 decision typically completes the Preliminary Inquiries process.

Very often a complaint may be resolved while HCSCC is within the Preliminary Inquiries stage. This is because many complaints are the result of poor communication between the parties. By providing each party with more detailed information, or by arranging a safe place to meet where the views of all parties to a complaint can be heard, HCSCC can often assist the parties to better communicate. Good communication will often clarify the complainants' concerns and the issues of complaint. Once aired, most reasonable concerns can be addressed and misconceptions resolved.

In most of the complaints made to HCSCC, the (section 29) decision is not to investigate or take the matter further; the decision is to close the complaint and to take no further action. This is because after making Preliminary Inquiries, the complaint may have already been resolved under section 30 of the Act.

HCSCC will move from section 30 of the Act to a Part 6 investigation if a complaint:

- needs an expert opinion
- raises significant public safety issues
- raises a systemic concern.

### Case Study 1

Jayne's medical condition can result in skin infections which she has learnt to manage herself at home. When she went for treatment at the specialist's clinic she felt the specialist didn't pay attention to her and that her treatment didn't include the things she thought were important.

Jayne contacted HCSCC to complain after unsuccessfully complaining to the clinic directly.

HCSCC wrote to the clinic and asked for a response to Jayne's complaint. HCSCC asked that the clinic Manager meet with Jane to talk with her about her complaint. Jayne wasn't able to go to the clinic for the meeting so the meeting was held on the telephone. The clinic Manager stayed at the clinic while someone from HCSCC met with Jayne at her home. On the telephone Jayne was able to explain to the clinic Manager why she didn't feel part of her treating team and why she felt like the specialist didn't want to talk with her about treatments. Jayne said she often didn't understand the specialist and the specialist didn't take the time to explain.

The clinic Manager apologised to Jayne and told her that the clinic wanted Jayne to be an active part of the treating team. The Manager told Jayne that their communication could be better. The Manager agreed to talk to all the clinic specialists, about Jayne's complaint and how services could be improved for all their patients.

Jayne was pleased with the outcome of her telephone meeting with the clinic Manager. When she received a written apology from the clinic, Jayne was sure that complaining had helped improve services for everyone at the clinic.

## Case Study 2

Dianne contacted HCSCC following her partner Simon's death because she wanted to find out if her partner had been given the best possible care in hospital. Dianne said she thought that errors had been made and when she asked the doctors to help her understand the health problems caused by Simon's medications, she was mostly ignored. Dianne said she had been told that some medications caused serious problems and needed constant monitoring. Dianne said she didn't want to think that Simon's death had been premature because of his medical care.

Dianne had approached the hospital some time ago and asked them to investigate her concerns but they had not come back to her with any explanation.

After receiving Dianne's complaint, HCSCC wrote to the hospital and asked for a detailed response to Dianne's concerns. HCSCC asked for a copy of Simon's medical notes. HCSCC also contacted Simon's GP and the rehabilitation service that Simon had sometimes attended and asked for copies of all the relevant information about Simon's treatment and care. When HCSCC had gathered all the information, an independent expert was found to assess Simon's care and treatment and provide HCSCC with an opinion as to whether Simon's treatment had been appropriate.

The independent expert asked HCSCC to find out if particular tests had been done for Simon because the results were not in his medical records. The hospital was able to provide HCSCC with the records for the tests and the results for Simon.

In the independent expert's opinion, everything was in order and Simon had received treatment that was above the standard expected. The expert advised HCSCC that Simon had died, not as a result of having the wrong treatment but as a result of a particular reaction to the medication and Simon's reaction could not have been foreseen. Everything had been done to monitor and control Simon's exposure to the medication and it was unfortunate that unlike most other people, Simon had not benefited from the treatment provided to him.

HCSCC were able to tell Dianne that after investigating her concerns HCSCC believed that Simon had received the appropriate treatment. It would seem that the hospital staff were compliant in handling Simon's medications and they had monitored him correctly. It was unfortunate that Simon had reacted negatively to the medications.

Although Dianne was not happy to find out that Simon had died because of the medications he was given, she said she knew that Simon was going to die and there was a chance the medication may have helped him live stronger, for a little longer. Dianne's fears about the hospital were dispelled and she felt relieved that she could be confident about the standard of care offered by the hospital.

Dianne agreed to allow the hospital to use her complaint as a case study in training sessions with the hospital staff to help improve communications between hospital staff and patients, their family and carers.

## 6.4 Conciliation (Part 5 of the Act)

Following a section 30 Preliminary Inquiry or a Part 6 Investigation, the Commissioner may make an assessment in accordance with section 29 of the Health and Community Services Complaints Act 2004 (the Act) to refer the complaint for formal conciliation under Part 5 of the Act.

Conciliation assists the complainant and the health or community service provider to reach an agreed outcome on the complaint.

The role of HCSCC is to encourage settlement by arranging and assisting in the conduct of those discussions or negotiations between the parties.

If considered appropriate, conciliation can be undertaken without bringing the parties together. This is known as shuttle conciliation and has the same aim of bringing the complaint to a satisfactory resolution.

For the reporting period 2014-15, HCSCC invited a number of complainants and service providers to participate in formal conciliation. Three parties accepted the invitation and those matters were successfully resolved.

### Case Study 1

A complaint was received from Stella, mother of an adult intellectually disabled man with a number of chronic health conditions, including Type 1 diabetes, who had been admitted to the intensive care unit (ICU) of a public hospital. She complained that in the course of her son Theo's treatment, an intubation tube had been secured so tightly at the back of his head that it split the edge of his lips causing injury and severe scarring to his face.

Stella submitted that the ICU staff failed to clinically manage the application and monitoring of the tape used in the intubation, resulting in permanent facial disfigurement.

HCSCC's investigation focused on whether the generally accepted standards for the securing of the intubation and the key principles of open disclosure following the incident were met.

From all the information provided, HCSCC determined that the generally accepted standards expected were not met by the hospital. HCSCC concluded that ICU staff failed to identify Theo as a patient at high risk for pressure injury given his compromised immune function, failed to implement a pressure injury prevention plan and did not provide an adequate open disclosure process.

The matter was referred for conciliation and the parties reached an agreed outcome.

## Case Study 2

Colleen complained to HCSCC about the excessive delay in receiving diagnostic treatment from the Urology Department of a public hospital. The delay directly led to Colleen needing more invasive surgery and enduring a longer recovery period, including suffering ongoing related health complaints that were not resolved.

Following Preliminary Inquiries, HCSCC decided there was reason to investigate the individual complaint alongside the systemic issues identified as possible (mis)management of the hospital's Urology Department's waiting lists. The systemic complaint was dealt with separately to the individual complaint with HCSCC focusing on service users excessive time on waiting lists while waiting for treatment from that hospital and other SA Health sites.

Despite Colleen being rated as a high priority patient by the hospital's Consultant General Surgeon, she was not reviewed and her position on the waiting list was not amended. This resulted in her waiting a much longer time than others on the waiting list assessed as semi urgent.

To assist HCSCCs preliminary inquiries, an independent expert was identified to review the complaint, the medical case notes and other related material.

The independent expert opinion found that the waiting time for Colleen's surgery after presenting with high risk symptoms was unacceptable and therefore, did not meet the generally accepted standards expected under the circumstances.

The complainant sought financial settlement as redress and the complaint was resolved via the conciliation process to the satisfaction of both parties.

## 6.5 Investigations (Part 6 of the Act)

During 2014-15, HCSCC commenced or continued work on a total of 117 investigations under Part 6 of the Act.

Number of investigations	Reasons for investigation	Comments and examples
38	Individual complaints requiring independent expert opinion	<p>Sometimes an individual's complaint is moved into an investigation because Part 6 of the Act allows HCSCC to obtain expert advice.</p> <p>Most of these complaints relate to medical issues and the experts assist HCSCC to identify whether:</p> <ul style="list-style-type: none"> <li>- the generally expected standard was met and/or</li> <li>- there are issues to address for the individual and/or</li> <li>- whether there are systemic issues to be addressed.</li> </ul> <p>HCSCC has also obtained expert opinions in relation to individual complaints about disability services.</p>
46	<p>Systemic issues</p> <ul style="list-style-type: none"> <li>- some arising from individual complaints that identified systemic issues</li> <li>- some own motion investigations were opened based on information received from a variety of sources</li> </ul>	<p>Examples of systemic investigations:</p> <ul style="list-style-type: none"> <li>- whether disability services are provided in line with the HCSCC Charter of Health and Community Services Rights in South Australia</li> <li>- improving the safety of patients against sexual assault in mental health inpatient facilities</li> <li>- how public hospitals manage prisoners who are shackled by correctional services staff</li> <li>- improving the standard of prison health services</li> <li>- improving safety in disability services</li> <li>- reliability of blood results across pathology labs</li> </ul>

Number of investigations	Reasons for investigation	Comments and examples
21	Investigations relating to individual Unregistered Health Practitioners	<p>The Code of Conduct for Unregistered Health Practitioners (the Code) came into effect in March 2013. The Code provides HCSCC with powers to place conditions or prohibitions on unregistered health practitioners if there are concerns about serious public safety issues.</p> <p>Examples of investigations:</p> <ol style="list-style-type: none"> <li>1. individuals whose health services may breach one or more clauses of the Code <ul style="list-style-type: none"> <li>- illegal use of prescribed medication</li> <li>- use of the title of Doctor that may mislead the general public about qualifications</li> <li>- recommending unsafe products</li> <li>- lacking a reasonable level of competence in a specific field of work</li> </ul> </li> <li>2. individuals whose AHPRA registration was suspended or cancelled due to concerns about risks to the public who then continue to provide health services, either as an employee (eg care worker) or sole practitioner (alternative health) <ul style="list-style-type: none"> <li>- impact of drug or alcohol use on an individual's ability to provide safe services</li> <li>- providing health services that put the public at risk</li> </ul> </li> </ol>
12	Own motion  Follow up on Coroner Inquest recommendations	<p>In June 2014 the Commissioner decided to commence investigations into recommendations made by the Coroner that relate to HCSCCs jurisdiction.</p> <p>This has continued throughout 2014-15.</p>

## HCSCC Improvements Register

In order to improve the safety and quality of health and community services during a complaint, HCSCC may:

- recommend service improvements to a service provider
- note the areas of improvement identified by a service provider in the course of a complaint
- require a service provider to report on the implementation of identified service improvements.

Examples of service improvements on the HCSCC Improvement Monitoring Register for 2014-15 are:

- public hospital radiology department - complaint used as a case study for radiology department staff to learn improvements in radiology process to avoid human error in missed injuries
- non-government disability organisation - developed processes to improve matching of individuals with long term accommodation settings
- statewide public hospitals - developed and implemented Colonoscopy Urgency Categorisation Surveillance Timing Guideline and the inclusion of colonoscopies in Booking List Information System to ensure patients are not left on waiting lists for excessive times without review
- state health service - conducted a review of business rules about costs to recommend improvements to ensure a standardised approach to business rules and eliminate variations in fees across different sites
- joint activities between SA Health and Disability Services - to promote the Country Referral Unit (CRU) to staff and clients
- Aboriginal controlled non-government organisation in the community services sector agreed to review policies and procedures to identify gaps in administrative processes and management in order to meet legislative requirements and service delivery standards
- public hospital agreed there could be a role for patients and a family member, carer or supporter to be involved in multi-disciplinary clinical team meetings to improve communication for those patients, particularly at end stage of treatment
- public hospital reinforced the need to follow directives and guidelines around the preparation and handling of sterile equipment prior to surgery, in order to meet established quality standards
- public hospital agreed to review its discharge policy and practices regarding elderly patients who may have variable capacity to make sound decisions, in conjunction with improved communication with nursing homes
- non-government organisation, respite – policy and procedure improvements for medication management, storage, handling, administering and recording of patient medications
- public hospital outpatients clinic – informal mediation provided feedback for the service improvement of patient-clinic communication and interaction
- non-government organisation, disability accommodation support service – improve relationships between community and residents to improve lifestyle choices and experience; improve internal and external complaints processes which have included the development of a residents committee to provide the service with client feedback.

## Service Evaluation

During 2014-15, services users and service providers involved in complaints were invited to provide feedback on their experiences with HCSCC.

Feedback was received from 12 service users. Whilst only two service providers gave written feedback, informal responses from other service providers indicated satisfaction with HCSCCs handling of complaints.

The table below summarises the views of service users:

### Service Users - Collated Responses

	1 = Strongly Disagree / 5 = Strongly Agree						
Questions	1	2	3	4	5	n/a	Total
I found it easy to contact HCSCC				7	5		12
I found HCSCC staff helpful and easy to understand				9	3		12
I thought it took the right amount of time to deal with my complaint		4		6	2		12
I felt confident HCSCC would keep my personal information safe			1	8	3		12
I was kept informed and knew what to expect from HCSCC and the complaint process		2		8	2		12
I think HCSCC was fair and the final decision about my complaint was based on the information available		3		7	2		12

HCSCC will continue to invite feedback and look at a range of ways to ensure that it is aware of how HCSCC services are perceived. HCSCC also notes research that surveys with low response rates are often minimally less accurate than surveys with higher response rates.

## 6.6 Registered Health Service Providers (Part 7 of the Act)

Since it was established on 1 July 2010, the Australian Health Practitioner Regulation Agency (AHPRA) has been the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. The Scheme sets the standards that practitioners must meet in order to register and maintain ongoing registration.

Fourteen health professions are now regulated by national boards, supported by AHPRA. Commencing 1 July 2010, the first 10 nationally registered professions were chiropractic, dental, medical, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology. On 1 July 2012, four additional professions were registered and included in the national scheme; occupational therapy, Aboriginal and/or Torres Strait Islander health workers, Chinese medicine and medical radiation practitioners.

The role of AHPRA and the national boards is to protect the health and safety of the public by maintaining professional standards of competence and conduct. Information about AHPRA and the 14 national boards is available at [www.ahpra.gov.au](http://www.ahpra.gov.au).

Part 8 of the national law and Part 7 of the HCSC Act require AHPRA and HCSCC to notify each other as soon as practicable and to consult each other about the management of any matter they receive concerning the health, performance or conduct of an individual nationally registered health practitioner, including a student health practitioner.

A Memorandum of Understanding (MOU) was developed between AHPRA and all the state/territory (except NSW) Health Complaints Entities (HCEs).

The MOU represents the agreement between AHPRA and the HCEs to achieve timeliness and consistency about:

1. notifying each other about the receipt of complaints and notifications
2. consulting about the future management of a complaint or notification and
3. sharing information.

The MOU describes the legal obligations of HCSCC and AHPRA to one another and how HCSCC and AHPRA will meet them. The MOU is available at [www.hcsc.sa.gov.au](http://www.hcsc.sa.gov.au)

HCSCC and AHPRA meet fortnightly to exchange information and consult about the management of notifications and complaints involving individual nationally registered health practitioners.

### Case study - Registered health service providers and AHPRA

Caitlin took her 11 year old daughter Jennifer to a general practitioner asking to have some small warts removed from her foot by freezing. The doctor undertook the procedure however it resulted in significant skin damage, scarring and an open wound requiring follow-up care. What was meant to be a simple procedure turned into a more complicated and painful issue for Jennifer. Caitlin questioned whether the doctor knew how to undertake the procedure safely.

HCSCC referred Caitlin's complaint about the doctor to AHPRA. AHPRA investigates complaints about allegations of unprofessional conduct of doctors and other registered health professionals.

The following tables provide information about HCSCC-AHPRA consultations during 2014-15.

#### HCSCC consultations with AHPRA and referral of complaints to AHPRA by HCSCC

	Number of HCSCC complaint consultations with AHPRA	Number of HCSCC complaints referred to AHPRA	Number of HCSCC complaints split* with AHPRA
Medical	134	42	11
Dental	10	5	0
Nursing & Midwifery	15	3	2
Pharmacy	1	1	0
Chiropractic	1	0	0
Physiotherapy	4	1	0
Optometry	1	0	0
Osteopathy	0	0	0
Psychology	3	0	0
Podiatry	3	0	0
Chinese Medicine	1	1	0
Medical Radiation Practice	0	0	0
Occupational Therapy	0	0	0
Aboriginal and Torres Strait Islander Health Practice	0	0	0
<b>TOTAL</b>	<b>173</b>	<b>53</b>	<b>13</b>

\*Part of the complaint involving a registered health practitioner is referred to AHPRA and part of the complaint is dealt with by HCSCC.

## AHPRA investigation outcomes resulting from referral of complaints by HCSCC to AHPRA

	Number of outcomes notified by AHPRA of action taken from HCSCC complaint referrals	AHPRA notified outcome *	
Medical	30	13	No further action following assessment
		14	No further action following investigation
		2	Caution following investigation
		1	Caution following investigation
Dental	1	1	No further action following assessment
Nursing & Midwifery	5	3	No further action following assessment
		1	No further action following investigation
		1	Undertakings accepted following assessment
Pharmacy	0	0	No outcome advised as at 30.6.15
Chiropractic	No complaints referred		No complaints referred
Physiotherapy	1	1	No further action following investigation
Optometry	No complaints referred		No complaints referred
Osteopathy	No complaints referred		No complaints referred
Psychology	No complaints referred		No complaints referred
Podiatry	No complaints referred		No complaints referred
Chinese Medicine	0	0	No outcome advised as at 30.6.15
Medical Radiation Practice	No complaints referred		No complaints referred
Occupational Therapy	No complaints referred		No complaints referred
Aboriginal and Torres Strait Islander Health Practice	No complaints referred		No complaints referred
<b>TOTAL</b>	<b>37</b>	<b>37</b>	

\*Note: 29 ongoing investigations - no outcomes notified by AHPRA as at 30.6.15

## AHPRA consultations with HCSCC and referral of complaints from AHPRA to HCSCC

	Number of AHPRA complaint consultations with HCSCC	Number of AHPRA complaints referred to HCSCC
Medical	70	1
Dental	11	2
Nursing & Midwifery	15	1
Pharmacy	6	0
Chiropractic	1	0
Physiotherapy	2	0
Optometry	0	0
Osteopathy	0	0
Psychology	5	0
Podiatry	1	0
Chinese Medicine	1	0
Medical Radiation Practice	0	0
Occupational Therapy	0	0
Aboriginal and Torres Strait Islander Health Practice	2	2
<b>TOTAL</b>	<b>114</b>	<b>6</b>

**AHPRA outcomes and outcome of any AHPRA action taken on AHPRA complaints consulted with HCSCC**

	<b>Number of outcomes notified by AHPRA of action taken by AHPRA</b>	<b>AHPRA notified outcome</b>	
Medical	60	37	No further action following assessment
		12	No further action following investigation
		4	Caution following assessment
		1	Caution and conditions following assessment
		4	Caution following investigation
		2	Closed following investigation – accept undertakings
Dental	7	5	No further action following assessment
		1	No further action following investigation
		1	Closed following investigation – conditions imposed
Nursing & Midwifery	11	8	No further action following assessment
		1	Caution and conditions imposed following assessment
		1	Closed – Accept undertakings following Health or Performance Assessment
		1	Closed – Caution and Accept undertakings following Health or Performance Assessment
Pharmacy	5	3	No further action following assessment
		1	No further action following investigation
		1	Caution following assessment
Chiropractic	0	0	No outcome advised as at 30.6.15
Physiotherapy	1	1	No further action following investigation
Optometry	0	0	Nil consulted
Osteopathy	0	0	Nil consulted
Psychology	5	4	No further action following assessment
		1	No further action following investigation
Podiatry	1	1	No further action following assessment
Chinese Medicine	1	1	Caution following investigation
Medical Radiation Practice	0	0	Nil consulted
Occupational Therapy	0	0	Nil consulted
Aboriginal and Torres Strait Islander Health Practice	0	0	Nil consulted
<b>TOTAL</b>	<b>91</b>	<b>91</b>	

As at 30.6.15 AHPRA had 3 complaints open from HCSCC referrals to AHPRA in 2012-13

As at 30.6.15 AHPRA had 1 complaint open from AHPRA complaints consulted with HCSCC in 2012-13

As at 30.6.15 AHPRA had 15 complaints open from HCSCC referrals to AHPRA in 2013-14

As at 30.6.15 AHPRA had 15 complaints open from AHPRA complaints consulted with HCSCC in 2013-14

## 6.7 Review of HCSCC Actions and Decisions

If people have concerns about the actions or decisions of HCSCC, either during or on conclusion of their complaint, they are able to:

1. request an internal review by the Commissioner
2. complain to the State Ombudsman.

The Commissioner is legally obliged to write to every complainant when a complaint is closed. Information about the complainant's right to seek a review from HCSCC and contact details for the State Ombudsman are included in these letters.

### Internal Review

Cases where reviews were requested are captured in the table below. In all cases, reviews were requested by complainants after HCSCC had decided to close a file.

Review open prior to 1.7.14 and closed during 2014-15	Review opened and closed during 2014-15	Review opened during 2014-15 and still open at 30.6.15
1	20	3

Of the 21 reviews closed during the year, HCSCC decided in 19 cases to uphold the original decision. Of the remaining two, HCSCC made further inquiries in one case and agreed in the other to follow up with the service provider on improvement actions they had identified as a result of the complaint.

### Case study

Karl complained to HCSCC about treatment provided to his friend, Quan, at an Adelaide hospital. Karl was Quan's legal guardian. Karl did not believe he was consulted properly about what treatment Quan, who could not speak for himself, wanted to receive. The hospital also thought Quan should be discharged to an aged care facility but Karl wanted him to return to his home.

HCSCC arranged a meeting between Karl and the service provider to attempt to resolve the issues. This was partly successful. HCSCC sought an expert opinion on the case.

During the time the complaint was open, there were changes to the law that should mean situations like the one Karl and Quan were in would be less likely to occur in the future. This related to the introduction of Advance Care Directives that enable people to spell out in advance, their wishes should they become incapacitated.

On the basis of these changes and improvements identified by the service, HCSCC closed the file. Karl complained to HCSCC about the decision. After this, HCSCC decided to follow up with the service provider to ensure the changes they proposed were actually implemented.

**Ombudsman review**

Section 86 (c) of the Act entitles a person who has made a complaint to HCSCC to request that the State Ombudsman review HCSCCs decision and action in regard to their complaint. At various times during the HCSCC complaint process, HCSCC will advise complainants of this right of review. Service providers can also complain to the Ombudsman about HCSCC.

The Ombudsman does not advise HCSCC in all cases if a complainant has sought a review of an HCSCC decision or action. HCSCC only becomes aware that a review has been sought if the Ombudsman requests information from HCSCC. The Ombudsman requests information from HCSCC in order to decide if he should investigate a complaint more formally. In most cases the Ombudsman requires HCSCC to have conducted an internal review prior to accepting a complaint.

During 2014-15, the Ombudsman informed HCSCC of six reviews. One matter that HCSCC was notified of in the previous year was closed during this reporting year.

Open prior to 1.7.14 and closed during 2014-15	Opened and closed during 2014-15	Opened during 2014-15 and still open at 30.6.15
1	6	0

Of the seven matters closed in 2014-15, the Ombudsman found no reason to investigate one matter after a response from HCSCC and found that HCSCC had not acted in a manner that was unreasonable, unlawful or wrong in the remaining six cases.

**Case study**

Joan complained to HCSCC about the treatment of her late husband, Fred, at a hospital. Fred had died in hospital and Joan believed it was because Fred had not been looked after properly.

HCSCC gathered information on the complaint from the hospital and sought an independent expert opinion on the complaint. The expert opinion showed that Fred had not died as a result of any shortfall in standards on the part of the hospital or treating team, but due to a complex set of pre-existing conditions.

HCSCC closed the file on this basis. Joan disputed the decision. HCSCC reviewed the file but could not find any justification to overturn the original decision or to make further inquiries.

Joan complained to the Ombudsman who requested information from HCSCC about its handling of the complaint and the basis for its decisions. HCSCC provided the required information. The Ombudsman found that HCSCC had not erred in its handling of the case.

## 6.8 Reasons for Closure of Complaints

Within the Act, the Commissioner may determine at any stage to take no further action on a complaint, or to suspend action on a complaint.

During 2014-15, HCSCC made a total of 2039 determinations to close complaints.

A summary of determinations are listed below:

<b>Reasons for Closure of Complaints</b>	
Advice and information provided	355
Outside Jurisdiction	8
Part 6 - s 54, 55 reports or 56 orders	87
Part 7 - s 58 Referred to registration authority	53
s 33 (1) (a) not entitled to make a complaint	8
s 33 (1) (b) does not disclose ground of complaint	43
s 33 (1) (c) should be determined by legal proceedings	7
s 33 (1) (d) proceedings have commenced before a tribunal, authority or other	8
s 33 (1) (e) reasonable explanation(s) or information provided	147
s 33 (1) (f) grounds should have been disclosed earlier	0
s 33 (1) (g) the complaint lacks substance	4
s 33 (1) (h) the complainant has failed to comply with a requirement	236
s 33 (1) (j) the complaint is abandoned	32
s 33 (1) (j) the complaint is resolved	71
s 33 (1) (k) reasonable cause - agreement to take reasonable steps to resolve complaint and/or prevent recurrence	7
s 33 (1) (k) reasonable cause - differing versions of events - unable to prefer one over the other	3
s 33 (1) (k) reasonable cause - other	214
s 33 (1) (k) reasonable cause - s 27 outside of time limit	11
s 33 (1) (k) reasonable cause - s 29 (2) (d) referral to another agency	38
s 33 (1) (k) reasonable cause - s 29 (3) referral to Aged Care Complaints Scheme	4
s 33 (1) (k) reasonable cause - s 29 (5) attempting direct resolution	658
s 33 (1) (k) reasonable cause - service provider met reasonable standards	20
s 33 (1) (k) reasonable cause - service providers resources are limited and equitably provided	21
s 33 (1) (k) the complaint has been adjudicated by a court or tribunal	1
s 34 (1) complaint withdrawn	3
<b>Total</b>	<b>2039</b>

## 7. Other Functions

In addition to the HCSCC Complaint Resolution Service, the Commissioner also has a statutory obligation to promote and protect the rights of people who use health or community services and to improve the safety and quality of health and community services.

Much of this work is multi-dimensional and often involves a broad range of activities such as education and awareness raising, the development and distribution of resources, liaising with sector/consumer representatives, influencing strategic policy development, provision of specialist training in complaints resolution and undertaking community engagement activities such as outreach projects, to name but a few.

The following information provides a summary of HCSCCs supplementary actions during 2014-15.

### 7.1 HCSCC Charter of Health and Community Services Rights (Part 3 of the Act)

Given that the HCSCC Charter of Health and Community Services Rights (the HCSCC Charter) came into effect on 23 June 2011, HCSCCs focus continues to be meeting HCSCCs statutory obligations to provide information, education and advice about the HCSCC Charter. This is a critical task in ensuring that the HCSCC Charter becomes an important statutory lever to uphold the rights of people seeking or using health or community services in South Australia.

The Charter Champion network currently has 67 registered Champions who are integral in promoting the Charter of Health and Community Services Rights.

HCSCC Charter Champions represent a broad range of consumer groups, health and community service providers, professional groups, local government, private hospitals, multicultural groups and other peak bodies.

HCSCC will continue to take advantage of the timing of consumer engagement initiatives to promote Charter Champions and increase numbers accordingly.

Charter Champions have a critical role in extending knowledge of the HCSCC Charter. It is important that the valuable Charter Champion network consolidates and grows and information and resources are key in that effort. Further work with Charter Champions will continue in 2014-15.

In addition to promoting the HCSCC Charter, section 85 of the Act requires HCSCC to take the HCSCC Charter into account when managing complaints. The Act requires HCSCC to consider several elements:

- the HCSCC Charter
- the generally accepted standard of service delivery expected of the service provider
- the resources reasonably available to the service provider and
- anything else the Commissioner thinks is relevant.

### 7.2 Code of Conduct for Unregistered Health Practitioners (Part 6 of the Act, Division 5)

Made under the Health and Community Services Complaints Regulations 2005, the Code of Conduct for Unregistered Health Practitioners came into effect on 14 March 2013.

#### Actions taken under the Code of Conduct

In 2014-15, there were six matters that involved the consideration of prohibition orders for unregistered health service providers who breached the code. One matter resulted in a final order that was made public whilst interim orders were considered or imposed on the remaining five cases.

New South Wales and South Australia are currently the only states with a Code of Conduct for Unregistered Health Practitioners and both states have provided valuable input into a proposed national code. Consultation on the national code will occur during 2014-15.



## Code of Conduct for Unregistered Health Practitioners

### Made under the Health and Community Services Complaints Regulations 2005

Unless exempt by the Regulations all unregistered health practitioners must display this Code of Conduct and the information for clients about how a complaint may be made to the Health and Community Services Complaints Commissioner. If an unregistered health practitioner has relevant qualifications, these qualifications must also be displayed. All of these documents must be displayed in a position and manner that makes them easily visible and accessible to a person entering the relevant premises. This requirement to display material does not apply to the following premises:

- Premises of any hospital, whether public or private (within the meaning of the *Health Care Act 2008*).
- Premises of any health care service established or licensed under the *Health Care Act 2008*.
- Premises of any day procedure centre.
- Premises of the SA Ambulance Service Incorporated.
- Premises of an approved aged care services provider (within the meaning of the *Aged Care Act 1997* of the Commonwealth).

## Schedule 2 – Code of Conduct for Unregistered Health Practitioners

### 1 – Preliminary

What is an unregistered health practitioner?

An unregistered health practitioner is someone who provides a health service and who doesn't have to be registered with a registration authority in order to provide his or her service.

In this schedule an unregistered health practitioner is called a health practitioner.

In this schedule a service user is called a client.

### 2 – Health practitioners to provide services in a safe and ethical manner

This code requires that health practitioners provide services in a safe and ethical manner. This means that the health practitioner must:

- (a) Maintain a reasonable level of competence in his or her field of practice.
- (b) Not provide health services that are outside his or her experience or training.
- (c) Not use his or her qualifications to mislead or deceive clients about his or her competence to provide a particular treatment.
- (d) Only prescribe treatment or devices that serve the needs of the client.
- (e) Recognise the limitations of treatments they can provide and, where appropriate, refer clients to other

competent health service providers.

- (f) Recommend that a client seek additional opinions or services where appropriate.
- (g) Assist a client to find other suitable health care professionals where appropriate.
- (h) Encourage a client to inform his or her medical practitioner (if any) of treatment received from the health practitioner.
- (i) Have a sound understanding of any adverse interaction between the therapies and treatments provided or prescribed and any other medications or treatments the client might be taking or receiving.
- (j) Ensure that appropriate first aid is available if needed during a consultation.
- (k) Obtain appropriate emergency assistance (such as an ambulance service) in the event of any serious misadventure or outcome during a consultation.

### 3 – Health practitioners diagnosed with infectious medical condition

Health practitioners who have been diagnosed with an infectious medical condition must:

- (1) Ensure that any services provided do not put the client at risk.
- (2) Take and follow advice from an appropriate medical practitioner regarding steps to avoid the possibility of transmission to clients.

### 4 – Health practitioners not to make claims to cure certain serious illnesses

- (1) The health practitioner must not claim to be qualified, able or willing to cure cancer or other terminal illnesses.
- (2) Health practitioners must not claim the ability to treat, alleviate or cure serious illnesses unless the claim can be substantiated.

### 5 – Health practitioners to take precautions for infection control

Health practitioners must take appropriate precautions for the control of infection while providing a service.

### 6 – Appropriate conduct in relation to treatment advice

- (1) Health practitioners must not attempt to dissuade a client from seeking or continuing treatment by a registered medical practitioner.
- (2) The health practitioner must accept a client's right to make an informed choice in relation to his or her own health care.
- (3) Health practitioners should communicate and cooperate with colleagues and other health care practitioners and agencies in the best interests of the client.
- (4) Health practitioners who have serious concerns about the treatment provided to a client by another health practitioner must refer the matter to the Health and Community Services Complaints Commissioner.

### 7 – Health practitioners not to practise under influence of alcohol or drugs

- (1) Health practitioners must not provide services while intoxicated by alcohol or any other substance.
- (2) The health practitioner on prescribed medication must obtain advice from the prescribing health practitioner on the impact that medication might have on his or her ability to practise and must not treat a client if his or her ability might be impaired.

### 8 – Health practitioners not to practise with certain physical or mental conditions

A health practitioner must not provide a service while physically or mentally impaired, including if he or she is impaired by addiction to alcohol or a drug, or if his or her

impairment may lead to the client being harmed.

#### **9 – Health practitioners not to financially exploit clients**

##### **Health practitioners must not:**

- (1) Accept a financial inducement or gift for referring a client to another health practitioner or supplier of medications or therapeutic goods or devices.
- (2) Offer a financial inducement or gift in return for a referral from another health practitioner.
- (3) Provide a health service or treatment to a client unless they are designed to maintain or improve the client's health or wellbeing.

#### **10 – Health practitioners required to have clinical basis for treatments**

Health practitioners must have a valid clinical basis for treating a client. Health practitioners must not diagnose or treat an illness or condition unless there is an adequate clinical basis to do so.

#### **11 – Health practitioners not to misinform clients**

- (1) Health practitioners must be truthful about their qualifications, training or professional affiliations if asked by a client.
- (2) Health practitioners must not make claims, either directly or in advertising or promotional material, about the efficacy of treatments or services if the claims cannot be substantiated.

#### **12 – Health practitioners not to engage in sexual or improper personal relationship with client**

Health practitioners must not engage in sexual or other close personal relationships with clients.

Before engaging in a sexual or other close personal relationship with a former client, a health practitioner must ensure that a suitable period of time has elapsed since the conclusion of his or her therapeutic relationship.

#### **13 – Health practitioners to comply with relevant privacy laws**

Health practitioners must comply with State or Commonwealth laws relating to the personal information of clients.

#### **14 – Health practitioners to keep appropriate records**

Health practitioners must maintain accurate, legible and up to date clinical records of each client consultation.

#### **15 – Health practitioners to keep reasonable insurance**

Health practitioners should ensure that his or her practice has reasonable indemnity insurance.

### 7.3 Health and Community Services Advisory Council (Part 8 of the Act)

The Health and Community Services Advisory Council ceased operation on 8 November 2014 when the terms of all but one member concluded. The Council was identified for abolishment in the review of government boards and committees in that month.

The Council included a diverse membership representing people who use health and community services, health and community service providers and health practitioner registration authorities.

During 2014-15 the following people were members or deputies on the Council:

<b>Stephanie Miller</b> Presiding Member	<b>Jennifer Hall</b> Member representing the interests of users of health services	<b>Vacant</b> Member representing the interests of users of health services
<b>Athena Karanastasis</b> Member representing the interests of users of community services	<b>Dr David Walsh</b> Member representing the interests of health and community service providers	<b>Jennifer Hurley</b> Member representing the interests of health and community service providers
<b>Josephine Bradley</b> Member of registration authorities representing interests of the public	<b>Linda Starr</b> Member of registration authorities representing interests of the public	<b>Dr Naquibul Islam</b> Member representing the interests of users of community services
<b>Lynette Woodforde</b> Member representing the interests of carers	<b>Virginia Wilkinson</b> Member with appropriate experience in relation to the quality and safety standards of health care	<b>Vacant</b> Deputy Member representing the interests of users of health services
<b>Lorraine Sheppard</b> Deputy Member of registration authorities representing interests of the public	<b>Carolyn Donaghey</b> Deputy Member representing the interests of carers	<b>Dr Elaine Pretorius</b> Deputy Member with appropriate experience in relation to the quality and safety standards of health care
<b>Konrad Gawlik</b> Deputy Member representing the interests of users of community services	<b>Harold Stewart</b> Deputy Member representing the interests of health and community service providers	

The Council met twice in 2014-15, before ceasing operations, at which time the Commissioner provided Council members with information about HCSCCs activities and work plan. The Council also provided the Commissioner with support and helpful and timely advice on strategic directions and relevant contextual information for considering significant matters.

## 7.4 Assistance to service providers

One of HCSCCs roles is to assist service users, complainants and service providers to improve the safety and quality of services provided and to improve management of complaints.

During the year a wide variety of service providers contacted HCSCC to seek assistance with issues that may never become complaints.

HCSCC seeks to provide sufficient information or appropriate referrals to assist the service provider to manage the situation. Sometimes HCSCC identifies that formal action needs to be taken and HCSCC will either request the matter be referred or will take action at the Commissioner's discretion, based on the information provided.

The following are examples of the types of assistance, information and advice service providers sought from HCSCC during 2014-15:

- concerns about the actions or inactions of other health or community service providers
- whether particular complaints should be referred to HCSCC
- drawing reasonable boundaries around complainants who are dissatisfied with the handling of a complaint
- where and how to access advocacy services
- drafts of complaints handling policies and procedures
- how to meet obligations under the HCSCC Code of Conduct for Unregistered Health Practitioners.

HCSCC also received requests from service providers and peak bodies for feedback on their complaints policy and guidelines.

## 7.5 Community Engagement

The breadth and complexity of HCSCCs jurisdiction requires HCSCC to develop a broad range of networks and professional partnerships. The following information provides a brief summary of HCSCCs key initiatives for 2014-15.

### External Relationships

HCSCC met regularly throughout the year with a number of key stakeholders, some of which include representatives from SA Health, Health Consumers Alliance SA, Carers SA, Council on the Ageing (COTA), the Department for Communities and Social Inclusion (DCSI), Disability SA, Department for Education and Child Development (DECD), Department for Aboriginal Affairs and Reconciliation, Families SA, the South Australian Council of Social Service, the Public Advocate, other South Australian statutory authorities networks, interstate complaints bodies, the South Australian Parliament and Ministers of relevant portfolios.

Much of this work relates to the direct exchange of information, the progression of individual matters and/or to influence the development of strategic policy or service initiatives for the purpose of addressing identified systemic issues.

Examples of some of this work include:

- Community Visitor Scheme Advisory Committee with SA Health and DCSI
- SA Health Partnering with Consumers and the Community Advisory Group
- SA Health Open Disclosure Work Group
- Office of the Public Advocate Supported Decision Making Project
- Safeguarding and rights for people living with disabilities.

### Australian Complaints Commissioners' Conferences

The Complaints Commissioners from each state and territory meet twice each year. They are joined by the federal Aged Care Commissioner, the New Zealand Health and Disability Commissioner and a representative of the four Queensland Complaints Commissioners. The meetings are hosted in turn by each participant and the last financial year's

conferences were held in New Zealand and Melbourne.

The conferences provide a forum to showcase new approaches to complaints management, to lift and improve practices and to consider matters of common interest, including the three year review of the national law for registration of registered health practitioners and the Australian Health Practitioner Regulation Agency, the body that administers the law and also a national code for health care workers whose work does not come within the scope of the national law.

New Zealand often provides an interesting contrast in approach and with two spheres of government it is most agile in its approach to providing integrated health services with primary health care providers utilising the same systems as the hospital sector.

In line with public sector reporting requirements, the international travel costs incurred in representing South Australia at the New Zealand conference will be available on the HCSCC website or by contacting the HCSCC office. In short, the airfare and accommodation costs were approximately \$2000.

### Submissions

Throughout 2014-15, HCSCC provided submissions and comment in response to a number of papers including:

- Australian Health Ministers' Advisory Council – Review of the National Registration and Accreditation Scheme for health professions
- Child Protection Systems Royal Commission
- Department of Education and Child Development – Complaints Management and Resolution Procedure and Unreasonable Complainant Conduct Procedures
- Independent Commissioner Against Corruption SA – Review Of Schemes Governing The Oversight And Management Of Complaints About Police And Complaints And Reports About Public Administration
- National Disability Insurance Agency – Safety and Quality Framework
- Proposed Commissioner for Children and Young People Consultation Draft Bill
- Parliamentary Select Committee on Statutory Child Protection and Care in South Australia
- SA Health – Transforming Health.

## Communications

HCSCC promotes its activities through its newsletter, Rights Insights.

During 2014-15 HCSCC distributed one issue of Rights Insights to its registered subscribers and key stakeholders with updates about HCSCCs activities and work program.

HCSCC was promoted at diverse forums and events, for example:

- Disability Expo
- Homelessness Expo
- NAIDOC
- National Sorry Day
- Southern Reconciliation Week.

## HCSCC Presentations

During 2014-15, HCSCC staff provided a number of external presentations which included:

- The Queen Elizabeth Hospital 'Grand Rounds'
- SA Prison Health Senior Nurses Group
- Onkaparinga Council Health Rights Event
- Julia Farr Youth Mentor Group
- UCWPA Mental Health Programs
- National Disability Agency north and south offices.

## HCSCC Resources

In 2014-15, HCSCC distributed 6405 consumer brochures and 7310 Know Your Rights – a guide to the HCSCC Charter of Health and Community Services Rights brochures in response to requests from a wide variety of individuals and organisations. Demand for other HCSCC resources also included high levels of interest in the Speak Up brochures and posters.

In addition to the resources that are available in printed format, HCSCC also has a wide range of resources available to download directly from the HCSCC website, including:

- Code of Conduct for Unregistered Health Practitioners
- HCSCC Charter Information Sheet
- Know Your Rights - a guide to the HCSCC Charter in South Australia brochure.

HCSCC, assisted by SA Health, translated two brochures for consumers from non-English speaking backgrounds:

- HCSCC Consumer Brochure (A step by step guide about how to complain about a health or community service). This brochure has been translated into the following languages: Arabic, Chinese simplified (Mandarin), Croatian, Greek, Hindi, Italian, Persian, Serbian, Spanish, Swahili, Vietnamese.
- HCSCC Charter of Rights – Information Sheet (Your Rights when using a health or community service). This has been translated into the following languages: Arabic, Bulgarian, Chinese simplified, Chinese traditional, Croatian, Dari, Dinka, English, German, Greek, Hindi, Hungarian, Indonesian, Italian, Kurdish, Macedonian, Nepali, Persian, Polish, Punjabi, Pushto, Russian, Serbian, Swahili, Tamil, Vietnamese.

## Training

HCSCC has a range of courses that can be tailored to meet an organisation's needs - the majority are free of charge. For more information please contact HCSCC.

## 7.6 HCSCC Supported Decision Making Project

As reported in previous annual reports, in August 2013, HCSCC decided to fund a two year demonstration project working with vulnerable people living with disability, to highlight the importance of having the opportunity to develop and strengthen skills and social supports to explore and engage in fuller lives. Over the last two years, the Supported Decision Making Project (SDM) has unquestionably demonstrated that in a relatively short period of time, people with complex lives who were mainly service dependent, could live dramatically different lives that were not reliant on services but became part of the wider social community.

The HCSCC SDM Project Officer, Ms Cher Nicholson, successfully completed the second round of the project in June 2015 with participants from Strathmont and Cara.

The second round independent evaluation will be made publicly available after September 2015. The evaluation of the first round is available on the HCSCC website.

HCSCC has completed the two year funding of the SDM project and will now redirect that part of the budget to another demonstration project aimed at promoting and strengthening the rights and safety of people living with disability.

HCSCC would like to thank Ms Nicholson and the staff and management of Cara and Strathmont for their dedication to this important work and share their hope that the project will continue into the future.

## SDM project after HCSCC and into the future

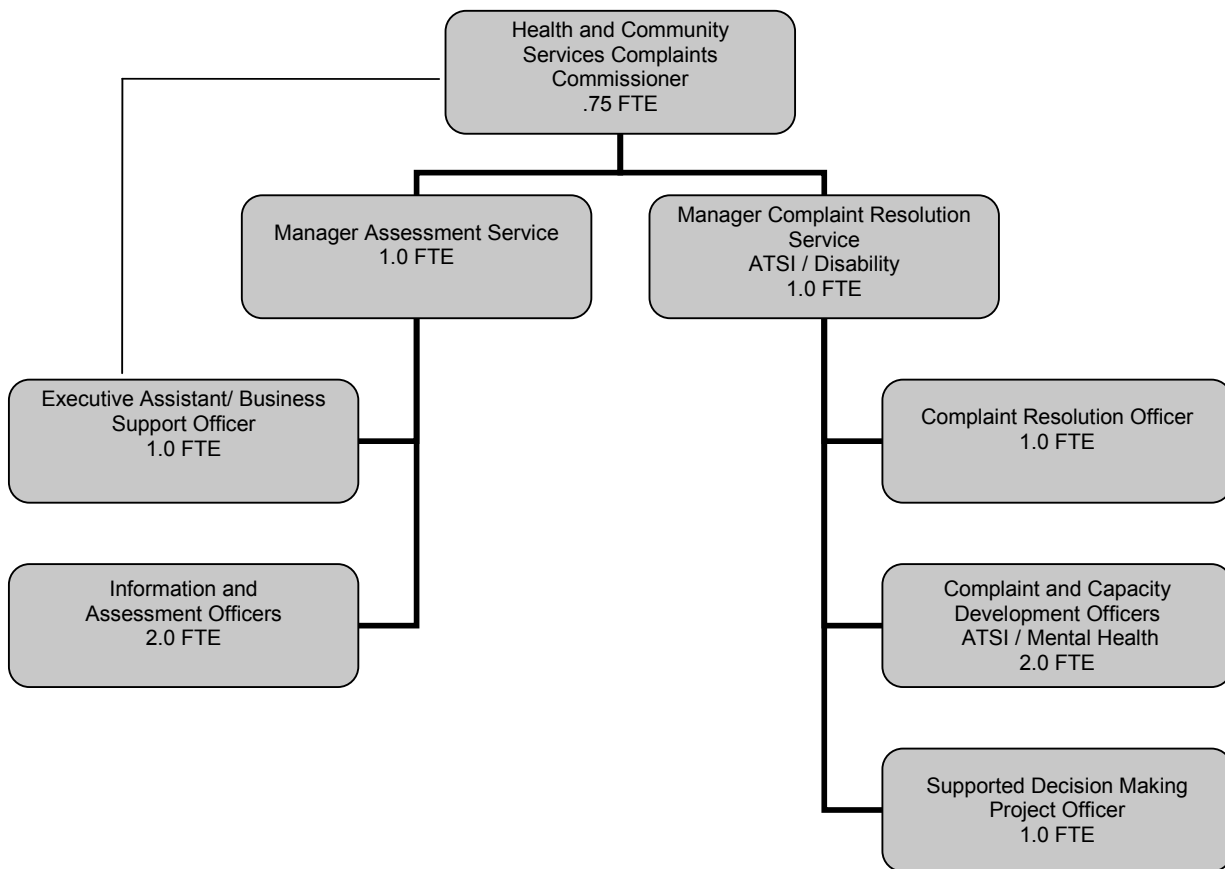
In early 2015, Cara, Strathmont and HCSCC agreed that the SDM project needed to continue beyond HCSCCs two year funding.

A collaborative funding submission was made in May 2015 to the Community Inclusion and Capability Development Fund managed by the National Disability Insurance Agency. The application was for three rounds of the SDM project over two years with an emphasis on developing a 'train the trainer' model to increase accessibility and sustainability.

HCSCC was advised that the NDIS application was unsuccessful. HCSCC, Cara and Strathmont will continue to explore how to continue with this important work.

## 8. Human Resources

HCSCC organisational chart as at 30 June 2015



Staff of the office of the HCSCC (excluding the Commissioner) are employed by the Department for Health and Ageing. Statistical reporting relating to HCSCC staff is also captured in the Department for Health and Ageing 2014-15 Annual Report.

## Executives by Gender, Classification and Status

Classification	Ongoing		Term Tenured		Term Untenured		Other (Casual)		Total			
	M	F	M	F	M	F	M	F	M	%	F	%
Commissioner			1						1	100		
<b>Total</b>			<b>1</b>						<b>1</b>	<b>100</b>		

## Leave Management - Average Days Leave Per Full Time Equivalent Employee

Total Days Leave Taken – 2015 Average FTE – 11.8 days

Leave type	2011-12	2012-13	2013-14	2014-15
Sick Leave	9.60	7.40	9.0	9.46
Family Carer's Leave	1.50	1.10	0.5	1.66
Special Leave With Pay	1.40	1.60	7.0	2.54

## Workforce diversity - Employees by Age Bracket by Gender

Age Bracket	Male	Female	Total	% of Total	2014 Workforce Benchmark*
15 - 19					5.5%
20 - 24					9.7%
24 - 29					11.2%
30 - 34					10.7%
35 - 39	0	1	1	9.09	9.6%
40 - 44	0	1	1	9.09	11.4%
45 - 49	2	1	3	27.27	11.1%
50 - 54	0	2	2	18.18	11.4%
55 - 59	0	1	1	9.09	9.1%
60 - 64	1	1	2	18.18	6.7%
65+	0	1	1	9.09	3.6%
<b>Total</b>	<b>3</b>	<b>8</b>	<b>11</b>	<b>100</b>	<b>100</b>

\*Source: Australian Bureau of Statistics Australian Demographic Statistics, 6291.0.55.001 Labour Force Status (ST LM8) by sex, age, state, marital status – employed – total from Feb78 Supertable, South Australia at November 2013

## Total Number of Employees with Disabilities (According to Commonwealth DDA Definition)

Male	Female	Total	% of Agency
0	1	1	9.1

## Types of Disability (Where Specified)

Disability	Male	Female	Total	% of Agency
Disability requiring workplace adaptation	0	1	1	9.1
Physical	0	0	0	0
Intellectual	0	0	0	0
Sensory	0	1	0	9.1
Psychological / Psychiatric	0	0	0	0

## Documented Review of Individual Performance Management

HCSCC uses the SA Health Performance Development and Review Policy and resources to review performance and development for all permanent staff.

As a small, agile office, HCSCC relies on strong internal communication strategies and regular case reviews. Performance management is ongoing and constant.

## Leadership and Management Training Expenditure

Training and Development	Total Cost	% of Total Salary Expenditure
Total training and development expenditure	\$0	0%
Total leadership and management development expenditure	\$2100	0.22%

## Work Health and Safety and Injury Management

HCSCC Work Health and Safety and Injury Management information is included in the Department for Health and Ageing Annual Report.

## 9. Financial Statements

HCSCC is funded from the State Budget. HCSCCs financial transactions are included in the financial statements of the Department for Health and Ageing (DHA) Annual Report. HCSCC transactions are audited by the Auditor-General, along with those of DHA.

HCSCCs funding and expenditure (expressed in rounded dollars) for 2014-15, as provided by the DHA (pending certification by the Auditor-General), is summarised below.

<b>Recurrent Base as at 1.7.14</b>	<b>\$ 1 286 307</b>
Crown Solicitor's Office Budget*	\$ 79 000
<b>Revised Annual Budget as at 1.7.14</b>	<b>\$ 1 365 307</b>

### Summary of Revenue and Expenditure

<b>Total Revenue</b>	<b>\$ 131 216</b>
<b>Salaries and Wages</b>	<b>\$ 939 689</b>
Goods and Services	\$ 511 954
<b>Total Expenses</b>	<b>\$ 1 451 643</b>
<b>Net Operating Result</b>	<b>\$ 1 320 427</b>
<b>Under / (Over) Budget Result</b>	<b>\$ 44 880</b>

\*The Crown Solicitor's Office budget cannot be reallocated away from legal advice and represents the majority of under-expended funds.

### Fraud

This section of the report deals with resourcing issues. For completeness, it is reported that HCSCC had no incidents of fraud or theft to report.

### Contractual Arrangements

HCSCC did not enter into any major contracts.

# 10. Mandatory Reporting Items

## **Reporting Against the Carers Recognition Act 2005**

HCSCC expended monies on supporting a staff member in their capacity of carer and provided carers leave to staff as warranted.

## **Disability Access and Inclusion Plans**

The needs of two staff members who need workplace modifications are continually monitored and any requirement is actioned accordingly.

## **Freedom of Information Statement**

Under the Freedom of Information (Exempt Agency) Regulations 1993, the Commissioner is exempt from the provisions of the *Freedom of Information Act 1991*. HCSCC follows the SA Health Code of Fair Information Practice as far as possible.

## **Whistleblowers Protection Act 1993**

HCSCC has appointed a responsible officer for the purposes of the *Whistleblowers Protection Act 1993* (WPA) pursuant to Section 7 of the Public Sector Act 2009. There have been nil instances of disclosure of public interest information to a responsible officer of the Department under the WPA.

## 11. Glossary

ACCS	Aged Care Complaints Scheme
AHPRA	Australian Health Practitioner Regulation Agency
COTA SA	Council on the Ageing SA
CRU	Country Referral Unit
DCSI	Department for Communities and Social Inclusion
DECD	Department for Education and Child Development
GP	General Practitioner
HCA	Health Consumers Alliance
HCE	Health Complaints Entity
HCSCC	Health and Community Services Complaints Commissioner
ICU	Intensive Care Unit
MOU	Memorandum of Understanding
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NSQHS	National Safety and Quality Health Service
SDM	Supported Decision Making Project
SMS	Short Message Service
TTY	Text Telephone
UCWPA	Uniting Care Wesley Port Adelaide

# Notes



**hcsc**c  
health & community services  
complaints commissioner