Annual Supervision Report 2007

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Editor: Lars E. Hanssen
Editorial Group: Magne Braaten, Helge Høiføldt, Sverre Nesheim, Finn Pedersen (leader), Kristina Totlandsdal and Nina Vedholm

Nynorsk translation: SPRÅKSMIA as
English translation: Linda Grytten
Sami translation: Inger Anna Eira Andersson

Graphic layout and printing: 07 Gruppen (formerly GAN).
Illustrations: Svein Størksen.
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Comments and questions can be sent to: tilsynsmelding@helsetilsynet.no
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"We cannot afford more, so this must be good enough"

We sometimes hear the above statement when we carry out supervision of health and social services. This is a statement that we do not like. We know that the services have economic constraints that must be taken into account. But the statement reflects the attitude that the service has given up working to improve the quality of the services provided.

One of the main tasks of the Norwegian Board of Health Supervision is to ensure that health and social services are provided in accordance with statutory requirements. The requirements laid down in laws and regulations are central elements when health services are planned, provided and evaluated. Statutory requirements should be fulfilled within the given economic restraints. This presents considerable challenges. Good management involves not only keeping within the budget, but also producing the best results possible with the available resources.

Clients have the right to receive essential services that meet sound professional standards. The legislation demands that services shall be adapted to the individual needs of the client. Therefore, service providers cannot just say to clients: "this is how we do it here", or "these are the limits we have set and that you have to accept".

The way services are organized and the procedures that are laid down should be seen as providing the foundation for developing services that are adapted to individual needs.

Unfortunately, a common finding from supervision is the lack of adaptation of services to the needs of individual clients. We believe that this is an important area for service providers to work on, if people are to have faith in services in the next few years. The experiences of clients must be taken into account when developing services. The same applies to the experiences of employees. This is an important element in an internal control system.

An internal control system shall ensure that management of services is founded on assessment of health-related and social-related factors, and not just on economic and administrative considerations. In this respect, leaders, administrators and directors have a lot of work to do.

We believe that the results of supervision point out areas that need to be developed. We hope that you will find food for thought in the following pages.

Lars E. Hanssen

"The legislation demands that services shall be adapted to the individual needs of the client."

Do municipalities ensure provision of adequate respite care and support contact services?

"Awareness of and adequate knowledge about the special needs of each client is essential for providing high quality respite care and support contact services."

In 2007 the County Governors carried out countrywide supervision of respite care and support contact services, as laid down in the Social Services Act. The aim of supervision was to see whether these services are provided, and whether the municipalities ensure that people who provide respite care (respite carers) and support contact services (support contact persons) have adequate knowledge and skills. In 61 of the 66 municipalities where supervision was carried out, the County Governors detected nonconformities (breaches of laws or regulations) or observations were made (this means that the supervision authority commented about areas identified as having potential for improvement) in one or both of the areas investigated.

The municipalities have a duty to provide respite care and support contact services, but can organize these services in the way they think is most appropriate, as long as the right of clients to receive these services is fulfilled. The municipalities must also manage the services in such a way that they detect cases of clients who receive respite care and support contact services that are not adapted to the clients' individual needs.

Knowledge and skills

Awareness of and adequate knowledge about the special needs of each individual client is essential for providing high quality respite care and support contact services. People who provide these services must receive training in different aspects of care for each individual client, such as communication, technical aids, diet and medication. The municipality has responsibility for providing training for all social services staff, so that they have the knowledge and skills required to carry out their work. The staff also have a duty to participate in the training that the municipality has decided they shall have. Even if the municipalities ensure that training and guidance are provided, this does not automatically lead to high quality services. Knowledge and skills must be applied and used in practice, for example in interaction with the client.

Adequate allocation of services?

In three-quarters of the municipalities, the County Governors detected deficiencies related to allocation of respite care and support contact services.

In many of the municipalities, administrative procedures were found to be inadequate, for example procedures for assessing needs and making individual evaluations. The municipalities often provided support contact services for a set number of hours per week, for example three hours, without assessing the need of each individual client for support contact. Regular assessments for detecting the need for changes were seldom carried out. In many municipalities, decisions were given orally, without the possibility to appeal against the decision, documentation was lacking, and information was not given about the possibilities to apply for other services. Information about the possibility for applying for respite care was often only given for children and people with physical disabilities. Private respite care and support contact services are seldom available for elderly people. Allocation and provision of respite care and support contact services were often carried out by several different units in the municipality, and often organized according to diagnosis or the age of the client. This could lead to differences in allocation practice within the same municipality.

The results of supervision also show that some municipalities do not distinguish clearly between respite care in an institution according to the Social Services Act, and short-term residence in an institution according to the Municipal Health Services Act. Short-term residence is granted to a person who needs rehabilitation after he or she has been treated in an institution. Respite care is granted when the carer needs respite from providing care. The municipality can demand payment from the client for short-term residence. When the municipality does not distinguish clearly between respite care and

References:
- Report from the Norwegian Board of Health Supervision 4/2008
- Guidelines for supervision. www.helsetilsynet.no

"In well over half of the municipalities that were included in the supervision, the County Governors found that the municipalities did not ensure that people who provide respite care and support contact services have adequate knowledge and skills to carry out their work."

short-term residence, the result can be that payment may be claimed for respite care, which is not in accordance with the regulations.

Many of the municipalities have problems in providing the services they have allocated. One reason for this may be that it is difficult to recruit respite carers and support contact persons. This applies particularly to private persons who provide these services. When services that had been allocated were not provided, provisional measures were often not provided either, as should be done according to the regulations. For example, respite care can be provided in an institution until a respite carer is appointed. In many places, respite care was provided according to what was available, for example a place in an institution – a nursing home or sheltered housing – and not according to the needs of the client.

Do respite carers and support contact persons have adequate knowledge and skills?

In well over half of the municipalities that were included in the supervision, the County Governors found that the municipalities did not ensure that respite carers and support contact persons had adequate knowledge and skills to carry out their work. Many municipalities do not follow up the services, do not have regular contact with respite carers and support contact persons, and do not offer them training and guidance. Training is given more often before these services are initiated rather than during the time the client is actually receiving the service. Often the client or his or her family have to find a respite carer or support contact person themselves, and have to provide training and give information about the job. Many of the municipalities lacked routines or procedures for evaluating the services. Evaluation is essential in order to be able to improve the services and to ensure that clients receive the services they are entitled to according to the legislation.

Support contact

Support contact is a service that aims to help clients to have meaningful leisure-time and social contact. The support contact person shall accompany the client to different leisure-time activities, ensure that the client has social contact, and provide support for the client to deal with social situations. This service can be an important measure for elderly people, children, young people and adults with mental disorders, people with physical disabilities, immigrants who are unfamiliar with Norwegian society, families with complex problems, and people with alcohol and drug problems.

Respite care

Respite care has two aims. The first aim is to take care of the client, for example a physically handicapped child or an elderly person with needs for care. The second aim is to help the carers, for example parents and spouses. Respite care is only provided for people who have especially burdensome caring work, and includes both people who provide care, but who have no duty to do so, and parents who have a duty to provide care for their children. Usually the municipalities provide three different types of respite care:

- individual or private respite care in which the respite care is provided in private homes, or in the home of the client. This type of respite care is often provided for young children, but also for people with physical disabilities.
- respite care provided in sheltered housing, or in an institution such as a nursing home
- respite care provided for a group of clients, such as trips or journeys.

For someone to have the right to receive respite care, they must fulfil the requirements laid down in the Social Services Act, Section 4-3, that is to say: "persons who are unable to care for themselves, or who are completely dependent on practical or personal help to manage their daily tasks…". The municipality can provide respite care for people in all phases of life, and respite care must be adapted accordingly. Respite care can make it possible to maintain good family relationships and prevent the carer becoming worn out.

Municipal health and social services for adults with mental disorders

In 2007 the Norwegian Board of Health Supervision in the Counties and the County Governors carried out country-wide supervision of health and social services for adults with mental disorders. This involved 68 municipalities and urban districts throughout the country. In 44 of these municipalities, nonconformities (breaches of laws or regulations) were detected. No nonconformities were detected in the other 24 municipalities, but in eleven municipalities observations were made – this means that the supervision authority commented about areas identified as having potential for improvement. In thirteen municipalities, no nonconformities were detected and no observations were made.

"The staff were unsure about who had responsibility for making assessments, what should be assessed, and how this should be done."

During the last few years, the municipalities have been given increasing responsibility for taking care of people with serious mental disorders, and for providing services for them so that they can manage to live in their own homes. This is a complex, non-homogenous group of clients, who have a wide range of needs. The clients with the most serious mental disorders may have long-term illness, and the severity of their illness may vary over time. In addition, some of these clients have alcohol and drug problems. Many of them have extensive needs for services and may require comprehensive support and follow-up 24 hours a day. For example, they may require daily activities, help and support in the home, and sheltered employment, in addition to treatment and follow-up from primary and specialized health services.

There is great variation in the way in which Norwegian municipalities have organized and developed their services. However, most of the municipalities have specific services for people with mental disorders, with personnel who have special responsibility for assessing these clients and providing services for them. Particularly in large municipalities, many different services and people are involved in providing care for each individual client. This is also the case in the municipalities that were included in supervision.

The aim of supervision was to investigate whether municipalities provide health and social services for adults 18 years of age and older who have serious mental disorders, in accordance with statutory requirements. Specific areas for supervision were: whether services were adequate and available for all the people who needed them, whether services were adapted to the individual needs of the clients, and whether the different services were coordinated so that the total service was comprehensive. Other specific areas for supervision were: whether the municipalities fulfilled the statutory requirements for client participation, individual adaptation of services, coordination of services, and provision of services of sound professional standards, throughout the whole continuum of care – from the beginning when the need for care is identified and assessed, through planning, implementing, following up and adjusting services and measures.

Since supervision involved many aspects of a complex area, the supervision teams may have focussed on different aspects. Based on their previous knowledge of the municipalities, the teams may have made an assessment about which areas the danger for deficiencies occurring was greatest, and given priority to these areas.

Assessment and planning of services

The more complex clients' needs are, the greater the demands for assessment and planning. But the risk for services not being based on sound assessment of individual needs is also greater. Clients with the most comprehensive needs have the most to loose if they are not given an adequate assessment, or if they do not receive adequate services. Assessment of clients shall be made within reasonable time, and decisions that have been made shall be clearly documented. It is important that all relevant information is collected for making an assessment and for planning which services to provide. A thorough assessment of the client's needs, wishes and suggestions is essential, in order to provide services that the client can gain the maximum benefit from.

In one out of four of the municipalities where supervision was carried out nonconformities were detected or observations were made about the way in which needs for services were assessed. There were several examples in which applications and requests for services were not assessed within reasonable time. In some municipalities, responsibility was unclear, tasks were not clearly allocated, and staff were unsure about who had responsibility for making assessments, what should be assessed, and how this should be done. In such a situation, decisions about service provision may not be based on the real needs of the client. In several municipalities, information and documentation was not collected from other units and services. There is then a danger that different units and services can

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References:

- Report from the Norwegian Board of Health Supervision 3/2008
- Guidelines for supervision. www.helsetilsynet.no

make different assessments, without these assessments being coordinated. Without a complete picture of the client's needs for services, it is difficult to formulate clear goals for care, and to give clients the possibility to have an influence.

Inadequate service provision

Based on the reports from this supervision, there is reason to believe that in many places the services offered are determined to a large extent by available resources rather than by clients' needs. For example, in many municipalities follow up was not offered outside normal working hours, and in some municipalities there were no contingency plans to deal with crisis situations in the evenings, at night, at weekends, or on public holidays. In some places, counselling services provided by psychiatric nurses were cancelled for long periods during holiday times, and no alternative service was offered.

Coordinated and stable service provision

In order for the different services to be comprehensive, the different service providers must communicate with each other, they must coordinate the services, and they must cooperate with each other. The greater the number of services required, the greater the need for practical adaptation of the services offered. This is the case because these services are organized in different units, they are regulated by different legislation, and they are provided by many different types of professionals (for example milieu therapist, accommodation consultant, home help, district nurse, psychiatric nurse, general practitioner). Without clear management and clearly defined delegation of tasks, responsibility and authority, there is a high risk that deficiencies may occur. The consequences of deficiencies are most serious for clients who have the most comprehensive needs, and who need services over long periods of time. There is a risk that they do not receive all the services they require, or that different measures pull in different directions.

In one out of three of the municipalities where supervision was carried out, the arrangements for coordination of service provision were so inadequate that the supervision authorities either confirmed that there was a nonconformity (failure to meet statutory requirements) or observations were made (comments were given about the need to improve the arrangements).

In some municipalities the different services had inadequate knowledge about the services and measures provided by others, and there were different views about how tasks should be distributed between the different units. Thus it was difficult to establish a common understanding among the units about clients' needs, about who does what, and about the aims of service provision.

Exchange of information necessary for providing services was also found to be inadequate in many municipalities. In several municipalities, the different services not only had their own patient records, but they also had different systems for documenting information about clients, and they had different assessments about what information was important to record and archive. Some of the personnel in sheltered accommodation had limited information about the residents. Some of the district nurses lacked important information about the clients they had responsibility for. Not everyone knew what the opening times of the mental health unit were. Some general practitioners had not been given all the information and documentation that they required. In order to ensure that services are adequate all the time, service providers need to have access to information within the limits of confidentiality, they must be able to identify the need for changes in service provision, and that they must be able to act accordingly.

Individual plans

The purpose of individual plans is to ensure that the needs of each client for services are seen in relation to each other, that services are comprehensive and adapted to the individual, and that responsibility for following up the client over time is clearly allocated. In other words, individual plans should prevent the type of deficiencies that were detected in many municipalities.

In almost half of the municipalities where supervision was carried out, the supervision authorities made observations about areas with potential for improvement, and in many municipalities they found nonconformities in relation to individual plans. In many municipalities there is a long way to go before the right of clients to have an individual plan is met, and before these plans function as intended. Not everyone with the right to have a plan had a plan, some clients had plans that were inadequate, some had plans that were out of date, and others had plans that had not been followed up. Some of the leaders did not manage the services adequately, and they did not appoint coordinators with adequate responsibility and authority to follow up the work. In some municipalities, the function of coordinator was regarded as a voluntary task.

Inadequate management in accident and emergency units

"The leadership of the health trusts have responsibility for ensuring that daily tasks are planned, organized, carried out and improved in accordance with legislative requirements."

In 2007 the Norwegian Board of Health Supervision in the Counties carried out countrywide supervision of 28 of the 53 accident and emergency units within specialized health services in Norway, to see whether these services were provided in accordance with legislative requirements. We found that, in general, inadequate management and leadership affects the day-to-day running of these services. In our view, this sometimes results in provision of treatment that does not meet sound professional standards. When the units are busy and many patients arrive at the unit at the same time, patients often have to wait for a long time before the doctor examines them and makes a diagnosis. There is often a long waiting time before the patient comes to the department where medical treatment is provided. While waiting, patients may become dehydrated, or may not receive adequate pain relief. The result may be that the patient's condition becomes worse, that the medical assessment is inadequate, or that the wrong treatment is given.

The leadership of the health trusts have responsibility for ensuring that daily tasks are planned, organized, carried out and improved in accordance with legislative requirements. Reception, prioritization, examination, diagnosis, monitoring and treatment of patients in accident and emergency units shall be in line with sound professional standards. The main aim of supervision of these services was to investigate whether health trusts fulfil their responsibilities, and how they do this. In order to investigate this, patients with undiagnosed conditions were chosen as an example. These are often elderly patients with multiple organ failure, and with a range of symptoms, such as back pain, stomach pain, confusion and nausea. In many ways, these patients present greater challenges for accident and emergency units, both medically and organizationally, than patients with complicated injuries, or patients with suspected heart attack, for whom there are standard routines, including transferral to the relevant hospital department.

"When it is most hectic, I am worried that serious conditions can go undetected..."

When there are many patients at the accident and emergency unit at the same time, this presents a challenge to register and give priority to patients in the correct order. The leadership has responsibility for ensuring that the unit has routines for standard practice when patients arrive at the unit, that patients are received, registered and assessed in an ordered queue, and that those who need the most urgent medical attention are given priority.

In more than half of the accident and emergency units that were included in the supervision, it was uncertain whether patients were examined and diagnosed in line with sound professional practice. In many units we found that, when the unit was very busy, patients with undiagnosed conditions had to wait several hours to be examined and for a diagnosis to be made. Long waiting times can increase the danger that the patient's condition can become worse, that patients become dehydrated, that they do not receive adequate pain control, or that they become confused. It is important that patients are observed and followed up while they wait, that the personnel have relevant qualifications and skills, and that appropriate measures are implemented in time. We found that, in many cases, patients were not followed up adequately while they waited. If routines and practices are inadequate, serious conditions may go undetected, and treatment may not be given in time.

Sound routines for ensuring that adequate resources are available

Provision of adequate treatment in accident and emergency units depends on the availability of health care personnel with relevant qualifications and adequate skills to made complex medical decisions and assessments.

The results of supervision give cause for concern about whether the leaders of the units organize personnel resources in such a way as to ensure that patients receive adequate treatment during hectic periods. In most of the units, trainee doctors and junior doctors examined patients first. When newly appointed doctors, with variable qualifications and skills are the first doctors to see the patients, they must be given systematic training in tasks and routines. Routines must be flexible and robust, and there must be a low threshold for calling a more experienced doctor for help. This was not the case in several of the units where supervision was carried out.

Through routines and well-established practices, all the staff must know who shall call for help when

"There is cause for concern that routines and procedures for central tasks and working processes are unfamiliar and thus not followed by the health care personnel in many of the units."

personnel with higher or more specialized skills are needed, and who shall call for extra health care personnel in specially hectic periods or in times of crisis. Such situations can arise if many patients arrive at the same time, or if there are many patients waiting to be transferred to other hospital departments. In several of the units, the staff had different perceptions about situations that required extra help, and about who was responsible for calling extra help. Also, it seems that there is a high threshold in many of the units for calling in staff with more experience and qualifications. It does not seem to be usual practice to utilize the resources that are available in the health trust, when this is necessary to ensure that patients in accident and emergency units receive adequate examination and treatment. This gives cause for concern.

Good leadership and management – necessary in order to ensure that patients receive adequate treatment

The accident and emergency unit is the gateway to the hospital. This presents challenges for managing and running these services. Provision of adequate treatment must be ensured through teamwork between the unit and the other clinical departments in the hospital. For example, doctors who provide treatment in accident and emergency units are usually under the administration of the medical and surgical departments, and not the accident and emergency unit. This increases the need for clear lines of management and reporting. In 24 of the 28 health trusts that were included in the supervision, the leadership did not work in a systematic and goal-orientated manner to ensure that the unit was run in an adequate way, and that patients received treatment in accordance with statutory requirements. In our view, this is unacceptable.

In many of the health trusts, the leaders did not systematically collect information about what happens in the accident and emergency unit. For example, they did not use activity data to monitor the running of the unit, or to identify critical stages in the system. The leaders did not use systematic overviews of the flow of patients through the system and of waiting times, to assess whether diagnoses were made and treatment provided within reasonable time. Bottle-necks occur and the number of patients builds up in these units. Several of the health trusts lacked systematic overviews and assessments of the consequences. Generally, the leadership had an inadequate overview of the running of the unit, and did not manage to assess the risks in a systematic way in order to ensure adequate planning and management of health care personnel in the unit. Thus, the leadership lacked the basis for implementing goal-oriented measures to correct existing deficiencies, to reduce the danger of new deficiencies occurring, and to improve patient safety.

As a result of supervision, we also identified other deficiencies in the quality management system in the health trusts. For example, there is cause for concern that routines and procedures for central tasks and working processes are unfamiliar and thus not followed by the health care personnel in many of the units. Also, many of the units did not have a well-functioning system for dealing with nonconformities. Such a system should function in such a way that the staff have well-established routines and practice for reporting non-conformities related to activity and results in the unit, and that the leadership uses these report systematically to improve the service. It is not only serious injury to patients that should be reported, but also departures from daily routines and failure to meet activity goals. In order to learn from adverse events and ensure provision of adequate services, the leadership should give priority to dealing with non-conformities.

References:
- Report from the Norwegian Board of Health Supervision 2/2008
- Guidelines for supervision. www.helsetilsynet.no

Regular risk analysis is necessary

Supervision of health and social services focuses on areas where there is a risk of deficiencies occurring, and where the consequences of deficiencies can be serious and unacceptable for clients and patients. For several years, the Norwegian Board of Health Supervision has asked organizations that provide health and social services to use the reports about countrywide supervision and local supervision as the basis for assessing and improving the services they provide.

When we summarized supervision in 2006 with health and social services for children with special needs, we chose to discuss some central issues. The municipalities in the county of Hordaland were asked to carry out a risk analysis of the services they provide and send the results to the County Governor in Hordaland. The aim was to get all the municipalities to use the reports to assess their services and to prevent deficiencies in service provision.

Children with special needs receive many different services. These services need to be coordinated, and there must be close cooperation between the client and the provider. Good management of activities and process is essential so that whether services are adequate or not is not just left up to chance, or dependent on individuals.

Twenty-nine of 33 municipalities answered. The municipalities evaluated the services according to the issues that were discussed in the report. The answers were generally in line with the findings from countrywide supervision. Allocation of responsibility was not clear and routines for cooperation did not function. Some municipalities lacked sufficient professional staff, there was not enough capacity for respite care, and there were too few support contact persons. Some municipalities were working with improving the services. Several municipalities had initiated measures to correct the deficiencies.

In one of the largest municipalities, it was the first time they had done a risk analysis of services for children with special needs. We do not know how often the other municipalities have carried out such analyses previously. This may indicate that there is a lack of knowledge about what internal control entails.

Organizations that provide health and social services are required to carry out regular risk assessment and to implement measures that are necessary to avoid deficiencies in the services.

The Office of the County Governor in Hordaland reached more than the two municipalities in the county where supervision was carried out. Even though service providers have responsibility for improving services, as supervision authority we need to assess different ways of spreading knowledge about the experience we have gained from supervision.

Coercive fine for the first time

In September 2007, the Norwegian Board of Health Supervision took the decision to impose a coercive fine. This was the first time that a such a decision has been made. The reason for the decision was failure to follow instructions to meet statutory requirements related to health services. The decision was made against Western Norway Regional Health Authority (the Health Authority). For over two years the Health Authority failed to follow instructions to ensure that people with acute mental illness in Health Bergen Health Trust (the Health Trust) received health services in accordance with statutory requirements.

In addition to ensuring that people in the region receive specialized health services, regional health authorities have responsibility for ensuring that health services are provided in accordance with statutory requirements. This case illustrates the difficulty of getting the Health Authority to take this responsibility seriously.

The Norwegian Board of Health Supervision issued instructions to the Health Authority because occupancy rates in acute psychiatric units/short-stay units in the Health Trust were consistently in excess of capacity. Patients have been accommodated in places not intended for the purpose (for example, in corridors or in day-rooms). Such a situation in acute psychiatric units and short-stay departments is not in line with sound professional standards, and can have adverse effects for patients. The Health Authority has not followed instructions to rectify this situation.

Reference:
Decision to impose a coercive file because of failure to follow instructions to provide health services in accordance with statutory requirements – Western Norway Regional Health Authority. Letter of 28 September 2007 from the Norwegian Board of Health Supervision to Western Norway Regional Health Authority. www.helsetilsynet.no

Responsibility for ensuring that essential health services are provided

According to the Specialized Health Services Act, the regional health authorities have responsibility for ensuring that the population in the health region is offered specialized health services, and that the health services that are provided meet both professional standards and statutory requirements. This means that the regional health authorities must organize and manage services in such a way that this responsibility is fulfilled, and they must carry out, evaluate and adjust their activities accordingly.

Their responsibility can be divided into four areas:

Responsibility for planning
The regional health authorities must assess, analyse and plan how to provide adequate health services to the population in the health region. This includes being familiar with the legislation that regulates health services, having an overview of the health care needs of the population, and identifying areas where there is a danger that health services may be deficient. In developing the plan for the region, a risk and vulnerability analysis related to implementation of the plan must be carried out. The authorities must also plan how to deal with the situation if health services are deficient, or in danger of becoming deficient.

Responsibility for implementing plans and measures
The regional health authorities have responsibility for implementing their plans and measures as intended, and at the time intended, so that health services are provided in accordance with statutory requirements.

Responsibility for evaluation
The regional health authorities must evaluate whether plans and measures have been implemented, what effect the plans and measures have had, and whether deficiencies in services have arisen or are in danger of arising. If deficiencies are identified, they must be remedied so that the health trusts provide adequate health services. The regional health authorities must collect information about management of the services, in order for them to evaluate services.

Responsibility for correcting deficiencies
The regional health authorities have responsibility for ensuring that health services meet statutory requirements. This involves a duty to react when health services are deficient, and to make appropriate adjustments and corrections. They must also ensure that such corrective measures have the desired effect, and that further measures are implemented if necessary.

Blood – safe to give, safe to

In accordance with the Blood Regulations, the Norwegian Board of Health Supervision investigated whether health trusts, through their internal control systems and quality management systems, ensure that there are necessary measures to provide a high level of safety for people who donate and receive blood.

The main focus in 2008 and 2009 is:
- to ensure correct identity in all stages from blood donor to patient
- to prevent spread of infection
- to ensure that the right blood is given to the right patient
- to ensure that the correct temperature is maintained during the storage and transportation of blood and blood components.

The Norwegian Board of Health Supervision found that the Health Authority was not meeting its responsibility to ensure that essential health services were provided, despite the fact that on 9 March 2005 we issued instructions to the health authority to do so. At the time when occupancy rates were consistently in excess of capacity in acute psychiatric units/short-stay units in the Health Trust, the Health Authority could not document that the plans were being evaluated. In the monthly reports that the Health Authority has a duty to produce, there was no assessment of whether measures were implemented, or whether they had any effect. In addition, the Health Authority was unable to demonstrate that corrective measures had been implemented to ensure that health services were adequate.

Coercive fine

A coercive fine is a measure that can be used to compel an organization to follow instructions that have been issued. If instructions are not followed within the deadline, a fine can be imposed. The purpose of the fine is not to punish the organization, but to compel them to meet the statutory requirements. A warning about an impending fine has the desired effect if instructions are followed within the deadline, so that imposing the fine becomes unnecessary. In other words, a fine can be avoided by following instructions.

In accordance with the Specialized Health Services Act, the Norwegian Board of Health can impose a fine for every day, week or month after the deadline, until the requirements are met. The fine can also be given as a single amount.

The deadline given to the Health Authority was 1 October 2007. The fine that would be imposed if the deadline was not met was NOK 600 000 per month. The Health Authority was instructed to ensure that occupancy rates were not in excess of capacity in acute psychiatric units/ short-stay units in the Health Trust, and to document that responsibility to ensure that essential health services were provided was being fulfilled.

Does this measure work?

One view is that giving a fine to health services that already have limited resources can result in health services becoming even worse. Another view is that a fine can lead to an increased level of conflict, and can hinder the process of giving guidance to the health service provider. Giving guidance may be more constructive than giving a fine.

On the other hand, a fine can be regarded as a necessary measure for ensuring that the population receives essential health services in accordance with statutory requirements. Fines can only be imposed in cases where the situation is unlawful and inadequate, and where there is a danger that patients may suffer. In addition, a fine is only imposed if the health service provider does not follow instructions issued by the Norwegian Board of Health Supervision. Finally, our possibility to impose a fine must be seen in the context of the possibility for other authorities to use this coercive measure. It is important for health services to understand that meeting requirements laid down in health legislation is just as important as meeting requirements laid down in other types of legislation.

The Norwegian Board of Health Supervision is currently assessing whether the Health Authority met the requirements given in the instructions within the deadline. This will determine whether the Health Authority will actually be given a fine or not. So far, the Health Authority has reported that after the deadline of 1 October 2007 occupancy rates have not been in excess of capacity in acute psychiatric units/short-stay units in the Health Trust. If the Health Authority can also document that responsibility to ensure that essential health services are provided is being fulfilled, then it seems that this coercive measure does actually work.

receive

In order to fulfil the above requirements, systematic leadership, organization and management are necessary. Good communication and teamwork between blood banks, other hospital departments and health trusts is important. Other important factors are: management of staff, guidelines, procedures, dealing with adverse events, and internal audits. In addition the leadership is required to monitor and follow up activity in the blood bank.

New Blood Regulations came into force on 1 January 2007, to be in accordance with the EU directive. According to the Blood Regulations, the Norwegian Board of Health Supervision is required to carry out supervision of all blood banks in the country every other year. In order to carry out this supervision, and to do it in the most appropriate way, in 2007 we have had several meetings with professionals who work in this area, and we have reviewed the available literature and other sources of information to find out which activities are most often deficient. We wish to focus our attention on situations where the risks for donors and recipients of blood and blood products are greatest. The rules in the Blood Regulations are detailed, both with regard to clinical matters and quality control. This gives the possibility for different approaches to and methods for supervision.

In 2008, supervision was carried out by studying documents that blood banks are required to have in accordance with the Blood Regulations. Supervision visits and spot checks were made when this was considered necessary. This approach has been continuously evaluated and adjusted as appropriate.

Supervision of blood banks will be carried out in about half of the health trusts in 2008, and in the rest in 2009. When supervision is completed, we will produce a report to summarize the situation for the whole country.

«Mind the gap»

"Gaps in continuity of care present a central challenge in health services."

Patients, treatment regimes, referrals, prescriptions and health care personnel cross borders – between primary health services and specialized health services, between different levels in the hierarchy, between work shifts, and between departments. Breeches in continuity can result in health care personnel loosing track of the situation. This can have unfortunate consequences for patients, since information can be lost and placement of responsibility can be unclear.

- A newborn baby had a lot of mucus in her airways after birth. The midwife contacted the paediatrician, who gave advice over the telephone that the child's stomach should be sucked out. An anaesthetist was contacted to carry this out, but he did not manage to get the suction tube properly in place. He reported back to the midwife, but there was no communication between the paediatrician and the anaesthetist about the child's symptoms. The child's condition deteriorated, and after 12 hours the child was examined more closely. A constriction in the oesophagus (gullet) with a fistula (a connection) to the trachea (windpipe) was detected, and the child was operated on for the condition.
- A middle-aged patient had his gallbladder removed using keyhole surgery. The operation was uncomplicated, but his recovery progressed slowly. First, it was suspected that he had a haemorrhage (bleeding) in the abdominal wall with subsequent infection. The clinician, who was a locum, did not rcord his suspicions, and he did not report the problems when he finished his locum. The doctor who took over observed the patient's condition for some days, while the patient's condition became gradually worse. Later, under a new operation, an infection in the abdominal wall and leakage of bile were detected.
- A 70-year-old patient had been treated for 30 years with lithium for a manic-depressive disorder. She was admitted to a surgical department for a minor operation, but for reasons that were not clear her recovery progressed slowly. She was discharged to a nursing home, but her general condition was weak. She was rather unsteady and forgetful. She was readmitted to hospital four weeks after the operation to check the incision, and was treated with antibiotics, including Flagyl, which potentiates the effect of lithium. All the time, she was taking the normal dose of lithium, even though she had periods when she ate very little. There are no notes in her patient record about her gradually deteriorating general condition. She was readmitted to hospital seven weeks after the operation, with kidney failure due to lithium intoxication, and she died three weeks later.
- A 50-year-old patient was admitted with acute abdominal pain to a medical department in a hospital before a weekend. Gastroscopy indicated a suspected hiatus hernia. An x-ray was ordered, but was not taken until after the weekend. This showed a large hiatus hernia, with half the stomach in the thorax. The patient had pain and nausea the whole time. The radiographs were read by the radiologist the following day, and seen by a student locum, but the doctor responsible for the patient was not aware of the result until five days after admission. The surgical department was contacted, and the surgeon, who was a holiday locum, examined the patient, and referred her for an operation. Because of fluid and salt imbalance, the anaesthetist wished to postpone the operation. The following day, blood tests showed improved values, but the operation was still postponed in order to continue to improve the values. The health care personnel from the four specialities that were involved never had a joint discussion. The next day, the patient's condition deteriorated and she suffered from respiratory and circulatory failure.

"Increased specialization and greater mobility of health care personnel make greater demands on management to guard against risky situations."

These case histories demonstrate the challenges of teamwork between different departments and staff in an acute situation, and of communication between actors when treatment is provided over a long period of time. They also demonstrate the importance of collecting and coordinating information from different sources, and of reconsidering the first diagnosis.

Gaps in continuity of care present a central challenge in health services. Gaps occur because of the way in which health services are organized, with different levels of responsibility, increasing specialization, and provision of health care at different times and in different places. Gaps can occur when patients are moved from one treatment institution to another, when there are changes in the health care personnel with responsibility for the patient's treatment, when oral or written information is transferred, when duty shifts change, and when processes are interrupted because of pressure of time.

Health services are often organized as teamwork, but without members from different areas of responsibility. Formal and informal teamwork presents challenges associated with a common understanding of procedures and allocation of responsibility. Health care personnel must be familiar with and agree with procedures and allocation of responsibility. The autonomy of professions or individuals must take second place to meeting common objectives.

Gaps often occur when patients are referred from primary to specialized health services. Therefore it is particularly important that information follows patients when they are referred – referral notes, patient records and case summaries. The discussion about electronic patient records and teamwork clearly demonstrates the importance of effective information systems.

A less stable labour market with increased use of temporary staff and a high turnover of health care personnel demands robust systems that ensure continuity, and that provide an overview of the course of patients'illness.

Increased specialization and greater mobility of health care personnel make greater demands on management to guard against risky situations. This will involve, for example, initiating measures for identifying areas where there is a risk of deficiencies occurring, for preventing deficiencies, and for detecting deficiencies when they occur in order to limit injury to patients. Health service managers and planners must acknowledge the fact that gaps in continuity of care occur all the time, and they must establish systems to deal with them.

Children and adolescents with mental health problems – what do they need and what do they get?

"Supervision has shown that many municipalities have built up and developed services for adults with mental disorders, but services for children and adolescents have not been developed to the same extent."

Neither the municipalities nor specialized health services provide sufficient services, or services of adequate quality, for children and adolescents with mental health problems.

The report *Services for People with Mental Disorders* (Report from the Norwegian Board of Health Supervision 8/2007) is based on experience of supervision and a review of the recent literature. In several areas, the Norwegian Board of Health Supervision means that more resources should be allocated and a wider range of measures should be available to improve services for children, adolescents and adults with mental disorders.

In this article we have chosen to present some of the challenges health trusts and municipalities need to face. Both individually and collectively, health services, social services and child welfare services must ensure that society adequately takes care of children and adolescents with mental health problems.

Supervision has shown that many municipalities have built up and developed services for adults with mental disorders, but services for children and adolescents have not been developed to the same extent. Different services may have been allocated sufficient resources, but without establishing a service network to meet the needs of children and adolescents.

We see that many municipalities do not manage to provide services for children and adolescents who have already developed serious mental health problems. An adequate service requires both satisfactory transfer of information and active teamwork between different services such as schools, health centres, mental health services, child welfare services, general practitioners and specialized health services. If allocation of responsibility and tasks between the different services is unclear, then the services can be uncoordinated and inadequate. We have seen, for example, that it can be difficult to get child welfare services and schools to cooperate with health services, and general practitioners are not involved enough in identifying and following up these clients, and coordinating services for them.

Children of drug addicts, and children who have parents with mental disorders, do not receive adequate services, particularly if they have parents with non-Norwegian ethnic background. Another vulnerable group are children and adolescents with both mental health problems and mental disabilities. The specialized health services do not have the capacity to treat all the children and adolescents who need care. The child welfare services have responsibility for these clients, but are unable to provide essential therapy and follow up.

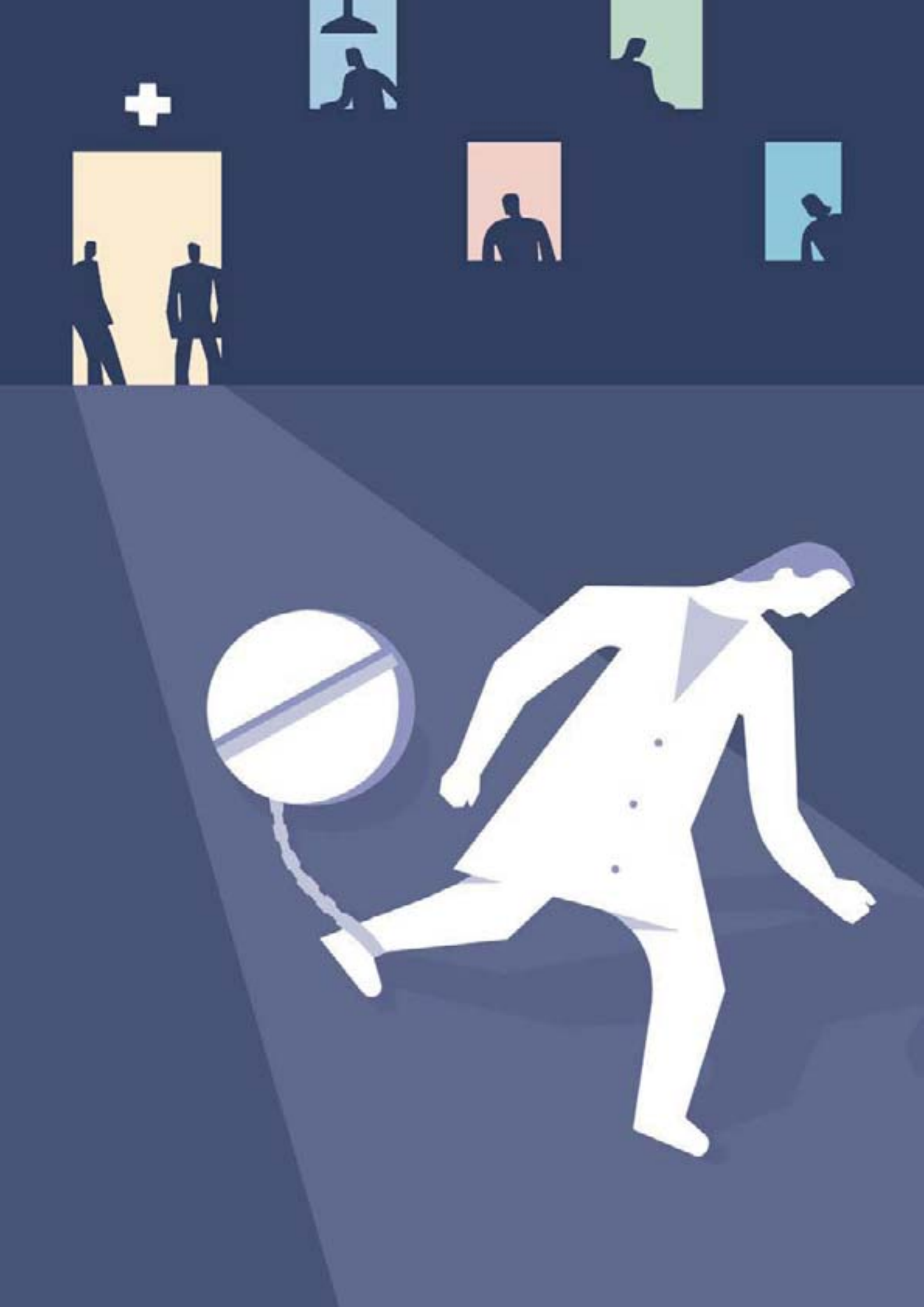
There are large variations in different parts of the country in availability of specialized health services – child and adolescent psychiatric departments and out-patient clinics. In many places there are long waiting lists, and they are getting longer. Research has shown that there is disagreement among health professionals about the limit for an acceptable waiting time. During the last few years, there has been a dramatic increase in the number of referrals for children and adolescents with behavioural problems and attention-deficit/hyperactivity disorder (AD/HD). A consequence of this may be that children in other groups do not get enough help, or that they get help too late.

In some places available in-patient capacity is not fully utilized, and several institutions have only acute admissions. In some areas, there is not enough capacity to assess clients 24 hours a day.

Capacity is closely related to availability of qualified staff. In some parts of the country it is difficult to recruit specialist doctors, but easier to recruit psychologists. The result may be that treatment is not adequately focussed and that clients are not adequately assessed. Treatment plans that the client and relatives have access to may not be made. One can question whether institutions and out-patient clinics that only have personnel with high school education, can be regarded as specialized services.

Limited capacity and lack of qualified staff in child and adult psychiatry has consequences for cooperation with health centres, general practitioners and child welfare services, and for counselling and follow up of individual children. Differences in legislation, roles, what it is possible to do, and in terminology between the different specialized health services and the different municipal units, also create problems with cooperation.

The Norwegian Board of Health Supervision suggests that the measures recommended in the development plan for mental health should be assessed to see whether they ensure that there are enough qualified staff at all levels. There is also a need to state what is demanded of the services more clearly, including demands for the services to cooperate with each other.



Cases of incident-related supervision

A basic requirement for health care personnel is that the care they provide shall be of a sound professional standard. This requirement is stated in the Health Personnel Act, Section 4. Health services have a corresponding requirement, laid down in the Specialized Health Services Act, Section 2-2. For primary health services, the requirement is laid down in the Municipal Health Services Act, Section 6-3.

Each year the Norwegian Board of Health Supervision receives several supervision cases related to specific incidents (Table 1). We assess these cases to see if there has been a breach of any provisions in the Health Personnel Act, the Specialized Health Services Act, the Municipal Health Services Act, or other acts.

Table 1 Number of administrative reactions and number of cases completed without an administrative reaction. 2002-2007

	Administrative reaction	No administrative reaction
2002	103	71
2003	125	55
2004	148	101
2005	168	87
2006	184	76
2007	183	95

Table 2 Administrative reactions against health care personnel given by the Norwegian Board of Health Supervision in 2007 – figures for 2006 in brackets

	Warning	Loss of authorization	Loss of the right to prescribe medication in groups A and B	Limited authorization	Loss of certificate of completion of specialist training
Doctor	54 (51)	22 (21)	5 (2)	0 (5)	0 (1)
Dentist	3 (4)	1 (3)	0 (0)	0 (0)	
Psychologist	3 (2)	2 (4)		0 (0)	
Nurse	6 (8)	28 (24)		3 (1)	
Auxiliary nurse	1 (2)	13 (11)		0 (1)	
Social educator	1 (0)	1 (2)		0 (1)	
Midwife	1 (0)	0 (0)		0 (0)	
Physiotherapist	5 (1)	0 (0)		0 (0)	
Other groups	2 (3)	3 (6)		0 (0)	
Unauthorized	1 (1)				
Total	**77 (72)**	**70 (71)**	**5 (2)**	**3 (8)**	**0 (1)**

The aims of the Health Personnel Act are: to ensure the safety for patients, to ensure that health services are of a high standard, and to ensure that people have trust in health care personnel and health services. The aim of the Specialized Health Services Act and the Municipal Health Services Act is, among other things to ensure that services are of a high standard.

Supervision cases are first dealt with by the Norwegian Board of Health Supervision in the Counties. These offices assesses whether services have been provided in accordance with statutory requirements. If they believe that requirements have not been met, they inform the health professional or the health care institution about this in writing. Most cases are completed by pointing out a breach of duty, without a formal administrative reaction being given. At the same time, the health professional is given advice about how he or she should have behaved. When the Norwegian Board of Health Supervision in the County believes that the breach of the requirements is so serious that an administrative reaction may be appropriate, the case is referred to the Norwegian Board of Health Supervision. This central office can give the following reactions to health care personnel:

- warning
- revocation of or limitation of authorization, or of licence to practice
- revocation of certificate of completion of specialist training
- revocation or limitation of the right to prescribe addictive medication
- suspension (temporary withdrawal) of authorization or of the right to prescribe addictive medication.

As a general rule, revocation of or limitation of authorization, of licence. or of certificate of completion of specialist training, can only happen if the person is found to be unfit to practise his or her profession in a responsible manner. Withdrawal of the right to prescribe addictive medication can happen if the person has prescribed medication in a way that is not in line with sound professional practice. In addition, if there is reason to believe that conditions for revocation are present, and the health professional is considered to be endangering the safety of the health service, the Norwegian Board of Health may suspend authorization, licence or certificate of completion of specialist training pending a final decision in the case, pursuant to the Health Personnel Act, Section 57.

The courts set strict conditions for revoking an authorization only on the grounds that the holder is unfit to practise his or her profession in a responsible manner. Such revocation occurs rarely, except in cases in which a health

Table 3 Reason for withdrawal of authorization, according to health care personnel group, 2007 – figures for 2006 in brackets

	Nurse	Auxiliary nurse	Doctor	Other	Total
Misuse of alcohol and drugs	17 (19)	5 (3)	4 (7)	2 (5)	28 (34)
Illness	0 (1)	0 (0)	1 (3)	0 (1)	1 (5)
Sexual misconduct with a patient	2 (0)	1 (3)	3 (0)	1 (2)	7 (5)
Behaviour	4 (2)	7 (5)	4 (3)	2 (4)	17 (14)
Unsound professional standards	0 (1)	0 (0)	2 (3)	1 (1)	3 (5)
Failure to comply after a warning	0 (0)	0 (0)	5 (2)	1 (1)	6 (3)
Authorization lost in another country	5 (1)	0 (0)	2 (3)	0 (0)	7 (4)
Other	0 (0)	0 (0)	1 (0)	0 (1)	1 (1)
Total	28 (24)	13 (11)	22 (21)	7 (15)	70 (71)

professional has had an unprofessional relationship with a patient. Authorization may be revoked for reasons of severe illness, criminal behaviour, misuse of drugs, or sexual misconduct with a patient (see Table 3).

However, each year there are many health care personnel who receive a warning for breach of the requirement to conduct their work in accordance with sound professional standards. Being given a warning means that the way the health professional has behaved, or the way he or she had conducted his or her work, is unlawful. A warning is also an encouragement to improve.

If an activity in the specialized health services is run in a way that may have adverse effects for patients or other people or in any other way is unfavourable or unacceptable, the Norwegian Board of Health Supervision may issue instructions to rectify the conditions. If the conditions are not corrected in accordance with the instruction within the deadline, the Norwegian Board of Health Supervision can impose a fine (see page 12). However, this measure cannot be used with municipalities.

Some cases in 2007 of unsound practice

A warning because of unacceptable professional behaviour

A patient contacted the accident and emergency service because he had severe pain in his back and stomach. When he first contacted the service, he informed them that he had eaten fish and had become ill afterwards. When he came to the accident and emergency unit, he was examined. It is not clear from the medical records whether his abdomen was examined. It was also not recorded in the medical records that he had recently had acute surgery for a ruptured aortic aneurysm, in other words a major operation in the abdominal cavity. After being observed for half an hour, he was sent home. It was concluded that the fish he had eaten was the cause of his symptoms. Four days later, the man's relatives contacted the accident and emergency unit again, and the same doctor was on duty. The relatives were advised to contact the patient's general practitioner the next day. The general practitioner arranged for the patient to be admitted to hospital immediately. He was found to have blood in his abdominal cavity and a leak from the aorta at the site of the operation.

The main function of an accident and emergency service is to select patients who need immediate follow up and patients who can wait. The Norwegian Board of Health Supervision therefore assessed this case in relation to whether it was professionally acceptable for the doctor not to check the information he had received about the previous surgical operation, and whether it was professionally acceptable not to refer the patient to hospital. We concluded that it was not acceptable that the doctor did nothing to reduce the risk of serious illness. When he examined the patient's abdomen, he should have seen the operation scar, and he should have obtained information about the operation. With the information that the doctor had, the patient should have been admitted to hospital the first time he contacted the accident and emergency service. It was clearly negligent that this did not happen, and this put the patient in a dangerous situation. The doctor was given a warning.

A warning for unacceptable prescribing of medication

A patient was discharged from medication-assisted rehabilitation (MAR) because of misuse of opioids and benzodiazepines, cheating with urine samples, and suspicion that he was selling heroin. The patient visited his doctor and said that he was motivated to be readmitted to MAR. At the first consultation, the doctor prescribed Temgesic for the patient. Because the patient had previously had problems with this medication, at the next consultation two weeks later, the doctor prescribed Dolcontin tablets. At the next consultation, about one month later, the doctor also prescribed morphine to be injected. Later, the doctor prescribed both morphine and pethidine, and later pethidine only. Dolcontin tablets were prescribed for one month at a time and most of the prescriptions were sent by post. During half a year, the doctor had six consultations with the patient.

"Being given a warning means that the way the health professional has behaved, or the way he or she had conducted his or her work, is unlawful, and is an instruction to improve."

The Norwegian Board of Health Supervision has stated that patients who are dependent on opioids can be stabilized and the dose can be reduced outside authorized units, if this can be done in a way that is in accordance with sound professional practice (Directives IK-15/2000 and IK-2755, Norwegian Board of Health Supervision). The aims of the guidelines are to prevent prescription of addictive medication leading to or sustaining addiction, and to reduce the risk of overdose. We have stated that Dolcontin is not a type of medication that is suitable to use as a substitute for patients who are addicted to opioids. This applies even more to opioid injections and morphine tablets. The reason is that these drugs have a short-term effect and they suppress respiration. Unstable serum levels lead to a danger of intoxication and thus a danger that the patient takes an overdose. Too low serum levels involve the risk of misuse of illegal drugs, because of lack of reduction of the craving for opioids. In addition, substitution treatment must be carried out with carefully controlled doses of the medication to ensure that the patient does not sell the tablets. In our opinion, the patient should have been followed up much more closely. Three months elapsed between two of the consultations, and not enough tests were taken, even though the doctor knew that the patient had had several relapses with benzodiazepines, heroin and amphetamines. We gave the doctor a warning for being in breach of the requirement to prescribe medication in a way that is in accordance with sound professional practice, and for inadequate follow up of the patient.

A warning because of unacceptable professional behaviour

A nurse employed in a clinic that, among other things, provided laser treatment for hair-removal, offered a patient treatment for the removal of eye-brow hair. The treatment was carried out without protecting the patient's eyes, and the patient's eyes were seriously damaged. It was found that the nurse had not received adequate training in the use of protective equipment or in the use of a diode laser for removing hair near the eyes. However, the nurse should have understood that, without adequate training and knowledge, she had used a powerful laser machine, and that this could be risky in the proximity of the eyes. The Norwegian Board of Health Supervision concluded that the nurse had acted in a way that was not in accordance with sound professional practice. We pointed out that health care personnel have a duty to act in accordance with their professional qualifications. The nurse was given a warning.

Revocation of authorization for unacceptable professional behaviour and serious lack of professional insight

A patient went to his regular general practitioner for the treatment of mental disorders such as sleep disturbance, anxiety and restlessness. The doctor started to have a private and sexual relationship with the patient, who she had been treating over a period of time. The patient moved into the doctor's house, and they lived together for a few weeks.

In the opinion of the Norwegian Board of Health Supervision, doctors must be able to distinguish clearly between a professional relationship and a personal relationship. Doctors must also be able to distinguish between giving a patient understanding, support and care, and using their professional relationship to satisfy their own or the patient's social and/or sexual needs. Doctors must be aware of the fact that patients are in a situation in which they may have to reveal aspects of themselves that are normally hidden from others. This creates vulnerability and attachment that a doctor must not take advantage of. We pointed out that for a patient, developing a close personal relationship with one's doctor, can seem to be a natural solution to many of their problems and desires. However, a doctor must respect the fact that the patient's judgement is often not sound. We found that the doctor mixed her professional and private roles. Her actions represent serious lack of professional insight. Establishing a close personal relationship with a patient is taking advantage of the trust that forms the basis for treatment. In other words, this is behaviour that is incompatible with the practice of one's profession as a doctor. The doctor did not manage to draw a clear dividing line between a professional and a private relationship. This weakens the trust the public has in health services. The doctor's authorization was revoked.

Some cases in 2007 of behaviour that is incompatible with the practice of one's profession

The provisions in the Health Personnel Act apply to professional groups that are dependent on the trust of the public. For this reason, health care personnel must have authorization. Therefore, authorization can be revoked on the grounds of unacceptable behaviour that is not directly related to the practice of one's profession (Health Personnel Act, Section 57), for example criminal acts. The purpose of this provision is to ensure that health care personnel in the future do not cause damage to patients, or violate the trust that there must be between themselves and the public. Being prosecuted for criminal offences can, in itself, weaken this trust.

Revocation of authorization for swindle related to the National Insurance Scheme

Over the course of five years, a doctor sent claims for reimbursement to the National Insurance Administration for consultations that had not taken place. The doctor deceived the National Insurance Administration, and received NOK 742 500 that he was not entitled to. He claimed the fee for a consultation, even though his contact with patients had been over the telephone and he had worked at home. He admitted that he was guilty of gross fraud, and he was duly sentenced.

Because of their authorization, doctors have special rights to administer national insurance payments. The reason for this arrangement is to simplify the reimbursement system, both for the doctor, the patient and the National Insurance Administration. The gross fraud that the doctor was guilty of was considered to be behaviour that was incompatible with the practice of his profession, and that had weakened

Leadership's responsibility to establish a system – incident-related supervision cases

Sometimes an individual health professional cannot be blamed when a patient suffers harm, for example because routines are inadequate. However, it may still be that the conditions for providing health services in accordance with statutory requirements have not been fulfilled (Specialized Health Services Act, Section 2 2, the Municipal Health Services Act, Section 6 3). Leadership must establish a system that, as far as possible, ensures that human error does not occur. According to the duty to have an internal control system, and pursuant to the Health Personnel Act, Section 16, an establishment that provides health care shall be organized in such a way that health care personnel are able to fulfil their statutory duties. If deficiencies occur, this should be identified by the system, so that harm to patients is limited, and in order to prevent similar events happening again (pursuant to the Internal Control Regulations, Section 4g).

Continued from page 21

trust to such a degree that the conditions for revoking authorization were fulfilled. We also found that the fraud the doctor was found guilty of involved serious breach of the duty not to incur unnecessary expenses for the National Insurance Scheme (Health Personnel Act, Section 6). His authorization could therefore also be revoked on the grounds of gross breach of duty.

The Norwegian Board of Health Supervision has a right, but not a duty, to make a decision to revoke authorization. When we assess whether to revoke authorization, we weigh up the grounds for revocation against consideration for the holder. The more serious the criminal offence or unacceptable behaviour is, the easier it is to justify revocation of authorization. However, we must assess whether revocation of authorization is necessary in order to achieve the aims of the law: to ensure the safety for patients, to ensure that health services are of a high standard, and to ensure that people have trust in health care personnel and health services.

When we assessed whether we should revoke this doctor's authorization, we took into consideration the fact that the fraud had occurred five years previously. The passing of time helped to restore trust. Also, revocation of authorization such a long time after the event could appear unnecessarily harsh for the holder. The fact that the doctor had served his sentence and had paid back the amount he had swindled, also helped to restore trust. He had also admitted guilt and understood the mistake he had made. As the doctor had served his sentence and repaid the money, we found that revocation of authorization was an unreasonable reaction, and was not necessary to achieve the aims of the law. The conditions for revoking authorization were assessed as having been fulfilled. However, the Norwegian Board of Health decided that it was not appropriate to revoke the doctor's authorization.

Revocation of authorization for insurance fraud

A doctor was sentenced to prison for six months for insurance fraud. Along with with a patient, he had arranged a road traffic accident. The patient ran his car into the back of the doctor's car. The purpose of the accident was for the doctor to receive insurance payments for sickness absence.

Being found guilt of a criminal act, in itself, weakens the trust that people have in health care personnel and health services. In this case, it was particularly serious that the doctor had planned and carried out an insurance swindle with one of his patients. This was behaviour that seriously weakened the trust that people had in the doctor. Such behaviour is not helpful and supportive for the patient, and can cause extra stress for the patient. The insurance fraud was assessed to be behaviour that was incompatible with the practice of the doctor's profession, and that weakened trust in him to such a degree that he was assessed as unfit to practice his profession. His authorization was revoked.

Theft of medication from an employer / misuse of drugs

A nurse who worked in the home nursing care service and in a nursing home in the municipality, stole medication from her employer. Several types of addictive medication disappeared from the medicines cabinet in the nursing home over a period of time. After checking the medication in the cabinet, it was found that there was only one nurse who had been on duty all the times medication had gone missing. The nurse was also found to have taken medication from home nursing care patients who had died. People also reacted to the nurse's behaviour, as she appeared to be intoxicated. She later admitted that she had stolen tablets because she was dependent on them. Theft of medication was assessed as behaviour that was incompatible with the practice of her profession, and that weakened people's trust in her to such an extent that she was considered to be unfit to practice her profession. Her authorization was revoked. The Norwegian Board of Health Supervision can revoke authorization when there is evidence that the health professional is dependent on addictive medication, or if he or she is unfit to practice his or her profession because of alcohol use, drug abuse or similar problems.

”A basic requirement of health services is that they are provided in accordance with sound professional standards. This requirement applies both to the way in which health care personnel provide health care, and to how the municipality organizes health care.”

Breach of the requirement to provide health services of a sound professional standard in the municipal health service

A patient died in a fire in her home. She had been allocated full-time care from the municipality. Most of the time she sat fastened in a specially-adapted wheelchair, with both wheels locked. She could not stand up, go to bed, go to the toilet, or move about in the house. She could also not manage to use the telephone. Towards the end, she could not manage to use the electronic door opener. The safety alarm that the patient had, had been reconnected from the home nursing care service to the personnel at the sheltered accommodation. If the alarm went off, this was registered by a mobile receiver that the staff had with them the whole time. The client was warned that this service could be withdrawn if she used the alarm repeatedly in situations that were not emergencies. The alarm was taken from her during certain periods, because she used it often. There were no routines for recording when the patient had access to the alarm, or when the alarm had been taken from her. The section leader was aware of the situation, and allowed the service to take the alarm away from the client.

The way in which health care was provided was not in line with routines in the municipality. However, this could not relieve the municipality of responsibility. An unacceptable practice had developed. It was also unclear how the municipality had tried to implement the routines. The municipality had not carried out systematic controls to detect breaches of the routines, in order to check whether the requirements of the authorities were fulfilled, in accordance with the Internal Control Regulations. A basic requirement for care that meets the standard of sound practice is that people who need 24 hour care, actually receive this. The client should have received adequate supervision day and night. It was not possible for the client to call for help, since her alarm had been taken from her. When a fire started in her home, she was not able to call for help. A basic requirement of health services is that they are provided in accordance with sound professional standards. This requirement applies both to the way in which health care personnel provide health care, and to how the municipality organizes health care.

The Norwegian Board of Health Supervision concluded that there were grounds for applying for prosecution of the municipality, pursuant to the Health Personnel Act, Sections 4 and 16, and the Internal Control Regulations, Section 4. The municipality was required to pay a fine of NOK 500 000 to the National Treasury for having breached these provisions, pursuant to the General Civil Penal Code, Section 48a.

Breach of the requirement to provide health services of a sound professional standard in the specialized health service

A patient was admitted to hospital by ambulance because of acute chest pain. An ECG was taken before she came to hospital, and the results were forwarded to the hospital. The patient had also had an ECG in 2003, in connection with treatment for deep venous thrombosis. The results of this test were in the patient’s medical records, but these were not retrieved on the day she was admitted. Two doctors concluded that the chest pain was not caused by heart disease, based on the case history, the response to treatment and the ECG results. Telemetry was not ordered, but the patient was under constant supervision. The patient suffered respiratory and circulatory failure and died. The autopsy revealed that the cause of death was acute heart failure with a rift in the heart and internal bleeding. According to the routines that the health trust had for initial assessment, observation and treatment of patients with chest pain, the doctor on duty should have decided how the further treatment regime and level of observation should be, when the conclusion of the initial assessment of the patient was that the chest pain was not caused by coronary disease. At the time, there was also a routine that earlier ECG results should be retrieved from the medical records. However, this routine, to an increasing degree, was not followed after the hospital introduced electronic medical records. Telemetry was not used because no indications were found for its use.

The Norwegian Board of Health Supervision concluded that the hospital was in breach of the requirement to provide health services of a sound professional standard, in accordance with the Specialized Health Services Act, Section 2-2, and the Health Personnel Act, Section 16. An important task of medical departments is to deal with patients with acute chest pain. This is a common condition, and is potentially serious, so that correct diagnosis, surveillance and treatment are important. Even though there was a routine that earlier ECG results should be retrieved from the medical records, this routine, to an increasing degree, was not followed. The leadership has responsibility for ensuring that routines are implemented in the department. If a routine is not followed, without the leadership reacting, the staff may assume that this is acceptable. The fact that the ECG results from 2003 were not retrieved, was therefore the responsibility of the leadership. In our opinion, failure to compare the previous ECG results with the current ECG results, was a decisive factor that led to the correct diagnosis not being made. We also mean that the threshold for using telemetry should be lower in the case of indeterminate chest pain, and when the ECG on arrival of the patient is not possible to interpret, as in this case. This provides extra security for the patient and the health care personnel when an unexpected situation arises, and in cases where the ECG is misinterpreted. Procedures for the use of telemetry were improved.

Jan Fridthjof Bernt:

Supervision of municipal welfare services

The welfare state is a national system consisting of different types of services and benefits, in which a large part of responsibility for providing the services lies with municipal, county municipal and private service providers. The requirements of these services are laid down in laws and regulations. Some of these requirements relate to how the services are organized: buildings, technical equipment and personnel, and some of them relate to the kind of services that shall be provided: the rights of clients to receive specific services, and requirements about the quality of the services. The supervision authorities have the final task of enforcing statutory requirements, usually with the Office of the County Governor as the first line[1], and as coordinating authority[2]. The nature and content of this supervision has been the subject of much discussion[3],[4].

The concept of supervision has often been used in a somewhat imprecise manner. The dividing line between supervision and counselling has been unclear, and this has led to unclear division of responsibility between those who carry out supervision and those who provide the services. In the two reports referred to above, it is stressed that these two functions must be clearly distinguished. The characteristics of supervision are as follows[5]:

«The aim of supervision is to ensure that the object of supervision fulfils the duties laid down in laws, regulations and other legislation. The main elements are control, assessment and reaction.»

State supervision of municipalities must have a legislative basis. The state can only intervene in municipal self-government if there is a specific provision in the legislation for them to do so[6]. Such a provision was given in 1992[7]:

The Ministry can, on its own initiative, control the legality of a decision.
This control applies to all aspects of the activity of the municipality, with the exception of legislation that governs purely private conditions[8]. The concept "decision" includes not only decisions about citizens' rights and duties, that is, individual decisions as defined in the Public Administration Act[9], but also decisions about what actually shall be done or not done[10], including decisions within administrative areas that are regulated by specific legislation. Thus all the provisions about state control that are found in specific legislation are actually unnecessary: the state has a statutory right to control the legality of all aspects of a municipality's activity[11].

However, in practice it is necessary to have provisions about state supervision in the specific acts that govern municipal welfare services, not only from a pedagogical perspective, but also because the state authorities only have a legal right to control the legality of a decision, not a duty to do so, and therefore no overall responsibility for supervision[12].

There are many provisions relating to supervision in specific acts, particularly in health legislation. According to the Supervision of Health Services Act[13], the Norwegian Board of Health Supervision has: "general supervision of health services in the country.... in accordance with that which is laid down in laws and regulations[14], and has the authority to issue instruction to rectify conditions: "if an activity in the health services is run in a way that may have adverse effects for patients or other people or in any other way is unfavourable or unacceptable"[15]. Correspondingly, the Municipal Health Services Act states that: "The Norwegian Board of Health Supervision shall carry out supervision of clinical and professional conditions to ensure that the municipalities promote the aims of health services in a satisfactory and appropriate manner"[16], with a corresponding provision giving the authority to issue instructions to rectify adverse conditions[17]. An identical provision giving authority to issue instructions is to be found in the Specialized Health Services Act[18].

These themes for discussion of supervision correspond with statutory requirements for health services that we find in the Municipal Health Services Act, the Patients' Rights Act and the Health Personnel Act. Here, it is laid down in the law

[1] Local Government Act, Sections 60b, 60c and 60d
[2] Local Government Act, Section 60e
[3] NOU 2004:17. Statlig tilsyn med kommunesektoren (Official Norwegian Report 2004:17. State Supervision of the Municipal Sector.
[4] Ot.prp. nr. 97 (2005-2006). Om lov om endringar i lov 25. september 1992 nr. 107 om kommuner og fylkeskommuner m.m. (statleg tilsyn med kommunesektoren). (Proposition to the Odelsting No. 97, 2005-2006
[5] Proposition to the Odelsting No. 97, 2005-2006, points 1 and 2, page 6
[6] Local Government Act, Section 6
[7] Local Government Act, Section 59, no. 5
[8] Proposition to the Odelsting No. 42, 1991-1992. Chapter 10, note to Section 59, No. 4 (page 300)
[9] Act No. 10 1967, Section 2, first paragraph, a and b
[10] Proposition to the Odelsting No. 42, 1991-1992, Chapter 10, note to Section 59, No. 1 (page 300). Here it is stressed that it is not a condition that the decision is an individual decision as defined in the Public Administration Act.
[11] Proposition to the Odelsting No. 42, 1991-1992, point 11.2. (page 202). Here it is stated that: "If the proposal for control of legality is accepted, to a large extent there will no longer be any need for specific provisions".
[12] Local Government Act, Section 59 No. 6
[13] Supervision of Health Services Act
[14] Supervision of Health Services Act, Section 1, first paragrap
[15] Supervision of Health Services Act, Section
[16] Municipal Health Services Act, Section 6-3, first paragraph
[17] Municipal Health Services Act, Section 6-3, third paragraph
[18] Specialized Health Services Act, Section 7-1, first paragraph

”The Norwegian Board of Health Supervision has responsibility for “general supervision of social services in the country”, which clearly involves the right and the duty to carry out supervi-sion of local regulations and practice for granting social secu-rity benefits.”

that patients have the right to“essential health care”[19], that this shall be provided in accordance with sound professional standards[20], and that health care personnel“ shall conduct their work in accordance with the requirements to professional responsibility and diligent care that can be expected based on their qualifications, the nature of their work and the situation in general[21]. Thus, provision of health services that meet sound professional standards has become a topic of judicial debate within health services.

The Offices of the County Governors have corresponding responsibility for carrying out supervision of municipal social services, to see whether services are“run in a way that can have adverse effects for clients, or in any other way can be unsatisfactory or deficient”[22]. The area of social security benefits pursuant to the Social Services Act, Chapters 5 and 5a, is not included in this control, but the Offices of the County Governors have supervision rights for this area as appeals body and to control legality pursuant to the provisions in the Local Government Act, Section 59. Assessment of whether services are acceptable is expressed in the provisions in the Social Services Act, Section 5-1: “Those unable to support themselves by working or exercising financial rights are entitled to financial support” and:“The support should aim at making the person self-supporting”. And the Norwegian Board of Health Supervision has responsibility for“general supervision of social services in the country”, which clearly involves the right and the duty to carry out supervision of local regulations and practice for granting social security benefits. The Norwegian Board of Health Supervision does not have the authority to issue instructions in this area, but must inform the Ministry or the Office of the County Governor about breaches in the legislation, so that the appropriate instructions can be given.

Supervision is application of the law, whether it is carried out by the Norwegian Board of Health Supervision, the Ministry, the Office of the County Governor, or in the form of a report from a municipal control committee to the municipal council[23]. The question of whether“essential health care”that is“adequate”(i.e. that meets sound professional standards, and that fulfils the requirements laid down in the legislation) has been provided, is a judicial issue, with the Supreme Court as the highest authority in principle. The executive officer or the organization that has responsibility for carrying out supervision on this basis, cannot instruct the institution on the basis of political or administrative assessments, but must have independent responsibility for making a purely legal assessment of the issue.

What makes the picture more complicated, is that we must go outside the law in order to define the content of the requirements of the law. The requirement that health and social services shall be“adequate”(i.e. meet sound professional standards, and fulfil the requirements laid down in the legislation), is a so-called“legal standard”. It refers to a basis for assessment that is other than the wording of an act. This basis for assessment is not static. It reflects professional knowledge, professional standards and health and social policy choices, made on the basis of economic and political priorities. Here, professional knowledge and practice are the obvious starting points. A general requirement is that both health and social services shall be provided“in accordance with the requirements to professional responsibility and diligent care that can be expected”. But the Supreme Court says that what“can be expected”[24], the minimum standard for how services shall be provided, and what each individual receives“is dependent on practice, and must be assessed on the basis of the economic situation in the health services in general and in the individual municipality in particular, according to the situation at any given time”[25].

Here, reference to practice is understood as a reference to a professional standard for sound practice. In other words, the first question is what requirements one must demand of the services or of the granting of social security benefits, based on available knowledge about what are adequate measures and what is an acceptable level of social security benefits, in order to achieve the aims of the services given in acts and legislative history. However, this does not mean that one can use a duty to provide optimal services and benefits as the sole basis for making assessments, without taking account of other factors. Professional opinion about what should be provided does not necessarily correspond with the limit of what is regarded as acceptable in an economic context. But it means that each municipal budget or the state budget does not have absolute power of definition in relation to the health and social assessment of whether service provision is adequate. The economic situation is only a background for the legal assessment, a relevant factor for interpretation of the provisions in the legislation. And because we are talking about the content of people’s statutory rights, it is not the state budget that is of interest here, but the general economic situation, and the general conclusions that the responsible central political authorities have made on this basis.

For lawyers, the health and social professional assessment will normally, as it is reflected in the norms for“sound practice”, form the basis for interpretation of an assessment of whether services are acceptable and meet sound professional standards as laid down in the legislation. This is what the legislation primarily refers to. Political and administrative assessments, primarily of economic character, will only be relevant as general instructions of what is regarded as acceptable, for example in regulations and guidelines. And even these assessments are only of importance if they lie within the standard requirements given in acts and legislative history. In the untidy everyday life of health and social policy, it is the responsibility of the supervision authorities to demand clarity and consistency in setting norms and practising the regulations governing the right to health and social services.

[19] Municipal Health Services Act, Section 2-1, first paragraph. Patients’ Rights Act, Section 2-1, first and second paragraphs
[20] Specialized Health Services Act, Section 2-2
[21] Health Personnel Act, Section 4, first paragraph
[22] Social Services Act, Section 2-6, last paragraph
[23] Local Government Act, Section 77, nos. 4 and 6

[24] Health Personnel Act, Section 4, first paragraph
[25] The judgement in the “Fusa Case”, Rettstidende (Register of Judgements) 1990, pages 874 and 887

Adverse events with medication

"The challenges must also be reflected in the training given to health care personnel during their education, in staff training programmes in institutions, and in routines for teamwork between health care personnel and between departments."

Adverse events related to the use of medication represent a widespread problem. The Norwegian Board of Health Supervision receives reports about such events. These reports account for about 27 per cent of all reports of adverse events. Hospitals report about 10 deaths per year related to errors in administration of medication.

Errors related to administering medication can have a number of causes. These causes are often related to confusing different medication. There is often a long chain from when a doctor prescribes medication to when the patient receives it. In this chain, information is transferred through different channels and between different people, giving many opportunities for errors to occur:

- The nurse can misunderstand a verbal message
- Members of staff can be unfamiliar with certain types of medication, for example, medication that is not often used, or that is new
- Two types of medication can be confused because of similar packets or similar names, for example Sorbangil and Sobril
- Errors can be made in calculating the dose (often 10 times too high a dose because of errors with decimal points)
- Medication can be administered by the wrong route, for example intravenous instead of orally
- Patients can be mixed up because they have similar names or because they swap beds
- Errors can be made when instructions about medication are transferred from one document to another
- Health care personnel from other countries may be unfamiliar with the Norwegian name of medication and the dose or concentration.

Below we present some examples from supervision cases dealt with by the Norwegian Board of Health Supervision.

Because we know that there is a high risk for adverse events occurring when medication is administered, different types of controls have been established in order to minimize the risks. Some of these controls are described in the regulations , and other controls are established through local procedures (double controls in certain situations).

There is cause for concern because of the endless number of local procedures that exist, and the many forms that are used, as this increases the risk that misunderstandings can occur. This also creates problems for health care personnel who change their place of work, and problems when many temporary staff are employed.

In some health institutions electronic packing and dispensing of medicinal products from pharmacies has been introduced, with electronic identification (bar codes) to ensure that the correct medication is given to the right patient. These systems have helped to improved safety, but are not one hundred per cent safe.

Other measures to improve safety include clear marking of syringes, colour-coding, and the use of different connections and syringes for intravenous, oral and spinal/epidural administration. But in the end, it is important to be aware of the fact that the nurse at the bedside has no more controls to rely on, and he or she must be aware of the potential causes of adverse events.

[1] REG 2001-12-18 No. 1576. Regulations relating to supply of medicinal products etc. to hospitals and other health institutions

Event:	Reasons for the event:
Incorrect route of administration On her first night duty in the children's department a newly-appointed nurse administered Captopril and Sildenafil medicine (medication for heart disease and high blood pressure) intravenously via a central venous catheter (CVC), instead of via a nasogastric tube. The nurse and her contact nurse drew up two syringes and signed that the medication and dose were correct in accordance with the written prescription. The syringes were not marked with the medication or the route of administration. The contact nurse was called to another patient. In the meantime, the nurse went in to the patient, who was rather restless. After feeding and attending to the patient, the nurse administered the medication via the central venous catheter, instead of via the nasogastric tube.	• Normal sterile syringes were used for drawing up medication to be administered orally/enterally • The syringes were not adequately marked • The CVC and the nasogastric tube were not adequately marked • The nurse was probably distracted because the child was restless and had to be attended to before the medication was administered.

Event:	Reasons for the event:
Incorrect dose Methotrexate is a very potent and toxic cytotoxin that is used in the treatment of cancer. It is also used to treat some patients who have serious arthritis. For the latter purpose, the dose is given once a week. This is a very unusual dose for tablets. Several cases have been reported when Methotrexate has been administered daily over a long period of time, often with very serious consequences for the patient. For example, the prescription may have been written: "Methotrexate x 1". This has been interpreted as meaning daily instead of weekly. In other cases, instructions that the dose should be given on a specified day of the week have not been seen.	Errors when transferring the prescription from • the specialist to the general practitioner • the general practitioner to the hospital • the admission papers to the patient's medical record • the patient's medical record to the patient's medication record • the old medication record to the new medication record

Event:	Reasons for the event:
Errors caused because health care personnel from other countries are unfamiliar with the Norwegian names of medication and the concentrations A German anaesthetist asked a nurse to prepare Pentothal (a general anaesthetic). 2500 mg powder was dissolved in 20 ml saline. The anaesthetist administered 15 ml of the solution, believing that it contained 500 mg Pentothal, as was usual in Germany.	• Lack of attention to differences in different countries • Inadequate teamwork • Inadequate marking of syringes

The role of highest authority for complaints regarding rights laid down in health and social services legislation

Complaints about clients' rights include complaints about rights that are laid down in the Social Services Act, the Municipal Health Services Act and the Patients' Rights Act. Since this type of complaint is dealt with in 19 counties, and involves judicial assessment, an important task for the Norwegian Board of Health Supervision as the highest authority is to ensure that people get their complaints dealt with fairly, independent of which county authority deals with their complaint.

With regard to complaints about social security benefits, which are dealt with by the County Governors, in March 2007, a report was published about dealing with complaints for the period 1995 to 2005. The report, produced by Oslo University College, clearly shows that there are differences between the counties in the outcome of complaints – that is whether the County Governors affirmed, reversed or revoked decisions made by the municipalities, or sent cases back to the municipalities to be dealt with again. On this background, the Norwegian Board of Health Supervision is investigating whether the differences reflect real differences, or whether they are the result of variation in administrative procedures in the municipalities.

As the highest authority, we have the authority to re-examine and reverse a decision made by the complaints authority, in accordance with the Public Administration Act, Section 35. This provision does not give patients and clients the right to complain about the decision again, but is meant to be a safety net for correcting unlawful or undesirable practice on the part of the complaints authority.

Since 2003, we have received 35 requests to assess whether to reverse a decision made by the complaints authority. We have reversed four of these decisions.

These were complaints about the following:
- the right to delete medical records, in accordance with the Patients' Rights Act, Section 5-2
- the right to receive essential health care (decision about being discharged from medication-assisted rehabilitation), in accordance with the Patients' Rights Act, Section 2-1
- unlawful deduction of social security benefits, in accordance with the Social Services Act, Section 5-9 (benefits for a day nursery place that was respite care).

Decisions made by the complaints authorities are only reversed in exceptional circumstances. The decisions that we have reversed were all based on incorrect application of the legislation. They were also decisions that were important for the complainant.

"Asbjørn Kjønstad, Professor of Law at Oslo University, was awarded the Karl Evang Award for 2007 for his pioneer work in the field of social welfare legislation. In particular, the adjudicating committee took into account his work to ensure welfare and legal safeguards for the most vulnerable groups in society, and his work with tobacco legislation."

"On the day of victory, who counts the number of battles lost?"

A man with a mission

My generation was the first generation to grow up with the welfare state. The welfare state was built by the so-called national strategists. They regarded disability retirement as a tool for doctors, not as a right for members of the national insurance scheme. For me, justice has always been an important principle, says Asbjørn Kjønstad. That is why he chose health and social legislation as his main field of work.

Professor Kjønstad has carried out important pioneer work with his research and investigations. For example, he has helped to develop competence and build up resources in the fields of legislation related to social security, health and welfare in Norwegian universities, colleges and public administration.

- The national strategists were entrepreneurs, but the idea that individuals had legal rights was totally absent. At the National Insurance Administration, where I worked around 1970, my bosses claimed that disability pension was not a legislative area. I met a lot of opposition about this, including from my teachers at the university. But it was a challenge, and it was exciting to go into a new area, says Professor Kjønstad.

His mission in life has been to argue that legislative philosophy, legal concepts and the securement of legal safeguards should be introduced in the area of the welfare state, as in other areas.

- It has been an honour to be involved in this work. It was essential to develop health and social legislation in the 1980s and 1990s in order to ensure that people were treated equally and received their legal rights. However, it now seems as though we have reached an optimal level. Further development of legislation can be counter-productive, believes Professor Kjønstad.

He points out that to an increasing degree attention has been directed at system errors when something goes wrong in the health services. This clearly has positive aspects, but we must not forget free will and personal responsibility, believes Professor Kjønstad.

Professor Kjønstad's office in the old university building in Karl Johans Gate is as a professor's office should be: many metres of books from floor to ceiling. His desk and table are also full. Just one corner of the table has been cleared to make space for guests and students. But it was not a foregone conclusion that the boy from Trondheim should end up here.

- Both my father and my grandfather were clever at writing, and functioned as legal practitioners. For example, they set up legal contracts. This may be what made me interested in law, says Professor Kjønstad.

Another interest he had when he was young was the war against tobacco.

- The war against tobacco has been like being on a roller coaster, said Professor Kjønstad two years ago when he was awarded a special prize on the World No Tobacco Day in 2005.

His interest in this area started in 1970, when, as a newly qualified lawyer, he was secretary of the Tobacco Act Committee, led by Professor Anders Bratholm. The Committee developed three major legal proposals: a total ban on advertising of tobacco products, compulsory marking of cigarette packets with a warning about the dangers to health of cigarette smoking, and a ban on selling tobacco products to children and young people. Professor Kjønstad also participated in the work with the report "Air is for Everyone! The Right to Breathe Smoke-free Air" in the mid 1980s. The aim was to introduce smoke-free workplaces and public places.

- The legal proposals received a lot of support from the people, but not from the media. Opposition came from the tobacco industry, celebrities and journalists. The reason why the arguments of a few celebrities received such a lot of attention was, of course, because of the celebrities' alliances with the journalists. Newspaper offices and the offices of the Norwegian Broadcasting Company were some of the places where smoking was most common. Journalists and editors ruthlessly used their power over the printed word and the ether to promote their own interests, says Professor Kjønstad.

We know what happened. Today, restaurants and cafés are smoke-free, and smokers are banished to chilly street corners.

- I once proposed a ban on smoking in children's bedrooms at home. This created an outcry, and I was accused of being a moralist. I now see that the Ombudsman for Children has come with the same proposal, Professor Kjønstad reminds us, and continues:

- I was opposed to smoking. And as a member of the Committee Against Child Abuse in 1983, I was also against hitting children. One would have thought that this was a winning issue, but there was a lot of opposition. However, later, everyone agreed.

But, as he says himself: On the day of victory, who counts the number of battles lost?

The right to essential health care – re-examination of decisions about complaints

The right to essential health care is laid down in the Patients' Rights Act, Section 1-2. Whether or not people receive the services they have a right to depends, among other things, on whether decisions can be re-examined by independent bodies. If a person means that their right to essential health care has not been met, they can complain to the Norwegian Board of Health Supervision in the County. This office has a duty to reassess all aspects of the decision. As the highest authority, the Norwegian Board of Health Supervision can reverse a decision made by the Norwegian Board of Health Supervision in the County. It is also possible to have a case re-examined in a court of law.

In cases that relate to discontinuing treatment, implementation of the decision can be delayed.

In 2007, important decisions were made in two cases in which the right to re-examine cases was assessed. Both these cases were about the right to continue treatment when a decision had been taken to discontinue treatment. In the first case, the decision of the health service was upheld. In the second case, the decision was reversed in favour of the patient.

Requirement to make a provisional decision to delay implementation of a decision to discontinue life-prolonging treatment

The first case concerns a decision to require Helse Bergen Health Trust to delay implementation of their decision to discontinue life-prolonging treatment for a patient born in 2007. The case was referred to a court of law, after the Norwegian Board of Health Supervision in the County had assessed the complaint made by the relatives, and did not uphold the complaint. The decision was still not in favour of the relatives when the case was re-examined by the District Court. The case was then referred to the Court of Appeal. The Court of Appeal did not uphold the appeal. The complaint of the relatives, regarding discontinuation of life-prolonging treatment, was not upheld. An appeal against the decision made by the Gulating Court of Appeal was later rejected by the Supreme Court. Thus, the decision made by the Gulating Court of Appeal is of principle interest. Below we present some of the points made by the court that are important in relation to re-examination of decisions about the right to essential health care.

An important issue that the Court of Appeal had to assess, was whether the relatives'demand for the patient's treatment to be continued could be re-examined by the court, or whether specific treatment for a patient should be decided on only on the basis of medical and ethical assessments. The judicial decision of the Court of Appeal provides a useful explanation of what can be re-examined, and how far the appeals bodies and the courts should go in explaining the reasons for their decisions regarding future treatment of patients.

From the judicial decision of the Court of Appeal:

- *The basis of Norwegian legislation for quite a long way back in time is that the courts, as a general rule, can re-examine all types of administrative decisions.*
- *Regarding the type of decision in this case, we have not found any basis in legislative history – or from the work of the committee – to limit the right to re-examine the decision.*
- *General, non-statutory principles about so-called discretionary assessments made by public administration, provide the framework for judicial re-examination.*

What limitations apply to re-examination of medical assessments?

From the judicial decision of the Court of Appeal:

- *The limitations will be dependent on, among other things, the type of decision to be re-examined, which parts of the decision shall be re-examined, and which other legal safeguards and quality control measures have already been taken care of in the previous decision-making process.*
- *Decisions concerning continuous medical assessments and choices about current treatment are generally at the limit of what the court can and ought to re-examine.*
- *Re-examinations done by a court will probably only be associated with more outer, formal conditions – typically about whether procedures have been followed, and about whether requirements for dealing with cases in a wider context have been fulfilled.*

"It must be possible to document that the patient has been adequately assessed by an interdisciplinary team, and that health care has been provided in accordance with the conclusions of the assessment"

Reversal of a decision to discharge a patient from medication-assisted rehabilitation (MAR)

The second case concerned a patient who was discharged from MAR because of drug use while under treatment. The issue was whether discharging him from MAR was in breach of his right to essential health care for drug abuse. The appeals body upheld the decision that had been taken by the health service. The Norwegian Board of Health Supervision reversed the decision, and implementation of the decision had to be delayed.

The Norwegian Board of Health Supervision found that:

- *the decision to discharge the patient was based on incorrect interpretation of the law, and was therefore invalid*
- *the decision to discharge the patient could not be justified, because it was not adequately documented that continuing with rehabilitation treatment while he was taking other drugs was unsound practice, or that the drug-taking led to lack of effect of the MAR treatment.*

In this case, the Norwegian Board of Health Supervision re-examined the medical assessment, and the new decision affirmed that the patient should continue with MAR. It was highly probable that discharge would have had serious consequences for him, with regard to the results he had already achieved during the rehabilitation process. Also, there was a need to clarify matters of principal with the case. This was why the Norwegian Board of Health exercised its right to reverse the decision.

Summary of the case

The patient had been a drug addict for over 25 years and had been admitted to MAR in 2005. He had managed to stop taking heavy drugs, but had not managed to stop smoking cannabis. The MAR institution meant that use of cannabis was not compatible with MAR treatment and was in breach of the guidelines (Directive I-35/2000). The patient was discharged from MAR after two years, even though his rehabilitation was going well, since he had re-established contact with his family, had moved into his own home, had begun vocational rehabilitation and had agreed to start job training.

In its decision, the Norwegian Board of Health Supervision pointed out that the MAR service, in its routines for discharging patients, must take account of the fact that MAR has become part of the responsibility of the specialized health services to provide interdisciplinary specialized treatment for drug addicts. This means that MAR patients must be ensured essential health care from other specialized health services, if this is necessary in order for them to stop using drugs. In such cases, patients can be discharged from MAR if the treatment is no longer of any benefit to them. The need for other types of treatment must also be assessed, while they are under treatment, and these must be offered. The care that is offered must include both health and social care, as appropriate. If treatment provided by specialized health services is not carried out as planned, or if municipal services are inadequate, this does not affect the patient's right to receive specialized health services.

According to Directive I-8/2004 from the Ministry of Health, when a decision is made, the benefits of rehabilitation must be assessed in a rehabilitation plan, which contains goals based on the patient's resources, former drug abuse, need for treatment and other factors of relevance for rehabilitation. The plan must be developed in consultation with the patient, and must be reassessed when the situation changes, or when the patient has other treatment needs. The assessment of the benefits of rehabilitation must include an assessment of whether drug use during rehabilitation is of such a dimension or character that it weakens the effect of the rehabilitation treatment, or whether continuation of medication is medically unsound. An assessment must also be made about whether discharging a patient from MAR because of drug use is likely to cause more harm than allowing the patient to continue with MAR.

In the case under discussion, the Norwegian Board of Health Supervision found that the patient benefited from MAR, despite the fact that he used cannabis. We found no basis to indicate that use of cannabis made it medically unsound to continue with MAR. However, we found that the patient had not received sufficient help to stop using cannabis. In other words, his right to receive essential health care, in accordance with the Patients' Rights Act, Section 2-1, had not been fulfilled. We also found that discharge was an unreasonable reaction that caused the patient serious harm, both in terms of increased drug use, and social, mental and somatic adverse effects.

Suicide among patients receiving mental health services

The Norwegian Board of Health Supervision has summarized information about cases relating to suicide. These are cases that were reported to the Norwegian Board of Health Supervision in the Counties, and that were finished being dealt with in 2005 and 2006.

The number of cases relating to suicide that were finished being dealt with in 2005 and 2006 was 176. Almost 20 per cent of these cases were not reported to the Norwegian Board of Health Supervision in the Counties as adverse events (pursuant to the Specialized Health Services Act, Section 3-3) but were reported as complaints from relatives, by the police, or by the Institute of Forensic Medicine.

Seventy-six cases of suicide (43.2 per cent) were committed by in-patients. Three quarters of these patients had been admitted voluntarily for mental health care. More than 1 in 10 cases of suicide had occurred while the patient was on leave of absence from the in-patient department, and almost one in ten occurred during the first weeks after being discharged from the department.

Of the 176 cases of suicide that were reported, 61 cases were investigated as supervision cases. For 19 of the supervision cases, the conclusion was that the institution was in breach of the requirement to provide health services in accordance with the Specialized Health Services Act, Section 2-2. Data was available for 18 cases. In eight cases, an adequate assessment of suicide risk had not been done when treatment was started. In eight cases, a reassessment of suicide risk had not be done at vulnerable times, such as transference from compulsory to voluntary care, before being granted leave of absence, transferral to other departments, and discharge. In six cases, inadequate patient record-keeping was identified. Inadequate security measures and inadequate securing of dangerous objects were identified in four cases. We found a general lack of systems for training health care personnel, and insufficient information was given to new members of staff about procedures and guidelines.

The study showed that very few institutions used the experience gained from individual cases to improve the quality of the services. Serious deficiencies were identified in their suicide prevention work.

There were great differences between the counties, both in the number of reports and in the way reports were followed up through supervision. The number of reports varied from about two to eight cases per 100 000 inhabitants over 18 years of age (mean 4.1) in the period of the study. Some of the county offices had routines for initiating a supervision case for all reports of suicide, while other county offices had not initiated any supervision cases.

See the article:
Tidsskr Nor Legeforen 2008; 128:180-3. Suicides committed by patients who receive psychiatric care (Selvmord hos pasienter behandlet i psykisk helsevern).

Not all municipalities offer client-managed personal assistance

Use of personal assistance has gradually increased since this service was laid down in the Social Services Act in 2000. Today, this service is provided for over 2 000 persons. However, there is great variation in the extent of the services offered by municipalities. There are still about one hundred municipalities that do not provide client-managed personal assistance, even though surveys have shown that clients are generally very satisfied with the arrangement.

However, the Offices of the County Governors receive quite a lot of complaints about this service each year. The complaints are mainly about rejection of an application for a personal assistant, and about the number of hours allocated – that the amount of assistance provided is inadequate to meet the client's needs.

In 2007, the Norwegian Board of Health Supervision collected available information about client-managed personal assistance. At the same time, the Ministry of Health and Care Services has put forward a proposal for changes to the legislation, with the aim of reducing differences between municipalities in the allocation of personal assistance, and of improving the range of services available and client participation.

Problem areas for services for people with alcohol and drug problems

"The municipalities have responsibility for providing comprehensive and coordinated services for people with alcohol and drug problems, so that they receive essential health and social services."

Specific problem areas for services for people with alcohol and drug problems are: availability of services, content of services and meeting statutory requirements. Other problem areas are: providing comprehensive services, and knowledge about treatment.

The Norwegian Board of Health Supervision has summed up the results of supervision of services for people with alcohol and drug problems for the period 2004-2006. From previous reports, articles and correspondence, we see that there are some areas where deficiencies in services have been identified, or where there is a danger for deficiencies occurring.

These problem areas are:

- inadequate or limited availability of services – too little capacity, regional differences and other types of variation
- danger of deficiencies in the content of services – lack of qualified staff, inadequate quality of services, and failure to meet professional guidelines
- failure to meet statutory requirements as a result of lack of knowledge, and weaknesses or limitations in the legislation
- inadequate provision of services and lack of coordination of services
- lack of knowledge and lack of systematic registration of service provision – at the national and local levels.

Previously, we have informed the responsible authorities about the results of supervision. The experience we have gained from supervision in this area is in line with the results of research and with knowledge gained from experience. Our findings have been followed up with various measures both at the political and administrative levels. The Government's Action Plan to Combat Alcohol and Drug Problems 2006-2008 shows that an initiative has been taken to follow up areas where there is a danger of deficiencies occurring, which have been identified by the Norwegian Board of Health Supervision. The Proposition to the Storting No. 1 (2007 2008) from the Ministry of Health and Care Services contains a proposal for a plan for this area.

We wish to highlight two areas that present particular challenges. The first area relates to the problem of lack of professional consensus and knowledge-based treatment practice in several of the multi-professional specialized services. The other area is municipal responsibility for providing comprehensive and coordinated services for people with alcohol and drug problems, so that they receive essential health and social services. These services should ensure that these people have accommodation, that they can develop a social network, and that they can have a life with meaningful activities.

The Norwegian Board of Health Supervision has authority to intervene when we find out that services are not provided in accordance with the legislation. During the annual process for deciding which areas to give priority to, we assess the need for further supervision of these services.

It is too early to know whether changes will be made to the arrangement, and what kind of changes. A relevant recommendation is that supervision should focus on the following: that client-managed personal assistance should be provided in accordance with sound professional and ethical standards, and that this service should be given high priority.

In many ways, client-managed personal assistance is a special service. The provider and the client are often alone together for many hours in the week in situations that are private and personal. Clients with mental handicaps can be extra vulnerable if the service does not function as intended. Many of these clients are completely dependent on assistance in order to be able to live at home.

Employer and leadership responsibility for client-managed personal assistance can be organized in different ways. However, as provider of the service, the municipality has responsibility for ensuring that these services are provided in accordance with statutory requirements. The municipality also has a duty to ensure that the services meet sound professional standards. The County Governors are responsible for carrying out supervision to see whether the municipalities meet these requirements. The Norwegian Board of Health Supervision will identify areas where there is a danger that the services may be deficient.

Supervision of physiotherapy institutes

The Norwegian Board of Health Supervision in Aust-Agder has carried out supervision of various private organizations in the county during the last few years. Supervision of three physiotherapy institutes has recently been carried as system audits. The themes for supervision were patient record-keeping, the duty of confidentiality, internal control, quality improvement, and whether the organization is run in accordance with statutory requirements. Supervision has shown that there is potential for improvement within all these areas.

Patient record-keeping varied from totally incomplete to fully acceptable. Several of the patient records that were checked were unclear, and not understandable for people other than the person who had written them. They were not adequate to be used as documents in a supervision case. Several of them lacked information about the date when the examination or treatment had taken place, and when treatment had been completed. There was very little documentation about cooperation with other professional groups.

The facilities in several of the institutes made it difficult to ensure confidentiality and anonymity for patients when they were examined and treated. We question whether it is possible to examine patients adequately when confidentiality and anonymity cannot be assured. The duty of confidentiality is not just a passive duty not to disclose information, but an active duty to prevent unauthorized people gaining access to confidential information.

In one institute, there was no clear demarcation between traditional physiotherapy treatment and alternative treatment. We believe that this is not the only institute where this is the case.

We also believe that many physiotherapy institutes have premises are not easily accessible for physically handicapped people. It is a paradox that these premises are not adapted for easy access, since the people who receive treatment here are primarily people with physical disabilities and/or pain in or disorders of the musculo-skeletal system.

Cooperation between municipal and private physiotherapy services also seems to be inadequate. There are no joint plans for the services and no requirements for reporting to the municipal administration.

The Norwegian Board of Health Supervision in Aust-Agder

Supervision of services provided by the offices of the Norwegian Labour and Welfare Organisation (NAV)

The first NAV offices were established as part of the NAV pilot project in 2006. In Telemark, the pilot NAV office was allocated all the services of the former social security office, including most of the services for people with alcohol and drug problems. The Office of the County Governor wished to carry out supervision of the municipal part of the NAV pilot project, to see whether the municipality ensures that services for people with alcohol and drug problems are coordinated, in accordance with statutory requirements.

The results of supervision showed that there were serious problems associated with coordination of services allocated to the NAV office and other municipal services pursuant to the Social Services Act Chapter 4, such as practical assistance and training, support contact services and institutional care. The municipality was instructed to correct the deficiencies, and the Office of the County Governor will closely follow up the municipality until this is done. A representative from the county NAV office was present as an observer during supervision, and the experience gained from supervision has been used when establishing new NAV offices. Important findings of supervision have also been taken into account when planning a locally-developed training package for use when NAV offices are established.

Services for adolescents with mental disorders or alcohol and drug problems

The Office of the County Governor shall monitor and have an overview over child welfare services and social services in the county. In 2007 we decided to examine the risk for deficiencies occurring in services for children aged 16-20 who have mental disorders or who have alcohol and drug problems.

The Office of the County Governor assumed that adolescents in this group do not always receive the services they need and that they have a right to receive. Reasons for this may be lack of coordination of services, lack of qualified staff, or lack of specific services. We looked specifically at the process of transferring clients from municipal services to specialized health services at the age of 18, and cooperation between the two services.

Information collected from three municipalities in Buskerud shows that follow up of clients is inadequate. Routines for transference of clients from child welfare services to social services at the age of 18 often relate to the technical transference, and only to a limited extent to clinical assessment of each individual case. No account is taken of the fact that these adolescents are vulnerable, they have complex problems, and they need extra care when they are transferred. Increased resources and individually-adapted measures can be beneficial in the long run, both for the municipalities and for the adolescents themselves.

In relation to cooperation between the municipalities and specialized health services (primarily district psychiatric centres and child and adolescent psychiatric services), the municipalities doubt whether the development plan for mental health has had the desired effect for this group. Contracts for cooperation with specialized health services have been entered into at the managerial level, but these have not been put into operation.

The municipalities feel that they do not receive sufficient guidance and help from specialized health services. Individual plans are not used enough as a tool for improving team work. There are also long waiting lists, few of these adolescents receive the essential health care they have the right to receive, and the start of treatment is determined by capacity and not by the individual needs of the adolescents.

Budget constraints in the institutions can influence the services these adolescents are offered, and how they are followed up. Inadequate and unsatisfactory management systems have been identified.

The different services have been aware of the lack of follow up, but little has been done to improve the situation. The Office of the County Governor has instructed all the municipalities in Buskerud to put this issue on the agenda, to identify the causes of deficiencies, and to develop a plan to ensure that these adolescents receive improved comprehensive services.

The Office of the County Governor in Buskerud

The Office of the County Governor has used the experience gained from this supervision during later contact with leaders of social services and the new leaders of the NAV offices. We also see how important it is for us to assess services for people with alcohol and drug problems and mental health services in the municipality in relation to each other.

The Office of the County Governor found that those responsible for services for people with alcohol and drug problems had little knowledge about internal control. This was true for several municipalities in the county. Therefore, we invited them to a seminar about this theme. We received positive feedback about the seminar.

Our aim has been to use the experience we have gained from supervision with other offices to prevent similar problems occurring when new NAV offices are established. We also wish to brush up the other municipalities' knowledge about the legislation.

The Office of the County Governor in Telemark

Social security benefits – a safety net or a stepping stone?

"Receiving social security benefits does not ensure that people have essential means of support over a long period of time, without receiving additional benefits."

Nearly five per cent of the population at some time receive social security benefits. As many as ten per cent in the age group 18-24 receive this kind of assistance. In other words – a large group of people are dependent on the arrangement working satisfactorily.

The Norwegian Board of Health Supervision has responsibility for supervision of administration of economic assistance (social security benefits pursuant to the Social Services Act Chapter 5). This responsibility involves following how the arrangement is practised by the municipalities, and particularly identifying areas where there is a danger of deficiencies occurring, and whether these deficiencies have adverse consequences for clients. In addition, the Office of the County Governor has authority to make decisions about individual cases of complaint. However, the Office of the County Governor does not have legal authority to carry out direct supervision with the way the municipalities administer social security benefits.

The Norwegian Board of Health Supervision has investigated this area. We found that there are differences between the municipalities, both in the level of benefits and in paying out benefits. This indicates that the standard of living of clients who receive social security benefits depends on where they live. We question whether some municipalities pay out benefits that are too low.

We are concerned that the threshold for applying for social security benefits may be so high that not everyone who needs such help receives it. We wonder whether municipalities have routines for ensuring that this type of assistance is available to the people who need it.

Social security benefits are meant to provide assistance in the short term. Therefore, the amount paid out each month is less than the amount for more long-term income. However, there is a significant number of people who receive benefits over a long period of time. Many of these people need coordinated health and social services, and they are often a long step from being employed. Children and adolescents in families with long-term recipients of social security benefits are a vulnerable group, who are difficult to protect from poverty. Receiving social security benefits does not ensure that people have essential means of support over a long period of time, without receiving additional benefits. In our view, other solutions must be found for people who need economic assistance over a long period of time.

Many young people who receive social security benefits are former clients of child welfare services. These clients also represent a vulnerable group. Research has shown that they often have problems in being integrated into the labour market. This gives them an unfortunate start to adult life.

The right to complain about administrative decisions is an important legal safeguard, but the number of complaints from social security clients is low – between one and two per cent. We do not know the reason for this, but assume that it is not only because they are satisfied with the economic assistance they receive.

We believe that legal safeguards for clients are not adequately taken care of in the current legislation. Supervision helps to ensure legal safeguards. Therefore, the Norwegian Board of Health Supervision have argued several times that the duty of internal controls should be extended to include the Social Security Act Chapter 5, and that the Offices of the County Governors should be allocated responsibility for carrying out supervision of the way in which municipalities administer social security benefits.

Social security benefits have been described as "a safety net" in society. A metaphor that paints a more ambitious picture is "a stepping stone" – leading clients forward. For this to become a reality, it is important that clients are given guidance and advice, and that they are closely followed up by other services.

A national reporting system for adverse events

It is often reported in the media that it is about time that Norway had a national reporting system for adverse events that occur in hospitals. For example, we can read in Health Review[1] that: "there are national reporting systems in both Denmark and Sweden, but in Norway there are only local systems". Norway does in fact have a national reporting system for adverse events that occur in hospitals.

Norway has been a pioneer country with regard to such systems. A reporting system was established in the Directorate of Health as early as 1993 (the Directorate of Health became the Norwegian Board of Health Supervision in 1994). In combination with the requirement to have an internal control system, this provides the conditions for dealing systematically with nonconformities (breaches of, or departures from, laws or regulations) and for working with quality improvement.

In other words:
– Norway has MedEvent – the Reporting System for Adverse Events in Specialized Health Services[2]
– Denmark has DPSD – the Danish Patient Safety Database[3]
– Sweden has Lex Maria[4]

The supervision authorities' jargon
– We talk about "Section 3-3-reports", and believe that everyone understands what we are talking about
– We talk about IK-2448, and believe that everyone understands that this is the form that is used for reports

But these need to be explained: Section 3-3 is a section in the Specialized Health Services Act5:
Health institutions covered by this act shall as soon as possible report in writing to the Norwegian Board of Health Supervision in the County about serious injury caused to a patient as a result of provision of health services or as a result of one patient injuring another. Events that could have led to serious injury shall also be reported.

The form IK-2448 is the form that is:
– filled out by staff in hospitals and other health institutions that provide health services
– sent to the Norwegian Board of Health Supervision in the Counties
– registered in the database – MedEvent.

A revised form was available from September 2007. The form was revised to take account of changes in the legislation, and to ensure better quality of the data. The form and the guidelines for filling out the form can be found on our website: www.helsetilsynet.no . We also have a project underway to introduce an electronic reporting system.

Why report?

The main aim of the reporting system is to clarify the background for the event and to prevent similar events happening again, so that patients do not risk being injured. The reporting system is meant to aid the work of the health institution with their internal control system and with improving the quality of services.

The Norwegian Board of Health Supervision in the Counties assess the reports and register them in the national database (MedEvent). They give advice and carry out supervision of the way the health institutions deal with adverse events, and the way their internal control systems function. Recurring events and other serious conditions that put the safety of patients at risk, or that can cause serious problems for patients, are followed up.

The Norwegian Board of Health Supervision uses data from MedEvent to develop a systematic overview of adverse events that occur in specialized health services and in deficiencies in the quality of services[6]. The annual reports for MedE vent provide feedback to the services, and the data are used in the process of deciding which themes and areas to give priority to for carrying out supervision.

The reporting system cannot be used to determine the prevalence of adverse events, deaths or injuries. The 2000 reports that are registered each year provide health institutions and the supervision authorities with useful information about what happens, but not about how often things happen. Even though we encourage health institutions to send in reports more often, we know that not all adverse events are reported.

The reporting system is also not meant to be used to punish health personnel who report events, but to identify errors in the system, so that they can be corrected.

Public statistics published by, among others, Statistics Norway[7] (SSB), the Norwegian Patient Register[8] (NPR) and the National Bureau of Crime Investigation[9] (KRIPOS) provide useful information. In addition, statistics published by the Norwegian System of Compensation for Injuries to Patients [10] (NPE) provide detailed information about risks in specialized health services.

"A man who makes a mistake and does not correct it, makes another mistake."

Confucius

[1] http://www.helserevyen.no. Sidsel Skotland, 01.11.2007
[2] http://www.helsetilsynet.no
[3] http://dpsd.dk
[4] http://www.socialstyrelsen.se
[5] Act 1999-07-02 No. 61 relating to specialized health services
[6] MedEvent - the Reporting System for Adverse Events in Specialized Health Services. Annual reports 1994-2006
[7] http://www.ssb.no
[8] https://www.helsedirektoratet.no/tema/statistikk-registre-og-rapporter/helsedata-og-helseregistre/norsk-pasientregister-npr
[9] http://www.politi.no
[10] http://npe.no

And in the opinion of the Norwegian Board of Health Supervision…

In this article we present a selection of the opinions of the Norwegian Board of Health Supervision, taken from hearing statements in 2007. All our hearing statements can be found on our web site: www.helsetilsynet.no.

Firmer anchorage in the legislation for client-managed personal assistance

In the opinion of the Norwegian Board of Health Supervision, setting a standard number of hours (20 hours) as a minimum limit for being able to organize a service in a specific way, is not in accordance with making a discretionary judgement, which must form the basis for allocating services. About 30 per cent of clients presently receive less than 20 hours assistance per week, and thus, according to this condition, no longer have the right to receive client-managed personal assistance.

The consequences of firmer anchorage in the legislation can be more far-reaching than those that are discussed in the hearing statement. Up until now, few clients have been over 70 years of age. As the arrangement becomes better known, and as the clients of today become older, this situation can change. Many older people with complex and comprehensive needs for care may desire to have help organized as personal assistance. Tomorrow's elderly people will be more self-determined and resourceful. They will demand services that are individually adapted to their needs. They will expect to be involved in the management of the care they receive, more than they have been able to before with traditional care services.

Measures to prevent misuse of social security benefits

The aim of the duty of confidentiality is to protect the integrity of clients, as is their right, and to ensure that the population has trust in health services and health personnel. The duty of confidentiality is one of the foundations for all treatment of patients. In order to detect misuse of social security arrangements, it may be necessary to have access to patients' or clients'records. But we advise against a provision in the legislation that allows the Norwegian Labour and Welfare Organisation (NAV) to have general access to records.

The Norwegian Board of Health Supervision points out some important issues that have not been addressed:

- Who in NAV shall have authorization to have access to records?
- How much of the records shall NAV be given access to? Records can be very comprehensive and cover a long period of time
- How shall records be transferred to NAV?
- What reasons must a third-party have in order to be granted access to records from NAV, instead of having to go via the doctor or the person who wrote the records?
- Who (the doctor/the patient) should be informed when access to records has been granted?
- What reasons must patients/clients and health care personnel have in order to object about access to records being granted?

Proposal to include municipal health and social services in the patient ombudsman arrangement

The Norwegian Board of Health Supervision agrees that extending the patient ombudsman arrangement to include municipal health and social services could help to improve legal safeguards for patients and clients, and to improve equality in provision of care. A formal representative for patients/clients is needed between the administrative level and the health and social services level.

Most cases of complaint sent to the Offices of the County Governors are pursuant to the Social Services Act Chapter 5. The number of complaints could perhaps be reduced, and the cases could perhaps be resolved at a lower level, if these cases were included in the ombudsman arrangement.

Proposal for a training programme for long-term recipients of social security benefits

This hearing statement gives the opinions of the Norwegian Board of Health Supervision about a proposal for a training programme for qualifying long-term recipients of social security benefits for the labour market, and for giving economic benefits to clients who participate in the programme.

We are not certain that such a programme will have the desired effect. Scientific evidence shows, among other things, that many of these clients have complex needs, and that they often have serious health and social problems, including drug problems and psychiatric disorders. This means that they need treatment and/or social services, often combined

with activities, rather than employment. The aim of full-time employment in the ordinary labour market may be too ambitious for these clients.

If the programme, and economic assistance for the programme, become statutory rights, we support the proposal that the Norwegian Board of Health Supervision should have responsibility for general supervision of the arrangement, pursuant to the proposed new Chapter 5A in the Social Services Act.

Acute services in local hospitals as part of a coordinated continuum of care

Services provided in local hospitals shall be in accordance with statutory requirements. Several local hospitals currently have problems to recruit doctors with specialist training. This means that many hospitals use temporary arrangements, such as employing temporary staff and using employment agencies. Not only does this have economic consequences, but supervision has shown that this can lead to deficiencies in the services and provision of treatment that does not meet sound professional standards.

We have found from the supervision we have carried out that some small district psychiatric centres (DPS) do not seem to have sufficient qualified staff. We believe that DPSs must have specialist health care personnel with adequate qualifications, such as psychiatrists and clinical psychologists.

Maternity units run by midwives can function satisfactorily if clear guidelines are developed for selecting women who can give birth in such units, and if these guidelines are followed. Supervision has shown that selection does not always take place as intended, and that routines for transferring women to maternity units with more advanced resources do not always function as they should.

Close proximity to a hospital is regarded as a quality indicator, particularly for patient groups who can make independent and informed choices about which hospital to be treated in. Patients who cannot choose, for example, because they have acute illness, must still be offered high quality services.

When the future functions of a local hospital are planned, it is important to consider treatment regimes for specific conditions. Because of geographic diversity in Norway, we are sceptical to standard models for accident and emergency services. Services must be adapted, taking into account demographic factors, activity statistics, risk assessment and local conditions. Other important factors are the distance to the nearest fully-equipped hospital and ambulance resources.

Seen in relation to available resources, the primary functions of local hospitals should be:

- stabilization of acute conditions and advanced diagnosis
- assessment and treatment of conditions that do not require specialist skills
- follow-up and rehabilitation of people with chronic conditions and people who have been treated in more specialized hospitals
- specialized support for municipal health services.

Revision of the overall plan for the education of nurses

One of the cornerstones for the education of most health care professionals is clinical practice. A high standard of teaching while they are in practice is essential for training competent nurses.

Teachers must have both teaching skills and professional skills. Having a teaching qualification must be an absolute requirement, and we are pleased that the overall plan lays down this requirement.

The Norwegian Board of Health Supervision wishes more emphasis to be placed on safety. The most common reason for supervision cases against nurses, and for their authorization to be withdrawn, is because of professional misconduct: primarily because of theft or use of alcohol or drugs. Anther reason is sexual abuse or misconduct with a patient. When students are in clinical practice, this is a good time to take up such issues, and to identify this kind of behaviour.

Facts and figures

Contents

This chapter in the Annual Supervision Report presents an overview of the most important tasks that the Offices of the County Governors, the Norwegian Board of Health Supervision in the Counties and the Norwegian Board of Health Supervision (the central office) carry out as supervision authorities and appeals bodies.

Complaints regarding failure to meet people's rights to receive social services

Table 1 Complaints regarding the Social Services Act dealt with by the Offices of the County Governors Trend 2005-2007 and the result of cases in 2007 according to type of case

	2005	2006	2007						
				Social services			Social security benefits		
Office of the County Governor	Cases dealt with	Cases dealt with	Cases dealt with	Cases dealt with	Proportion of decisions affirmed (%)	Proportion of decisions revoked or reversed (%)	Cases dealt with	Proportion of decisions affirmed (%)	Proportion of decisions revoked or reversed (%)
Østfold	514	426	416	70	53	47	338	70	28
Oslo og Akershus	1278	1223	1286	199	54	41	995	74	25
Hedmark	257	208	194	61	49	51	126	75	25
Oppland	183	193	169	50	66	32	118	87	13
Buskerud	393	384	366	77	47	47	278	79	19
Vestfold	318	336	258	72	46	54	179	87	13
Telemark	245	188	148	29	34	59	114	97	20
Aust-Agder	119	99	55	18	67	28	36	64	33
Vest-Agder	168	166	161	33	27	70	127	77	22
Rogaland	525	377	319	55	71	27	259	81	19
Hordaland	588	506	531	111	86	14	391	83	16
Sogn og Fjordane	117	104	85	19	53	47	65	65	34
Møre og Romsdal	280	224	174	54	46	48	111	86	14
Sør-Trøndelag	223	235	211	44	39	57	159	87	11
Nord-Trøndelag	137	95	97	14	50	43	78	76	23
Nordland	307	260	212	65	43	45	132	78	20
Troms	220	226	238	69	65	30	167	84	15
Finnmark	149	101	60	5	80	20	53	72	28
TOTAL	6021	5351	4980	1045	55	41	3726	78	21

* The total percentage is not always 100 % because rejected cases are included in the cases dealt with, but not in the result of the cases

An aim of social services is that clients and relatives are satisfied, and that clients receive high quality services that meet their needs. Do the statistics for 2007 regarding complaints give an indication that the services are moving in this direction?

In 2006[1] 170 000 people received home-based services. Some of these clients received only home nursing services, but most of them received social services. In the same year, 122 400 clients received social security benefits. In many cases, several decisions were made for an individual client, either because the decisions applied to different services, or because the decisions applied for a limited period during the year. Thus, the number of decisions made in one year is much higher than the number of clients. Altogether, in 2007, the Offices of the County Governors dealt with 4 980 cases of complaint pursuant to the Social Services Act. 1 045 of these were complaints about social services, and 3 726 were complaints about social security benefits.

The number of complaints received was 4 616, a reduction of 14 per cent from 2006 and 25 per cent from 2005. Part of the reason for this reduction is that cases are registered more precisely. However, the main impression is either that there are fewer complaints, or that more complaints are reassessed by the municipalities, so that the cases are not sent further to the Offices of the County Governors. The reduction is greatest for complaints about social security benefits.

Tables 1 and 2 present figures for cases in which individuals have complained about a decision that the municipality has taken pursuant to the Social Services Act, and that the Offices of the County Governors have dealt with in their capacity as appeals body. About four out of five complaints are about social security benefits. Other complaints are mainly about social services. Examples of complaints about social security benefits are complaints about the amount of the benefit, and more specific complaints about expenses for accommodation, clothes, dental treatment, medication, furniture and travelling. Complaints can also be about the conditions for receiving social security benefits and the type of help offered. Examples of this are complaints about social security benefits given as a loan, and complaints that the municipality has taken a refund in social security benefits paid later. Complaints about social services are often about economic assistance for carers and practical assistance, for example, reduction in home help services. Some complaints are about support contact and respite care services.

In 2007, the Offices of the County Governors affirmed the decision of the municipality in 73 per cent of cases (2006: 72 %, 2005: 71 %, 2004: 74 %). In 25 per cent of cases the decision was revoked and the case was returned to the municipality to be dealt with again, or the decision was reversed. This

[1] Figures for 2007 are not yet available

Table 2 Complaints regarding the Social Services Act dealt with by the Offices of the County Governors
Complaints about social services according to the different types of services. 2007

Office of the County Governor	Services in the Social Services Act Section 4-2 *						Other provisions in Chapter 4	Total
	a)	of these: CPA	b)	c)	d)	e)		
Østfold	14	6	8	8	0	39	1	70
Oslo og Akershus	44	12	32	32	6	84	1	199
Hedmark	25	12	3	8	2	23	0	61
Oppland	16	8	8	10	0	13	3	50
Buskerud	25	16	13	6	2	30	1	77
Vestfold	32	11	8	5	0	27	0	72
Telemark	10	5	7	2	1	9	0	29
Aust-Agder	6	4	1	3	0	5	3	18
Vest-Agder	6	1	1	13	1	8	4	33
Rogaland	17	13	13	9	0	15	1	55
Hordaland	22	9	14	29	0	43	3	111
Sogn og Fjordane	7	5	2	1	0	9	0	19
Møre og Romsdal	20	2	10	5	4	13	2	54
Sør-Trøndelag	11	5	6	6	2	19	0	44
Nord-Trøndelag	3	3	2	1	0	7	1	14
Nordland	15	7	13	16	3	18	0	65
Troms	18	11	8	7	1	35	0	69
Finnmark	1	0	1	0	0	3	0	5
TOTAL	292	130	150	161	22	400	20	1045

* The services are:
a) practical assistance and training including CPA (client-managed personal assistance)
b) respite care
c) support contact
d) places in institutions or accommodation with 24-hour caring services
e) economic assistance for carers

means that the decision was partly or wholly in favour of the complainant. This happened in 41 per cent of cases of complaint about social services.

In 2007 the Offices of the County Governors were required to deal with cases of complaint within three months. In 2005, 90 per cent of cases were dealt with within the deadline, in 2006 85 per cent, and in 2007 76 per cent. Nine of the 18 Offices of the County Governors dealt with over 90 per cent of cases within three months. The main reason for low percentage of cases dealt with within the deadline was that some of the large offices took a long time to deal with cases during the first half of the year. At the beginning of 2007, there were 871 cases that had not been dealt with, by the end of 2007 there were 471 cases. The number of cases that been dealt with in 2007 was ten times the number that had not been dealt with. This indicates that the Offices of the County Governors, with a couple of exceptions, deal with cases promptly and have good control over cases at the beginning of 2008.

The Norwegian Board of Health Supervision is the highest authority for complaints regarding rights laid down in social services legislation (see more about our role on page 28). In 2007 eight cases of complaint were sent to us to assess reversing decisions made by the Offices of the County Governors. However, no decisions made by the Offices of the County Governors were reversed.

Complaints regarding failure to meet people's rights to receive health services

The Norwegian Board of Health Supervision in the County is the appeals body when a person has not received their rights pursuant to the Patients' Rights Act and certain other regulations. Those who have responsibility for the services (the municipalities etc.) shall have reassessed the case before a complaint is sent to the Norwegian Board of Health Supervision in the County. The Norwegian Board of Health Supervision in the County can assess all aspects of the case. The decision of the Norwegian Board of Health Supervision in the County is final.

It appears that the number of complaints is levelling out, after an increase in the number of complaints over the last few years. In 295 of the 887 cases (33 %), the complaint was partially or wholly supported, or the decision was revoked because of errors in the way the case was dealt with, or for other reasons (see Table 3). The corresponding figures for 2006 and 2005 are somewhat lower: 40 per cent for 2006 and 39 per cent for 2005.

More than 40 per cent of complaints pursuant to health legislation were related to the right to reimbursement of transport expenses for journeys between the patient's home and the place where treatment was provided (Patients' Rights Act, Section 2 6). These complaints are often about relatively small amounts of a few hundred kroner. The proportion of complaints where the decision was in favour of the complainant (15 per cent) was less than for other types of complaint (42 per cent).

The Norwegian Board of Health Supervision is the highest authority for complaints regarding rights laid down in the Patients' Rights Act and the Municipal Health Services Act (see more about our role on page 28). We are also appeals body when the Norwegian Board of Health in the County rejects dealing with a complaint. In 2007 eight cases of complaint were sent to us to assess reversing decisions made by the Offices of the County Governors regarding patients' rights. Four of these cases were reversed in favour of the complainant. For two cases that were sent to us, the Norwegian Board of Health in the County had rejected dealing with a complaint. One of these decisions was reversed.

Use of coercion and restraint for people with mental disabilities

Legal safeguards associated with use of coercion and restraint for people with mental disabilities are regulated in the Social Services Act Chapter 4A. The Offices of the County Governors have several tasks related to these provisions (see Table 4).

The municipalities report decisions taken about measures taken to avoid injury in critical situations (individual situations) to the Offices of the County Governors, pursuant to the Social Services Act, Section 4A-5, third paragraph, a. In 2007, 31 533 decisions were taken, relating to 1 148 persons.

Planned measures to avoid injury in repeated emergency situations must be authorized by the Offices of the County Governors. Authorization must also be obtained for measures to meet clients' basic needs for food and drink, dressing, rest, sleep, hygiene and personal safety, including education and training, pursuant to Section 4A-5 third paragraph b and c.

In 2007, the Offices of the County Governors authorized 1 300 decisions, relating to 679 persons. These decisions related to:

Table 3 Complaints regarding failure to meet people's rights to receive health services. Number of cases completed by the Norwegian Board of Health Supervision in the Counties according to specific provisions in the legislation 2005, 2006 and 2007

Provision	Provision regarding:	[2]2005	[2]2006	2007	
		Number of assessments	Number of assessments	Number of assessments	Of which decision partly or wholly in favour of the complainant
Patients' Rights Act					
Section 2-1 first paragraph	The right to required health care from the municipal health services	66	62	53	13
Section 2-1 second paragraph	The right to required health care from specialized health services	140	165	212	72
Section 2-2	The right to an assessment within 30 workdays	25	25	14	10
Section 2-3	The right to a reassessment	3	8	7	2
Section 2-4	The right to choose hospital	15	30	18	12
Section 2-5	The right to an individual plan	13	20	6	5
Section 2-6	The right to transport to health services	323	394	390	56
Chapter 3	The right to participation and information	22	20	31	12
Chapter 4	Consent to health care / the right to refuse health care	1	5	5	1
Section 5-1	The right of access to medical records	32	31	39	20
Health Personnel Act					
Sections 42. 43 and 44, pursuant to the Patients' Rights Act, Section 5-2	The right to correct and delete medical records	26	30	25	12
Municipal Health Services Act					
Section 2-1	The right to required health care	186	161	151	80
Dental Health Services Act					
Section 2-1	The right to required dental care	2	2	0	
Other sections that give the right to health services		4	1	0	
Total number of assessments of specific provisions		858	954	951	295
Number of cases [1]		775	880	887	

[1] Several of the cases dealt with by the Norwegian Board of Health Supervision in the Counties are assessed on the basis of several provisions relating to patients' rights. Therefore the number of assessments is greater than the number of cases.
[2] The figures are slightly different from previously published figures, because the figures are corrected when inaccuracies are detected.

- measures to avoid injury in repeated emergency situations – 428 decisions
- measures to meet clients' basic needs for care – 473 decisions
- use of mechanical restraint – 65 decisions pursuant to letter b, 92 letter c
- use of radical warning systems – 48 decisions pursuant to letter b, 177 letter c
- education and training – 17 decisions.

The Offices of the County Governors gave dispensation from the requirement to undergo training in 602 cases, which in the Social Services Act, Section 4A-9, applies to personnel who shall implement measures according to Section 4A-5, third paragraph b and c.

The Offices of the County Governors made decisions about two complaints about measures pursuant to Section 4A-5, third paragraph a, and prepared the cases for three complaints regarding measures pursuant to Section 4A-5, third paragraph b and c, to be dealt with by the County Committee for Social Affairs.

On 224 occasions, the Offices of the County Governors carried out local supervision of measures pursuant to Section 4A-5, third paragraph b and c, according to the duty to carry out supervision in Section 2-6, first paragraph, second point. Local supervision was also carried out 22 times pursuant to other provisions.

Supervision of Social Services

System audits

In 2007, the Offices of the County Governors carried out 181 system audits (see Table 5). This supervision was carried out in 176 municipalities and urban districts. Five system audits were carried out in other organizations. In 38 of the system audits, no breaches of laws or regulations were detected.

Ninety-four of the 181 system audits investigated requirements pursuant to both health and social legislation. This supervision was carried out jointly by the Offices of the County Governors and the Norwegian Board of Health Supervision.

In 2007, the Offices of the County Governors carried out countrywide supervision of two areas, according to guidelines developed by the Norwegian Board of Health Supervision:

- municipal health and social services for adults with mental disorders – 68 system audits
- respite care and support services, pursuant to the Social Services Act – 66 system audits.

The summary reports of countrywide supervision have been published in the report series of the Norwegian Board of Health Supervision. See also the articles on pages 4 and 7.

Forty-seven system audits were carried out that were not part of countrywide supervision. The institutions and themes for these system audits were chosen on the basis of information that the Offices of the County Governors have about risk and vulnerability in their own county.

These system audits included:

- legal safeguards associated with use of coercion and restraint for people with mental disabilities – 13 system audits
- health and social services for people living in their own homes – 11 system audits
- services for people with alcohol and drug problems, living in or outside institutions – 7 system audits.

Other areas that were the theme for supervision include: municipal services for children, services for people with mental disorders, and health and social emergency preparedness.

Nonconformities from more than one year ago

Per 31 December 2007, there were still open nonconformities (breaches of laws or regulations that had not been corrected) relating to social services from 22 system audits carried out in 2006 or earlier.

Table 4 Use of coercion and restraint for people with mental disabilities Social Services Act Chapter 4A. Number of decisions etc. 2007

Office of the County Governor	Decisions taken by the municipalities - Section 4-A5 third paragraph, a		Decisions reassessed by the Offices of the County Governors - Section 4-A5, third paragraph, b and c			Dispensations from the requirement to undergo training - Section 4A-9	Local supervisions - Section 2-6
	Number of decisions	Number of people the decisions related to	Number of decisions approved	Number of decisions not approved	Number of people the decisions related to		
Østfold	858	93	22	0	18	9	7
Oslo og Akershus	3265	218	73	2	54	50	15
Hedmark	882	46	79	0	45	43	12
Oppland	409	40	57	1	48	44	28
Buskerud	1633	50	104	1	31	27	18
Vestfold	439	34	29	0	21	19	5
Telemark	216	35	64	3	20	17	7
Aust-Agder	233	31	12	1	10	7	1
Vest-Agder	502	57	65	0	38	10	11
Rogaland	3452	119	92	2	56	56	11
Hordaland	13168	186	200	8	99	93	35
Sogn og Fjordane	571	34	20	2	18	11	14
Møre og Romsdal	1634	55	139	8	55	59	16
Sør-Trøndelag	736	50	50	1	38	7	10
Nord-Trøndelag	250	16	101	17	29	74	9
Nordland	245	31	140	0	48	45	25
Troms	2064	43	40	3	43	23	10
Finnmark	976	10	13	1	8	8	12
TOTAL	31 533	1 148	1 300	50	679	602	246

Issuing instructions
In 2007, the Offices of the County Governors did not issue instructions pursuant to the Social Services Act.

Supervision of health services

The Norwegian Board of Health Supervision in the Counties carried out 247 system audits in 2007 (see Table 6):
- municipal health services – 168 system audits
- specialized health services – 72 system audits
- other services – 7 system audits.

In addition, the Norwegian Board of Health Supervision in Rogaland carried out supervision of health-related conditions in the petroleum industry: 24 cases of supervision (not system audits).

Ninety-four of the 168 system audits carried out in the municipalities, investigated requirements pursuant to both health and social legislation. This supervision was carried out jointly by the Offices of the County Governors and the Norwegian Board of Health Supervision.

In 42 of the 168 system audits of municipal health and social services, in 28 of the 72 system audits of specialized health services, and in three of the seven system audits of other organizations, no breaches of laws or regulations were detected.

In 2007, the Norwegian Board of Health Supervision in the Counties carried out countrywide supervision of two areas, according to guidelines developed by the Norwegian Board of Health Supervision:
- municipal health and social services for adults with mental disorders – 68 system audits.
- accident and emergency units in somatic hospitals: are services adequate and do they meet legislative requirements? – 27 system audits.

The summary reports of countrywide supervision have been published in the report series of the Norwegian Board of Health Supervision (see the articles on pages 7 and 9).

Altogether 100 system audits were carried out in the municipalities that were not part of countrywide supervision. These system audits included:
- nursing homes: 30 system audits
- emergency services: 11 system audits
- home nursing services: 12 system audits
- home-based services, including home nursing services: 11 system audits
- emergency planning: 9 system audits

Other areas that were the theme for supervision in several municipalities are: assessment of dementia, prison health services, services for children with special needs, and school health services.

Forty-five system audits of specialized health services were carried out that were not part of countrywide supervision. These included:
- multidisciplinary specialized services for people with alcohol and drug problems – 11 system audits
- investigation of psychiatric institutions – 7 system audits.

Other areas that were the theme for supervision include: rehabilitation institutions, communication to ensure provision of treatment of adequate standard, internal control in health trusts, and follow-up of patients at risk of committing suicide.

Nonconformities from more than one year ago
PPer 31 December 2007, there were still open nonconformities (breaches of laws or regulations that had not been corrected) from 37 system audits carried out in 2006 or earlier (28 at the end of 2006, 30 at the end of 2005 and 40 at the end of 2004).

The Norwegian Board of Health Supervision in the Counties will follow up nonconformities with the owners and the people responsible for running the services, until the services are in line with statutory requirements.

Issuing instructions
In 2007, the Norwegian Board of Health Supervision issued instructions to two municipalities, about lack of plans for health and social emergency preparedness. The cases have been dealt with pursuant to the Municipal Health Services Act and the Health and Social Emergency Preparedness Act. One municipality received a warning about issuing instructions, for having failed to reply to the supervision authority. One regional health authority was given a coercive fine because occupancy rates in acute psychiatric units/ short-stay units in the Health Trust were consistently in excess of capacity (see the article on pages 12-13).

Table 5 Supervision of social services. Number of system audits carried out by the Offices of the County Governors 2005, 2006 and 2007

Office of the County Governor	2005	2006	2007
Østfold	9	9	9
Oslo og Akershus	16	14	17
Hedmark	10	9	10
Oppland	7	7	8
Buskerud	11	13	10
Vestfold	8	8	9
Telemark	8	6	8
Aust-Agder	7	8	7
Vest-Agder	8	8	7
Rogaland	8	9	10
Hordaland	10	15	16
Sogn og Fjordane	9	9	8
Møre og Romsdal	6	12	13
Sør-Trøndelag	14	11	13
Nord-Trøndelag	7	6	8
Nordland	9	9	10
Troms	8	8	10
Finnmark	5	7	8
TOTAL	160	168	181

Table 6 Supervision of health services. Number of system audits carried out by the Norwegian Board of Health Supervision in the Counties. 2005, 2006 and 2007

Norwegian Board of Health in the county of:	2005	2006	2007
Østfold	10	13	12
Oslo og Akershus	23	23	13
Hedmark	11	10	12
Oppland	7	6	10
Buskerud	12	10	14
Vestfold	11	12	14
Telemark	10	13	13
Aust-Agder	15	14	13
Vest-Agder	8	13	12
Rogaland	11	18	11
Hordaland	23	20	26
Sogn og Fjordane	13	10	11
Møre og Romsdal	12	15	16
Sør-Trøndelag	15	14	16
Nord-Trøndelag	8	12	10
Nordland	14	22	19
Troms	14	14	14
Finnmark	5	7	11
TOTAL	222	246	247

Table 7 Supervision cases dealt with by the Norwegian Board of Health Supervision in the Counties. Number of completed cases and percentage of cases that took more than 5 months to deal with. 2005, 2006 and 2007

Norwegian Board of Health in the county of:	Number of completed cases 2005[1]	2006[1]	2007	Percentage of cases that took more than 5 months in 2007
Østfold	97	109	118	58 %
Oslo og Akershus	258	358	312	69 %
Hedmark	69	105	113	85 %
Oppland	54	58	74	49 %
Buskerud	139	86	94	59 %
Vestfold	74	92	118	30 %
Telemark	69	90	77	17 %
Aust-Agder	45	48	30	47 %
Vest-Agder	62	79	55	29 %
Rogaland	133	97	141	51 %
Hordaland	136	173	158	39 %
Sogn og Fjordane	34	38	42	10 %
Møre og Romsdal	69	62	70	77 %
Sør-Trøndelag	112	107	93	43 %
Nord-Trøndelag	41	65	41	88 %
Nordland	104	124	94	28 %
Troms	49	72	76	24 %
Finnmark	66	37	21	67 %
Arrears Project[2]	117			
TOTAL	1728	1800	1727	51 %
In addition: cases completed without being assessed [3]	268	348	279	

[1] The figures are slightly different from previously published figures, because the figures are corrected when inaccuracies are detected.
[2] Because the Norwegian Board of Health Supervision in Oslo and Akershus, Østfold and Hedmark took a long time to deal with cases, the Norwegian Board of Health Supervision (the central office) took over 224 cases (the Arrears Project). The project was completed in September 2005.
[3] These are cases that were completed without being assessed, by requesting the person who was complained against to contact the complainant in order to find an amicable solution.

Table 8 Supervision cases dealt with by the Norwegian Board of Health Supervision in the Counties Number of cases according to legislative basis for assessment of cases. 2005, 2006 and 2007

Legislative basis	Number of assessments		
Provisions in the Health Personnel Act	**2005**	**2006**	**2007**
Section 4. Sound professional standards: behaviour	218	231	182
Section 4. Sound professional standards: examination, diagnosis and treatment	1362	1510	1538
Section 4. Sound professional standards: medication	204	218	204
Section 4. Sound professional standards: other	255	295	256
Section 7. Emergency treatment	56	40	40
Section 10. Information	78	98	82
Section 16. Organization of the services	150	149	133
Chapters 5 and 6. Duty of confidentiality, right of disclosure, duty of disclosure	87	104	102
Sections 39-41. Patient records	214	271	226
Section 57. Fitness to practice: alcohol and drug abuse	41	32	28
Section 57. Fitness to practice: other reasons	51	53	57
Provisions in the Specialized Health Services Act			
Section 2-2. Duty of sound professional standards	378	383	480
Other legislative basis for assessment	481	537	469
Total number of provisions as legislative basis[1]	3575	3921	3797
Number of cases assessed [1]	1728	1800	1727

[1] Several of the cases dealt with by the Norwegian Board of Health Supervision in the Counties are assessed on the basis of several provisions. Therefore the number of assessments can be higher than the number of cases.

Supervision cases (individual cases) in the health services

Supervision cases dealt with by the Norwegian Board of Health Supervision in the Counties

Supervision cases are cases dealt with by the Norwegian Board of Health Supervision in the Counties on the basis of complaints from patients, relatives and other sources, concerning possible deficiencies in provision of services.

In 2007, the number of new cases per 100 000 inhabitants ranged from 31 in Møre og Romsdal and 32 in Rogaland to 78 in Troms. For the whole country, there were 2 112 new supervision cases (45 per 100 000 inhabitants, compared with 50 in 2006).

The number of supervision cases being dealt with by the Norwegian Board of Health Supervision in the Counties (the backlog) decreased slightly from 1 071 at the end of 2006 to 1 054 at the end of 2007.

The requirement concerning the length of time taken to deal with cases, laid down in the government budget, is that more than half of the cases shall be dealt with within five months. This requirement was met in ten counties in 2007 and 9 counties in 2006 (see Table 7) (Oslo and Akershus are counted separately). For all the counties seen as a whole, this requirement was just about met. However, the requirement applies for a maximum of 2 000 new cases. There were 112 fewer cases than this in 2007.

Supervision cases are often complex. Table 8 shows that on average each case has more than two legislative bases for assessment. The theme that is most often assessed is sound professional standards. The next most common theme is the duty to keep patient records. There are few cases about alcohol and drug abuse and other issues relating to fitness to practice, but these cases often end up with an administrative reaction from the Norwegian Board of Health Supervision.

Supervision cases dealt with by the Norwegian Board of Health Supervision (the central office)

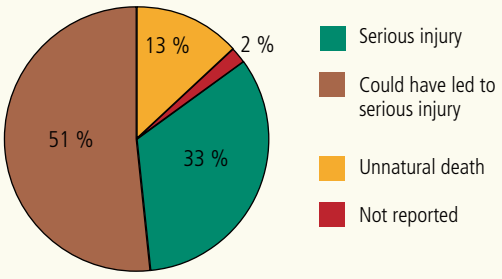
The Norwegian Board of Health Supervision (the central office) deals with the most serious supervision cases, which are sent over from the Norwegian Board of Health Supervision in the Counties. Supervision cases dealt with by the Norwegian Board of Health Supervision are presented in the article on pages 19-22, including statistics.

Medevent

Medevent (Meldesentralen – the Reporting System for Adverse Events in Specialized Health Services) is a database for reports of events that are registered according to the Specialized Health Services Act, Section 3-3. Health institutions have a duty to send a written report to the Norwegian Board of Health Supervision in the County in the event of serious injury to patients, or events that could have led to serious injury to patients, that occur as a result of provision of health care, or as a result of one patient injuring another.

The number of reports of adverse events that were registered in the database in 2006, was 1 855 (2 053 in 2005). One-third of the reports (33 %) were reports of serious injury, and one half (51 %) were reports of incidents that could have led to serious injury. 246 reports of unnatural death were registered in 2006 (13 % of all reports).

Figur 1. Meldingar registrerte i 2006 fordelte på skadegrad



Twenty-seven per cent of these reports were associated with use of medication.

Four per cent of reports registered in 2006 were of events associated with birth. In 74 per cent of these, the event was associated with the woman, and in 26 per cent the child. There were nine reports of unnatural death of the child during birth.

Sixteen per cent of reports registered in 2006 were of events that occurred in mental health care. 89 reports of suicide, 47 reports of attempted suicide and 37 reports of self-inflicted injuries were registered. Most of these events involved patients in psychiatric units or patients who were receiving psychiatric treatment in somatic units.

A number of changes were made to Medevent in 2007. The old registration form, which had been in use since January 2001, was extensively revised. The revised form was available from September 2007. A new database, adapted to the new registration form, was established and in use from October 2007.

In 2007, 1 787 reports were registered in the old database, and 64 in the new database, a total of 1 851 reports. These reports have not yet been organized and analysed.

Use of our web site: www.helsetilsynet.no

In 2007, there were approximately 1 220 000 visits to our web site (2006: 1 065 000) and about 4.1 million visits to specific pages (2006: 4.2 million). The most popular sites were (number of visits in brackets):

- publications (1 183 000)
- supervision reports (1 103 000)
- the web sites of the Norwegian Board of Health Supervision in the Counties (418 000)
- legislation (328 000).

Access to documents and references to us in the media

In 2007, the Norwegian Board of Health Supervision received 1 367 requests from the media for access to documents in the Electronic Mail Records. There were 3 009 in 2006, 2 265 in 2005, 2 136 in 2004, and about 1 700 in 2003.

The Norwegian Board of Health Supervision was mentioned about 8 900 times in the mass media in 2007 (the surveillance system Retriever). This figure is about the same as for 2006.

Financial Statement 2006

Expenditure for dealing with complaints, and supervision carried out by the Norwegian Board of Health Supervision in the Counties, was covered under the budget chapter 1510, the Offices of the County Governors.

Financial statement

Table 9 Financial statement 2007. Budget chapters 721 and 3721, the Norwegian Board of Health Supervision (all amounts in NOK 1 000). 2007

Income / expenditure	Budget	Accounts	Difference
Expenditure: fixed wages	47 619	43 013	4 606
Expenditure: variable wages	1 988	6 502	-4 514
Operating costs (rent, cleaning, electricity, security etc.)	7 220	7 665	- 445
Other expenditure	18 719	15 849	2 870
Total expenditure	75 546	73 029	2 517
Income	-2 288	-2 538	250
Net expenditure / saving	73 258	70 491	2 767

Countrywide supervision in 2008

In January 2007, the Norwegian Board of Health Supervision decided that the areas for countrywide supervision in 2008 will be:
- **municipal children's welfare services, health services and social services, for children with special needs**
- **specialized health services for adults with mental disorders.**

"The reason why the Norwegian Board of Health Supervision chooses to inform about the areas for countrywide supervision for the following year, is that we expect organizations to introduce measures to improve management and internal control of the services."

A major reason for choosing municipal services for children as an area for countrywide supervision, is the desire to achieve better coordination between children's welfare services, health services and social services for children with special needs.

A reason for choosing mental health services as an area for countrywide supervision, is that in 2007, municipal services for people with mental disorders was an area for supervision, and we now wish to focus on specialized health services for the same group.

Countrywide supervision means that supervision is carried out in all the counties. Supervision is carried out as system audits. All providers of health and social services have a duty to have an internal control system to ensure that services are provided in accordance with statutory requirements. The method of system audits is a method of carrying out supervision that focuses on the relationship between professional and managerial challenges.

Municipal children's welfare services, health services and social services for children

The Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties will cooperate in carrying out supervision of services for children. This supervision was initiated by the Ministry of Children and Equality and the Norwegian Board of Health Supervision. Guidelines for supervision have been developed, with the help of representatives from the supervision authorities at the county level. Meetings have been with municipal service providers, researchers, client organizations, and other professionals who provide services for children. The Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties will investigate whether the municipalities, through their internal control systems, ensure that children and young people of school age with special needs receive adequate services that are coordinated, and that are provided when they need them. By children with special needs, we mean children that need assistance from at least two of the services included in the supervision. Reasons for this need can be withdrawal, aggressive behaviour, alcohol or drug use, or parental situation.

The following areas will be investigated:
- do the municipalities coordinate the different services, so that children are identified, investigated, assessed and followed up, to ensure that they receive the help that they require?
- do the different services inform each other about what they are doing, and cooperate in carrying out the measures that are required at the time they are needed?
- are all the services that are provided to children and their parents evaluated?
- do the children's welfare services and social services prepare and carry out the transition from one service to the other?

Supervision will focus on municipal services for children who live at home, in a foster home, or in a temporary foster home in their own municipality, not services for children living in institutions or in other municipalities.

Specialized health services for adults with mental disorders

The Norwegian Board of Health in the Counties will carry out supervision in 2008 and 2009, using a regional team. In each team there will be professional auditors: psychologists and psychiatrists. Guidelines for supervision have been developed, and meetings have been held with professionals and client organizations.

Supervision is limited to the district psychiatric centres. Focus will be placed on how the centres fulfil their functions within general psychiatry for people with serious mental disorders.

The following areas will be investigated:
- The district psychiatric centres have a "cross-roads function" to ensure that patients have continuity of care. Do the centres ensure that specialized health services and municipal services work together as a team?
- Is treatment provided in accordance with requirements laid down in the legislation? For example, have measures been implemented to avoid and prevent the use of coercion and restraint?
- User participation
- Services for relatives.

After one year, the results of supervision will be summarized.

Prevention is better than cure

The aim of supervision is to ensure that health and social services are provided in accordance with requirements laid down in the legislation. The choice of areas for supervision is based on assessment of risk and vulnerability, and the need to carry out supervision of services for clients that are specially vulnerable. Municipal services for children with special needs, and out-patient specialized health services for adults with serious mental disorders, are services for specially vulnerable clients.

Publications from the Norwegian Board of Health Supervision

Reports from the Norwegian Board of Health Supervision

In this series of reports, the Norwegian Board of Health Supervision presents the results of cases of complaint and supervision of health and social services. Full text versions of the reports in Norwegian, and summaries in English and Sámi, can be found on our website: www.helsetilsynet.no.

1/2007, Annual Report 2005 for MedEvent (Meldesentralen – the Reporting System for Adverse Events in Specialized Health Services)

2/2007, "If you go in alive, you come out alive"– but what happens next?
Follow-up after treatment for alcohol poisoning

3/2007, Summary of Countrywide Supervision in 2006 of Multidisciplinary Specialized Services for People with Alcohol and Drug Problems

4/2007, Summary of Countrywide Supervision in 2006 of Services for Children with Special Needs
Variable Services for Children with Special Needs

5/2007, Summary of Countrywide Supervision in 2006 of Legal Safeguards Related to Use of Coercion and Restraint for People with Mental Disabilities
Legal Safeguards for People with Mental Disabilities

6/2007, Complaints about Financial Support
An Analysis of Complaints Pursuant to the Social Services Act Chapter 5 Dealt with by the Offices of the County Governors from 1995 to 2005

7/2007, Summary of the Reports of the County Governors for 2006 about Cases of Complaint According to the Social Services Act

8/2007, Services for People with Mental Disorders

1/2008, Annual Report 2006 for MedEvent (Meldesentralen – the Reporting System for Adverse Events in Specialized Health Services)

2/2008, "While we are waiting…."– do patients receive adequate treatment in accident and emergency units?
Summary of countrywide supervision in 2007 of accident and emergency units in specialized health services – are services of adequate quality and do they meet legislative requirements?

3/2008, Summary of countrywide supervision in 2007 of municipal health and social services for adults with mental disorders

4/2008, Respite care and support contact – services that improve the quality of life
Summary of countrywide supervision in 2007 of respite care and support contact services

Correspondence

In many cases, the Norwegian Board of Health contributes to issues in the form of correspondence to other health and social authorities and services. Some of this correspondence is published on our website. Some of the themes are listed below:

Services for people with alcohol and drug problems. Summary and assessment of the results and experience gained from supervision in 2004-2006 (13 December)

Decision to impose a coercive fine because of failure to follow instructions to meet statutory requirements related to health services – Western Norway Regional Health Authority (28 September)

Completion of the supervision case – "the Sudbø case". Breach of the duty of internal control (28 August)

Education and authorization of health care personnel who participate in medication-assisted rehabilitation (7 July)

Investigation of some of the issues related to medication-assisted rehabilitation services, autumn 2005 – summary (23 February)

In addition, we publish hearing statements (see the article on pages 38-39, and correspondence regarding instructions given to organizations and administrative reactions given to health care personnel.

Annual reports abut health and social issues

The Offices of the County Governors and the Norwegian Board of Health Supervision in the counties publish annual reports about services, supervision and complaints in the county. These reports are aimed at health and social services and public administration in the county, and the central authorities. They can be found in full text in Norwegian on our website.

Articles

Articles published in journals and books by employees of the Norwegian Board of Health Supervision are either published on our website, or there is a link to the article.

www.helsetilsynet.no
The web site of the Norwegian Board of Health Supervision is primarily for people who have responsibility for health and social services, and for journalists.
In 2007, there were approximately 1 220 000 visits to our web site.

On the web site, you will find the following:
- *the requirements laid down by the authorities relating to services:*
  acts, regulations, directives, and other documents that present the authorities'interpretation of acts and regulations
- *`the results of the work of the supervision authorities:*
  supervision reports, the report series Report from the Norwegian Board of Health Supervision, other publications, hearing statements, decisions in individual supervision cases, other correspondence and articles
- information about people's rights and possibilities for making complaints about health and social services
- *information about how the supervision authorities work:*
  methodology, sources of information, plans for supervision, tasks, authority and organization.

Norwegian Board of Health Supervision
P.O. Box 8128 Dep
0032 OSLO
Norway

Tel.: (+47) 21 52 99 00
Fax: (+47) 21 52 99 99
E-mail: postmottak@helsetilsynet.no
Web site: www.helsetilsynet.no
Street address: Calmeyers gate 1

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