Annual Supervision Report 2009

HELSETILSYNET
tilsyn med barnevern, sosial- og helsetenestene

Contents

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Internal control is also professional management

Supervision challenges management systems. This is a recurring theme in many of the articles in this report. Both for those of us who have written articles for the report for several years, and for our readers, this is nothing new – unfortunately.

Of course, all services have management systems, of varying degrees of development. This also applies to child welfare services, social services and health services. But findings from supervision make us question whether the management systems these services have are suitable for their purpose.

Section 4 of the Regulations Relating to Internal Control in Health and Social Services outlines the elements that should be present in a management system for provision of welfare services. From our standpoint, the name of the regulations should have been changed to the Regulations Relating to Management Systems in Health and Social Services. This would have been a clear reminder that internal control is about professional management.

Most of the services that we supervise are financed by public funds. This means that the level of funding is both a framework for what can be used, and at the same time an instruction to provide a certain level of services. As such, using economic data alone as the basis for management is a doubtful exercise.

This assertion can also be justified on the grounds that provision of services is very demanding of personnel resources. Organizations have little control over costs for personnel, apart from by adjusting the level of staffing. And here we make an important point. Planning and adjusting the level of staffing must be seen in the light of the tasks to be performed, both the extent and the content. In order to provide adequate services, the expectations for provision of services must be clear, and how these expectations shall be monitored and met must also be clear. This is the core of a professional management system, and this is what internal control is really all about.

Other types of data in addition to economic data are also useful for management of other areas, not just the area of staffing levels, for example, organization of services. One must know what level of quality of the services one aims to achieve, and develop models and indicators for assessing whether the stated goals have been met. There is often uncertainty about what one can expect to achieve from an organization after changes have been made. Risk analyses can be useful. But even when a risk analysis has been carried out, there must be a system for assessing whether an organization has reached its goals or whether it is on the wrong track.

The owners and leadership of the services have the task of presenting their quality goals and demonstrating how they work systematically to meet these goals. This is internal control. This is what we want to see when we carry out supervision. Unfortunately we are not seeing enough.

Lars E. Hanssen

«The owners and leadership of the services have the task of presenting their quality goals and demonstrating how they work systematically to meet these goals.»

Children receive services – but the quality of the services is variable

The findings from countrywide supervision in 2009 with services for children in residential accommodation and respite care accommodation show that the services are inadequate in many municipalities. Parents and guardians must be able to feel confident that their children are adequately cared for. In many municipalities, professional management is weak, and they must work systematically to ensure that children receive adequate services that are adapted to their individual needs.

«In order to have an adequate overview of whether the services function as intended, the municipalities must have arrangements to obtain information about deficiencies, inadequacies and adverse events, and they must follow up with measures to improve the services »

Children in residential accommodation and respite care accommodation often have complex and demanding needs for care. They have serious functional disabilities, often in combination with health problems. Some of the children live in the residences permanently, but most of them have respite care for varying lengths of time. When children are living in these residences, the municipality has responsibility for providing adequate care that is adapted to the individual health needs of the child, but also to provide adequate conditions for growing up, in line with other children.

Supervision was carried out in 75 municipalities and urban districts that provide 24-hour services for children under 18 years of age in accordance with the Social Services Act. Through supervision, breaches of the legislation were identified in three out of four services. The extent and nature of the breaches varied. The areas that are presented below show trends, and do not apply to all municipalities.

Inadequate management to ensure services of high quality

Many of the staff in residential accommodation and respite care accommodation are part-time staff, temporary staff and staff who have no professional qualifications. They cooperate with many other people, such as regular medical practitioners, teachers and support persons, in addition to parents. When many of the staff have no professional qualifications, many work part-time, and there are no guidelines, this demands adequate staff training and sound professional management of the services. The need for professional staff must be assessed on the basis of the children's functional abilities and need for assistance. One out of three services had not ensured that the staff had received adequate training. Lack of training applied to the following areas: medication, daily care of the children, diseases and disabilities, and methods of communication.

One way of compensating for lack of professional staff is to develop written procedures, that is descriptions of how important tasks shall be carried out in different situations. The municipalities must assess the need for written procedures, based on an assessment of areas where there is a danger of deficiencies occurring. In several municipalities such assessments had not been made.

In order to have an adequate overview of whether the services function as intended, the municipalities must have arrangements to obtain information about deficiencies, inadequacies and adverse events, and they must follow up with measures to improve the services (dealing with nonconformities). Many municipalities lacked systems for evaluating and improving the services. If adverse events are not identified and made known, the organization has no basis for correcting deficiencies or for preventing similar incidents from happening again.

Lack of adaptation to ensure a meaningful daily life and adequate care for each child

Many municipalities lacked routines for systematic assessment of the children's needs for care, health care and daily activities, in order to provide services adapted to individual needs. Individual adaptation requires planning, but one service in four lacked plans, or the plans were inadequate. The greatest number of nonconformities were for lack of activity plans. The result can be that activities are only provided according to the skills of

the personnel who happen to be present. Duty rotas and the need for training were often not adequately assessed in relation to the children's needs. This is particularly unfortunate for children who live permanently or for long periods in the residences, and can limit their functional abilities.

Very few cases of inadequate nutrition were detected.

Administration of medication not always adequate

Many of the children have diseases that need to be treated with medication. The municipalities have responsibility for ensuring that the children are given the medication they need at the right time. This is an area where practice needs to be improved. In about half of the municipalities, breaches of the legislation relating to medication were detected. Nonconformities most often included lack of procedures or incorrect procedures, that procedures were not followed, that it was unclear who had responsibility for medication, and lack of professional personnel. This increases the risk for mistakes occurring in administration of medication, and that the children do not receive the medication they need.

Lack of adaptation of the residences for children with disabilities

Residences for residential care and respite care for children must be adapted to meet the special needs of the children who live there. One in ten residences were not adapted adequately. In addition, twenty per cent of the municipalities received notification about inadequate physical conditions. This means that conditions were in accordance with current legislation, but improvements aught be made to meet the children's special needs. A large proportion of children in residential accommodation and respite care accommodation have physical disabilities, which means that they have problems in moving around freely. Many of the findings related to conditions that created limited access for these children, particularly children in wheelchairs. This limits their possibilities to participate in activities with others.

Conclusions and recommendations

The leadership in the municipalities must monitor and follow up the quality of the services provided in each residence for children in residential care and respite care. In particular, the municipalities must:

- identify areas where there is a high risk of deficiencies occurring, in order to be able to prevent adverse events
- ensure that essential routines and procedures are developed to ensure that services for children are sound and adequate
- ensure that there are sufficient staff with adequate qualifications, skills and training to care for the children
- identify deficiencies and carry out work to improve the services.

Experience gained from supervision in other municipalities can be used to assess routines and discuss areas of high risk.

Supervision was carried out for services that are provided according to the Social Services Act. But most children in residential accommodation and respite care accommodation also need health services. This means that municipalities must pay special attention to the need for qualified staff, and ensure that they know which legislation is applicable.

The legislation is not well adapted for running residential accommodation and respite care accommodation. It is incomplete, and it is complex and difficult to interpret. In some areas, for example with adaptation of residences, it is difficult for the municipalities to know what standards the authorities require. The Social Services Act should be clearer regarding how children's health needs should be met. The Norwegian Board of Health Supervision recommends that the legislation should be reassessed in the light of the special situation and needs of these children.

(1)Literature:
Hopefully it will go alright….
Summary of countrywide supervision in 2009 of municipal health and social services for children in residential accommodation and respite care accommodation
Report of the Norwegian Board of Health Supervision 2/2010

Two years of supervision of district psychiatric centres is completed!

In 2008 and 2009, countrywide supervision of district psychiatric centres (DPSs) was carried out. It is the first time that the Norwegian Board of Health Supervision in the Counties has carried out countrywide supervision of the same area for two years. The aims were to focus on an area over a long time, and to encourage the exchange of knowledge and experience within the services. Supervision was carried out by regional supervision teams as system audits. In addition, two experts, a psychologist and a psychiatrist, assisted each team as professional auditors.

The Norwegian Board of Health Supervision in the Counties carried out supervision in 56 DPSs, that is two-thirds of the DPSs in the country. Breaches of the legislation in one or more areas were detected in three-quarters of the DPSs. Many of the same breaches were found both in 2008 and in 2009. Therefore it seems that the health trusts and the regional health authorities have not used the findings of supervision to correct and prevent breaches of the regulations in other DPSs.

«Breaches of statutory requirements relating to assessment and prioritization of patients referred to DPSs were detected both in 2008 and in 2009»

We investigated whether the DPSs ensure that assessment and prioritization of referred patients, and assessment, treatment and follow-up of patients who receive care, is in accordance with sound practice. Supervision was carried out in two or more DPSs in 16 health trusts both in 2008 and 2009. This has shown differences in organization, management and leadership of the DPSs, in access to specialists, and in the quality of the services provided. Such differences in services for adults with mental disorders present challenges in relation to ensuring that the population receives adequate health services, and that access to required health care is equal.

The right to be assessed and the right to receive necessary health care

When a DPS receives a referral, the patient has the right for his or her health status and need for health care to be assessed. All referred patients have this right. Patients with the greatest need for health care shall be given priority and shall receive necessary health care within a reasonable time. The DPS must ensure, using appropriate assessment and prioritization, that seriously ill patients receive treatment without delay, and that patients and their general practitioners are informed about further assessment, treatment and follow-up.

Breaches of statutory requirements relating to assessment and prioritization of patients referred to DPSs were detected both in 2008 and in 2009. We found that not all referrals were assessed by a specialist, and not all patients who needed treatment most urgently were identified and given priority. In some DPSs, deadlines for providing treatment were made, and patients were informed about these deadlines, without taking adequate account of the patients' individual needs, without adequate documentation of individual assessments. Some DPSs had not established routines for ensuring that deadlines for making assessments had been met. A few DPSs also lacked systems for recording the number of patients assessed as having the right to receive necessary health care, the number of patients assessed as having this right, but not given a deadline, and the number of referrals that were rejected. In some DPSs, patients were rejected without adequate reason. Some DPSs only informed the referring general practitioner about their decision regarding the referral, and requested the general practitioner to inform the patient.

In our opinion, it is serious that there are still many deficiencies with regard to dealing with referrals in the DPSs. The result can be that DPSs do not ensure that patients who have the greatest need for care are given priority over patients who can wait a while for treatment. This has consequences not only for individual patients, but also for cooperation between the DPSs and the services that refer patients. This is particularly serious, as deficiencies in meeting people's rights regarding necessary health care and prioritization have been identified previously.

Assessment, treatment and follow up

In order to ensure that patients receive adequate assessment, treatment and follow up, the DPSs need to have developed guidelines for what these procedures involve, how they shall be carried out, and how they shall be documented. The staff must be familiar with the guidelines, and the guidelines must be followed in practice by everyone involved. The leadership must ensure that this actually happens. The DPSs must ensure that staff have adequate knowledge and skills to carry out their work adequately, and that assessments and treatment are checked by a specialist.

We found that guidelines have been developed for various procedures, for example routines for use of diagnostic tools. But the DPSs must ensure that staff are familiar with these guidelines, and that they use them in practice. In several DPSs, deficiencies were detected regarding assessment of patients with psychosis or serious depression. In some cases, documentation of the aims, content and structure of counselling was inadequate. Documentation of assessment and treatment was not always found to be adequate. Documentation is important for ensuring the quality of assessment and treatment. Lack of documentation can create problems if a new therapist takes over the care of a patient. The result can be lack of continuity of care and a change in treatment approach. Lack of documentation also makes it difficult for treatment to be evaluated.

In some DPSs, the quality of treatment is not adequately checked by a specialist or through cooperation with other therapists. Lack of systematic quality control of assessment and treatment can make patients vulnerable.

Organisation, management and leadership

Findings from supervision indicate that there is still a long way to go before DPSs have a systematic approach to quality improvement of the services. The leadership of the DPSs and the health trusts do not monitor and assess services adequately to ensure that they meet acceptable standards. When the supervision authorities went back to the same health trust one year later, no further breaches of the legislation were detected, and in some cases the deficiencies were less serious. The leadership of the health trusts and regional health authorities have responsibility for using the experience gained from supervision. They can use what they have learned from one DPS to improve services in all the other DPSs.

The Norwegian Board of Health Supervision expects the health trusts to manage the services adequately to ensure that statutory requirements are met, and that the DPSs carry out the tasks they are required to carry out. We will take up this issue with the Ministry of Health and Care Services and the Regional Health Authorities.

(2)Literature: District psychiatric services – equal services for everyone? Summary of countrywide supervision in 2008 and 2009 of specialized health services provided in district psychiatric centres
Report of the Norwegian Board of Health Supervision 3/2010

When people who are mentally ill commit murder

In March 2009, three people in Tromsø were murdered by a person who had been followed up by specialist mental health care services and municipal services. For some time, the supervisory authorities have focussed on safety aspects of mental health care, and this incident highlights the relevance of this focus. The Norwegian Board of Health Supervsion decided to collect information from the Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties about cases they were aware of in which murder had been committed by a person who was mentally ill, for the period 1 January 2004 to 3 April 2009.

The aim of the investigation was to see whether there were any common factors or areas of particularly high risk. We received information about 23 cases, that had led to 18 supervision cases. Some of these cases had previously been dealt with by the Norwegian Board of Health Supervision.

Three people had committed suicide after they had committed murder, and one person had made a serious suicide attempt.

«… it appeared that episodes of violence occurred unexpectedly for the personnel.»

Systematic breaches of the requirement to provide sound care

We found four cases, in which the following breaches of the requirement to provide sound care were identified:

- A lack of documents describing procedures to ensure continuity of care for patients, such as compulsory routines for specialized health services to cooperate with regular general practitioners, district psychiatric centres or social security offices when patients are discharged.
- Routines/procedures for making adequate patient assessments, providing adequate treatment, writing patient's records and sending case summaries, were not adequately implemented.
- Clinicians who were not doctors or psychologists had been given too much responsibility to decide the limitations of their own skills.
- Systems for following up suicidal patients were inadequate.
- Technical personnel had not been given training in how to relate to patients in top security departments.

A warning

A senior consultant was given a warning by the Norwegian Board of Health Supervision for breach of the Health Personnel Act, Section 4: the requirement to provide sound care. Inadequacies were found relating to assessment, treatment and medication, and planning of measures related to patient discharge. Patient records were inadequate in relation to assessment and transference from compulsory to voluntary care, and the case summary was sent too late.

Inadequate assessment of the risk of violence

- Violent behaviour or threats were not recorded in the patient records in 13 cases, and it appeared that episodes of violence occurred unexpectedly for the personnel. In four cases in which violent behaviour and threats had been recorded in the patient records, the risk of violence had not been assessed in a structured way, as recommended by the Norwegian Directorate of Health (1).
- None of the patients who were known to have violent behaviour were asked by their therapist whether they had access to a weapon or another type of dangerous implement.

In our countrywide supervision over two years, summarized after one year in the report District psychiatric centres: Countrywide services, but variable quality? (2), it was pointed out that six of the 28 district psychiatric centres that were assessed did not have procedures or routines for when risk of violence should be assessed, who should do the assessment, and how the assessment should be followed up. In some of the centres, it was also pointed out that the departments had not assessed and developed skills in this area, and the personnel were unsure about how they should relate to this issue.

Follow up

In April 2009, the Norwegian Government appointed a committee, led by the County Governor Ann-Kristin Olsen, to examine possible inadequacies in systems and continuity of care for people with mental illness who have committed murder. We have sent our cases and our assessment of them to the committee. The deadline for the committee to present its report is 1 May 2010. After this date, the Norwegian Board of Health Supervision will assess the need for measures to ensure a comprehensive follow up of such cases by the Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties.

References

1. Vurdering av risiko for voldelig atferd (Assessment of the risk of violent behaviour). Norwegian Directorate of Health, IS-9/2007.
2. District psychiatric centres: Countrywide services, but variable quality? Report of the Norwegian Board of Health Supervision 4/ 2009. An English summary of this report is available at: http://www.helsetilsynet.no/

EASY AND EFFECTIVE SUPERVISION

In the summer of 2009, the Norwegian Board of Health Supervision carried out an investigation of staffing levels and the qualifications of staff in ambulance services. The aim was to investigate whether ambulance services were in accordance with the Regulations relating to the requirements for acute medical services outside hospitals.

On 25 June, the health trusts were informed that the Norwegian Board of Health Supervision on one day during the period 6-19 July would carry out an investigation. We asked the health trusts for a contact person who was available by mobile phone and e-mail.

On 14 July, the contact persons were informed by text message that the investigation would take place that day, and that a report form had been sent by e-mail. The health trusts were also informed that we would verify some of the information we received.

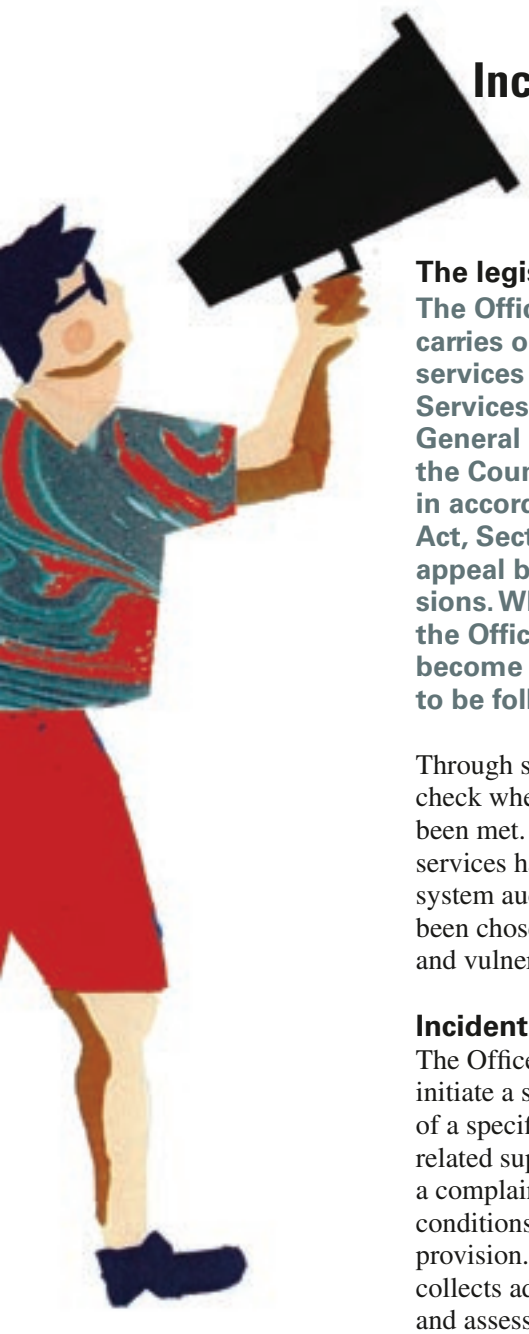
Later that day, we received information on staffing levels and the qualifications of staff for 488 ambulances that were on duty that day. The information was verified for one health trust.

After analysing the data, the results were sent to the health trusts on Friday 16 July for their comments. The deadline for responding was the end of August.

On 23 September, we sent out a report of the investigation. We reported that one ambulance in four did not have adequate staffing according to the regulations.

Based on the findings from the investigation, the health trusts, the regional health authorities and the Ministry of Health and Welfare have introduced measures to ensure that the requirements for staffing levels and the qualifications of staff for ambulances are met. The Norwegian Board of Health Supervision will follow up this matter in 2010.

Incident-related supervision with social services



«The Office of the County Governor can also initiate a supervision case on the background of a specific incident or situation.»

The legislative basis for supervision

The Office of the County Governor carries out supervision of social services in accordance with the Social Services Act, Chapters 4, 4A, 6 and 7. General responsibility of the Office of the County Governor for supervision is in accordance with the Social Services Act, Section 2-7. This body is also the appeal body for administrative decisions. When dealing with complaints, the Office of the County Governor may become aware of conditions that need to be followed up by supervision.

Through supervision, the authorities can check whether legislative requirements have been met. Planned supervision of social services has traditionally been carried out as system audits. Areas for supervision have been chosen based on an assessment of risk and vulnerability.

Incident-related supervision

The Office of the County Governor can also initiate a supervision case on the background of a specific incident or situation. Incident-related supervision is usually initiated after a complaint from a client or a relative about conditions or an incident related to service provision. The Office of the County Governor collects additional information if necessary, and assesses whether there are grounds to believe that a service or a municipality has not met the statutory requirements. In 2009, in cooperation with the Offices of the County Governor, the Norwegian Board of Health Supervision produced guidelines for how the Offices of the County Governor shall deal with such supervision cases.

Examples of events that can lead to supervision cases

- A home help does not provide services for a client, when a decision to provide services has been made.
- As a result of many changes of staff in an institution, a mentally handicapped person has to continually get used to new helpers. This may lead to the use of unnecessary restraint and coercion.

A concrete example

A client was granted a client-managed personal assistant. The client was unable to put the decision into practice, because the municipality required that the assistant had to have specific qualifications. In this case, the Office of the County Governor concluded that the municipality can only make requirements about qualifications that are necessary to ensure that the client receives adequate services.

When dealing with supervision cases, the Office of the County Governor checks that conditions, activities and decisions are in accordance with the legislation. The Office of the County Governor collects information and assesses whether there has been a breach of the regulations for social services. The conclusion is sent to the municipality. The municipality has a duty to correct the deficiencies. Deficiencies in services are often related to weaknesses in the services' management system. The supervision authority must therefore ensure that deficiencies are corrected, and that the service has a management system that ensures that deficiencies are detected in the future.

Organization of the Norwegian Labour and Welfare Organisation (NAV) – a great challenge

As a result of the reform of the Norwegian Labour and Welfare Organisation, tasks related to both municipal and state services are dealt with in the NAV offices. The areas of responsibility of the NAV offices are partly determined by the legislation and partly by contracts between the state and the municipality. Therefore, when the Office of the County Governor carries out supervision in a municipality, special attention must be paid to whether the municipality has organized social services under NAV. Contracts between the municipality and NAV are important documentation of the services that are the responsibility of NAV and the relationship to other municipal and social services.

Child abuse and inadequate care not reported often enough

It is estimated that nine children under three years of age die in Norway every year as a result of child abuse or inadequate care. In the county of Vestfold, a stepfather was prosecuted for having abused his five-year-old son, so that he died. The investigation and the supervision case showed that many services had information that they should have reacted to. Health personnel are often reticent about reporting. The duty of confidentiality is an important principle in health services, strictly controlled by l egislation, and a basic condition for maintaining trust. But sometimes confidentiality can be broken. Health care personnel are often afraid about breaking the duty of confidentiality, even in cases where they have a duty to do so.

The duty to report

Violence and abuse against children are regarded as public matters. For this reason, health care personnel in Norway have a duty to report to the child welfare service when they have reason to believe that a child is the victims of violence, sexual abuse, genital mutilation, or seriously inadequate care. It is not necessary to have definite proof in order to report, but there must be more than just a suspicion. The child welfare service decides whether the suspicion is founded. Even if this is not the case, the person who reported the matter has not been in breach of the duty of confidentiality.

Health care personnel also have a duty to report to the police in cases where it is necessary to avoid children being seriously injured.

In health institutions, a person shall be appointed who has responsibility for reporting to the child welfare service.. However, other people still have a duty to report if the appointed person does not report.

«In our opinion, reporting of violence, mistreatment and inadequate care of children must be improved.»

Where can standards for sound practice be found?

Standards for sound practice can be found in the literature, in guidelines, and from practical experience. Signals that can arouse suspicion of mistreatment and inadequate care are described, and procedures for reporting are outlined. The Norwegian Directorate of Health, the Ministry of Children and Equality and the Norwegian Board of Health Supervision are some of the bodies that have produced guidelines.

The tip of the iceberg

There are few cases which come to the notice of the Norwegian Board of Health Supervision in which health care personnel have neglected to reported to the child welfare service or the police. Therefore, we believe that we only see the tip of the iceberg.

But sometimes we see such cases. In 2009, a hospital was criticized for deficiencies in the internal control / management system. A patient told a member of staff that he had sexually abused a child. Neither the clinician nor the management reported this to the child welfare service. The man reported himself to the police after having been in contact with a psychologist at another treatment centre. The psychologist had informed him that she had a duty to report the matter. During the ensuing court case, it was found that he had continued to sexually abuse the child during the period he had been receiving treatment. The hospital had not appointed a person with responsibility to report to the child welfare service. Extensive use of foreign temporary psychiatrists did not ensure continuity of care, and patient records were inadequate. Four psychiatrists and a nurse were given warnings for breach of the duty to report.

A possible area of risk

In our opinion, reporting of violence, mistreatment and inadequate care of children must be improved. One possibility is to identify neglecting to report as an area of risk, and to instigate measures to improve the situation.

Requests for confidential information

Each year, the Norwegian Board of Health Supervision receives a large number of requests from employers, temporary staff agencies and others about the authorization status of health care personnel and requests for information about any previous supervision cases against the person. In 2008 we received 432 such requests. In most cases we have no information about a case dealt with by the Norwegian Board of Health Supervision relating to the person in question. However, this does not exclude the possibility that the person has been followed up through supervision by the Norwegian Board of Health Supervision in the County.

What information can be provided?

In cases where there has been a supervision case for a health care worker, the question arises: What information can the Norwegian Board of Health Supervision provide to an employer or a temporary staff agency? Basically, the answer to this question is that the Norwegian Board of Health Supervision has a duty, in accordance with the Freedom of Information Act, to allow access to all documents. Information that there has been a previous supervision case, and the result of the case, is always provided.

When documents contain personal information, the duty of confidentiality limits the information that can be provided by the Norwegian Board of Health Supervision. What is to be regarded as personal information must be decided for each individual case. But information about, for example, illness, use of alcohol and drugs, or sexuality is regarded as personal information. Information about gross lack of professional insight, irresponsible conduct and punishable offences that have occurred while on duty, are generally not covered by the duty of confidentiality.

Supervision over 200 years

The first Norwegian supervision authority for health services was established in 1809. At that time there was a transport blockade between Copenhagen and Christiania as a result of the Napoleonic Wars, which made it necessary to establish an authority in Norway. It was called *Det Kongelige norske Sundheds-Collegium i Christiania* (Royal Norwegian Health Board in Christiania). It ceased to exist in 1815, but its functions were transferred to other central administrative bodies..

From 1672 some supervision of the work of doctors and pharmacists had been carried out. The University in Copenhagen received reports about health status and health services, which they followed up. But with the new Health Board, for the first time, we recognise a supervision arrangement similar to that of today.

It is worth noting that the Health Board had a multi-disciplinary orientation, using professional expertise with legislative, medical and pharmaceutical skills. In addition, it had a clear supervision function. According to its remit, the Health Board had a duty to ensure that the requirements for health services laid down in current legislation were met. The Health Board also investigated and assessed specific situations and events. Thus it was not just a body that interpreted the legislation.

The Norwegian Board of Health Supervision has recently published two reports about former health administration. They are to be found on our web site: www.helsetilsynet.no. These reports are:

- Hans Petter Schjønsby: Health Board (Sundhedscollegiet) 1809-1815 (Report of the Norwegian Board of Health Supervision 1/2009)
- Ole Berg: Specialization and professionalization. An account of the development of the Norwegian civil health administration from 1809 to 2009. (Report of the Norwegian Board of Health Supervision 8/2009).

When health care personnel make mistakes

One of the main tasks of the Norwegian Board of Health Supervision is to deal with cases of incorrect treatment of patients. The aim of dealing with such cases is primarily to improve the safety of health services. In this article, we present some cases. But first – we will say something about the statutory requirements for health care personnel.

The requirement for sound professional standards

The Health Personnel Act, Section 4 first paragraph:

Health 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.

Health personnel shall act in accordance with their professional qualifications, and assistance shall be obtained and patients shall be referred on to others if this is necessary and possible. If the patient's needs so indicate, the profession shall be performed through co-operation and inter-action with other qualified personnel.

Upon co-operation with other health personnel, the medical practitioner and the dentist shall make decisions in matters concerning medicine or dentistry respectively in relation to examinations or treatment of the individual patient.

The Ministry may in regulations determine that certain types of health care shall only be provided by personnel with special qualifications.

Health care personnel shall provide care in accordance with sound professional standards. Care that is not in accordance with sound professional standards is not always professionally unacceptable. We must tolerate the fact that health care personnel are sometimes unable to provide the best possible treatment. The requirement for sound professional standards can be regarded as a requirement to provide care that meets a minimum standard, but the ambition must be to provided care above the minimum standard. Care of an unacceptable professional standard is therefore care that is of a standard that is below the minimum level.

In the legislative history of the Health Personnel Act, sound professional standard is referred to as a legislative standard. The level of care that is regarded as a sound professional standard can vary according to time, place and other factors. Therefore when assessing whether a patient has received care that meets sound professional standards, several factors must be taken into account, such as: What were the treatment alternatives? Could the treatment have caused damage? What qualifications and skills did the health care personnel have? Are there clear standard treatments for this condition?

The consequences of care that does not meet sound professional standards

Health care personnel who have provided care that is not in accordance with sound professional standards must be informed about this in such a way that the deficiency does not happen again. In many cases, it will be sufficient to point out the mistakes that have been made, and to provide guidance about how the person could have acted differently. In other cases it is necessary to give a warning, to point out the unsound practice, in accordance with Section 56 of the Health Personnel Act. We give a warning in serious cases, and when the message is that further unsound practice may lead to withdrawal of authorization as a health care personnel. In the most serious cases, authorization will be withdrawn on the grounds of unsound practice and gross lack of professional insight, in accordance with Section 57 of the Health Personnel Act. These are cases in which, in the opinion of the Norwegian Board of Health Supervision, the health care personnel will represent a danger to the safety of patients in the future.

«These are cases in which, in the opinion of the Norwegian Board of Health Supervision, the health care personnel will represent a danger to the safety of patients in the future.»

Transmission of infection from blood

A doctor infected patients with hepatitis B, by not following basic principles of hygiene when giving injections for pain relief. Investigations showed that the doctor, when drawing up Xylocaine into a syringe, used a procedure that involved the risk of transferring blood from the patient to the bottle of Xylocaine, which was used for other patients. The doctor had used this technique for 3-4 years.

We concluded that the method of treatment and the technique that the doctor used were not in accordance with sound practice. This involved a great danger for transmission of infection from one patient to another. The method of treatment used by the doctor was not in line with general principles of hygiene or sterile methods for giving injections.

In our opinion, doctors must have basic knowledge about transmission of infection, both the ways infection can be transmitted and the sources of infection. This also applies to techniques and methods for preventing transmission of infection.

The doctor said that a contributory factor for the transmission of infection was that he no longer had the assistance of a nurse or auxiliary nurse. He apologized for what had happened and admitted that his method of treatment involved a great danger for transmission of infection from blood.

We gave the doctor a warning for treatment that was not in accordance with sound practice. Since he had used this method over a long period of time, and had never considered that it was not in accordance with sound practice, we also assessed whether we should withdraw or limit his authorization. We concluded that this was not necessary, since he had changed his practice, and his unsound practice was limited to one specific area.

Vaccination not in accordance with sound practice

A midwife gave three newborn babies BCG vaccine with the same needle and the same liquid. She was authorized to give vaccinations, but had little experience with children. The incident happened during a hectic duty.

At the end of the duty, she began to doubt whether she had changed the needle between each baby. The next morning, she informed her leader about her doubts. After investigating the matter further, it was found that she had not changed the needle between each baby. The midwife reported the incident as an adverse event.

The midwife admitted her mistake, and apologized for what she had done. She found it difficult to understand and accept that she had made such a mistake.

The hospital had inadequate routines and procedures for vaccination and for training staff who gave vaccinations. There were procedures for double-checking injections for children, but these procedures were not followed.

We concluded that the midwife had acted in a way that was not in accordance with sound practice, and that it is basic knowledge that the same needle shall not be used for several children.

The conditions for giving her a warning were clearly met. However, we did not find it necessary to give her a warning, since she had admitted her mistake shortly after the event, and had reported the event immediately to her leader. Also, it had happened only once. Apart from this, the midwife was assessed as a competent member of staff, trusted by her colleagues and leader. Another factor that was taken into consideration was that the hospital had inadequate routines for vaccinating children and giving children injections. However, this was not decisive for our conclusion, since we expect that knowledge about sterile techniques to prevent transmission of infection should be basic knowledge for all midwives.

Wrong medication

One evening, a nurse gave a patient in a nursing home a tablet that should have been given to another patient. The nurse realized the mistake just after the patient had swallowed the tablet.

The nurse knew that the tablet could have an effect on breathing. Therefore, she observed the patient for the rest of the evening. At the end of the duty, she informed the nurse who was taking over, both verbally and in writing about the wrong medication. She asked her to observe the patient's respiration the whole night. When the nurse came home, she rang to the nursing home twice to hear how it was going. The next day, she went into the department to ask how the patient was. She was told that everything was OK and assumed that the nurse on night duty had informed the nurse on day duty that the patient had been given the wrong tablet. She reported the incident as an adverse event.

The next day, the patient was found lying on the floor. An ambulance was ordered, and the patient received an antidote in the ambulance. She was admitted to hospital, but recovered quickly and was soon sent back to the nursing home. The same morning, the patient became ill again, and was given an antidote intravenously three times over a short period of time, without response. The patient died soon afterwards.

The death was reported to the police, and a forensic post-mortem examination was ordered.

The Norwegian Board of Health Supervision concluded that the nurse had acted in a way that was not in accordance with sound practice when she had not made sure that the patient was given the right medication, and when she had not immediately contacted a doctor after she had realized that she had given the wrong medication. It was pointed out that preparation and administration of medication are basic tasks for nurses, that demand a high degree of care, since mistakes can be fatal. However, we did not find it necessary to give the nurse a warning. The reason for this was that she had documented the incident, she had reported it to her colleagues, she had asked them to carefully observe the patient, and she had checked how the patient was. She admitted that she had made a serious mistake by not contacting a doctor, and she apologized for this. In this way she showed that she had sufficient insight about what she had done, so that there was no reason to believe that she would make the same mistake again. It was also taken into account the fact that the incident was an isolated event.

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Act in accordance with the limitation of one's qualifications

Two emergency medical technicians (ambulance staff) were called out to a young man with severe headache, vomiting and increasing dizziness. They reported that they had carried out a simple neurological examination, in which they had checked that the patient had equal power in his upper arms. The examination showed that the patient's pupils were of equal size and reacted to light. His blood sugar level was 8.1. His blood pressure was 150/75. The emergency medical technicians assessed the patient to have reduced general condition and gastric flu. It was decided, in consultation with the patient's wife, that the patient should contact his medical practitioner during normal working hours (about four hours later). The chief emergency medical technician (the ambulance leader) then decided to leave the patient without calling for a doctor.

The next day the patient was admitted to hospital, and it was found that he had an infarction in the right cerebellum.

The Norwegian Board of Health Supervision concluded that the ambulance leader had acted in a way that was not in accordance with sound practice, and that he had acted in breach of the requirement to provide emergency care, since he had neither taken the patient to a doctor, nor ensured in another way that the patient was assessed by a doctor.

It was pointed out that the case was not completed, so the patient should have been examined by a doctor. The ambulance leader had not followed the procedure of the ambulance service, in which it is stated that a decision to leave a patient shall be taken in consultation with a doctor.

«It was difficult to understand why the pharmacy technician had not reacted to the error message given by the bar code. We pointed out that high doses of Neo-Fer can be poisonous, and can cause serious damage, particularly for young children and especially for newborn babies.»

The Norwegian Board of Health Supervision gave the emergency medical technician a warning. In the assessment, account was taken of the fact that he had acted in breach of the internal guidelines, and that he had not acted in accordance with his professional qualifications.

Due care and attention

A pharmacy technician mixed up the labels when dealing with a prescription for a baby, and overrode the error message that the bar code gave.

The baby was given :

- Multi Vitamin Nycoplus, with a label on which was written:
  1 ml twice daily from age 6 months to 1 year (a label that was for Neo-Fer)
- Neo-Fer, with a label on which was written:
  5 ml twice daily from age 1 year (a label that was for Multi Vitamin Nycoplus).

The Norwegian Board of Health Supervision concluded that the pharmacy technician had not detected the mistake as a result of lack of due care and attention. It was difficult to understand why the pharmacy technician had not reacted to the error message given by the bar code. We pointed out that high doses of Neo-Fer can be poisonous, and can cause serious damage, particularly for young children and especially for newborn babies. For these reasons, we regarded the incident as provision of care that was not in accordance with sound practice.

Since this was an isolated incident, and since the pharmacy technician made it clear that she had learnt from her mistake, we did not find it necessary to give her a warning.

Lack of knowledge and professional updating

A doctor at a nursing home treated two patients with heart failure. The doctor gave the patients digitoxin in doses that were much larger than the recommended dose. The recommended dose in the physicians' desktop reference is 0.8-1.2 mg. Both the patients were given 3 mg. In addition, there was no record that the doctor had considered the possibility of other diseases with similar symptoms. The Norwegian Board of Health Supervision found no medical reasons why the normal dose should be not have been prescribed.
Previous employers reported that the doctor: *"lacked necessary medical knowledge"*, that he had *"a rather deviant view about medication"*, and that they had the impression that he *"was not professionally updated"*.

We pointed out that treatment of patients with heart failure and use of digitoxin are regarded as basic skills for a doctor. Elderly people and people who are seriously ill have an increased risk for side effects, and the doctor should be extra careful when prescribing medication and determining the dose.

We concluded that the doctor had demonstrated a low level of professional knowledge within central areas of medicine, and that he had not understood the importance of keeping up-to-date.

We concluded that the doctor's treatment of the patients was not in accordance with sound professional standards, and that he had shown gross lack of professional insight. There seemed to be little probability that he would correct his behaviour, and there was therefore reason to believe that he would continue to provide care of an unsound standard. His authorization was therefore withdrawn, in accordance with Section 57 of the Health Personnel Act. The doctor appealed to the Norwegian Appeals Board for Health Personnel. This body upheld our decision.

Statutory requirements for professional conduct and informed consent

A doctor treated a patient periodically with antipsychotic medication without the patient's consent. The treatment was provided in consultation with the patient's wife. The doctor wrote out the prescription in the wife's name, and she mixed the medicine in the patient's food or drink when she believed that her husband was becoming manic. The aim of the medication was to prevent aggressive and violent behaviour. The medication was given periodically over several years, approximately one week at a time.

When assessing the case, the Norwegian Board of Health Supervision took into account the fact that informed consent is the statutory basis for providing health care. The requirement for informed consent from the patient is based on the basic right to decide over one's own life and health (patient autonomy). The requirement for consent can only be waived if there is statutory provision for doing so. The duty to provide information shall ensure that the patient can make an informed decision about whether to consent to treatment or not.

We concluded that the treatment was a clear breach of Section 10 of the Health Personnel Act relating to the duty to provide information to patients, Section 3-2 of the Patients' Rights Act relating to patients' right to be informed, and Section 4-1 of the Patients Rights Act relating to consent.

One of the conditions for provision of sound health care is that health personnel act in accordance with statutory requirements regarding professional conduct. We concluded that the doctor had acted in breach of Section 4 of the Health Personnel Act relating to professional conduct. When providing treatment, the doctor had ignored fundamental patient rights, in the knowledge that he was acting in breach of the legislation. Even if his only aim had been to help in a difficult situation, his actions deviated so much from that which is expected, that it was appropriate to give him a warning.

Countrywide supervision in 2010

One of the aims of supervision is to ensure that services meet statutory requirements. The Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties carry out supervision separately and together. Countrywide supervision is carried out according to guidelines, to ensure that the same themes are investigated and the same methods are used, so that the findings are assessed in the same way by the different offices.

From 1 January 2010, the Norwegian Board of Health Supervision is the general supervision authority for two new areas: child welfare services and social services that come under the jurisdiction of the Norwegian Directorate for Labour and Welfare (NAV). Work is underway to improve countrywide supervision of social services in 2010 and of child welfare services in 2011, in addition to the regular supervision activities that the Offices of the County Governors carry out in these areas.

The plan for supervision in 2010 includes supervision of municipal health and social services, and specialized health services.

Social services

The most important requirements in legislation that relates to social services hat come under the jurisdiction of NAV relate to social security benefits, the qualification programme and economic assistance for the qualification programme. In 2010, the Offices of the County Governors shall carry out supervision of these services according to guidelines. They will investigate whether the municipalities ensure that all applications for social security benefits are assessed individually.

Specialized health services

No regular countrywide supervision of specialized health services with a common theme is planned for 2010. The Norwegian Board of Health in the Counties shall make a coordinated regional plan for supervision on the basis of an assessment of the needs for supervision in each region. This supervision will be summarized regionally and nationally.

Municipal health and social services for elderly people

As part of the Norwegian Board of Health Supervision's four-year plan for prioritization of supervision of services for frail elderly people, a series of supervision activities are planned in the municipalities in 2010. These activities include system audits, supervision of regular medical practitioners, self-reported supervision, spot test checks and unannounced supervision. The areas for supervision will be decided on the basis of our knowledge of important and difficult challenges for the municipalities, and from our experience of areas where services for elderly people are often inadequate. We will investigate how elderly people with dementia who live in their own homes are assessed and followed up by municipal nursing and care services and by their general practitioner, how these services cooperate with each other, how they follow up and check medication, and how they check that the nutritional status of these elderly people is adequate. Other areas are rehabilitation services for elderly people, administration of medication in institutions and in the community, and allocation and provision of respite care for frail elderly people. On the basis of local knowledge about areas of risk, and supervision of services for elderly people that has been carried out previously, the areas for supervision will be chosen from the areas mentioned above. Thus, supervision can vary in different counties.

No papers, no legal rights? Health services for people without a residence permit

There are probably between 5 000 and 18 000 people in the country who do not have a residence permit. The largest group are asylum seekers whose application has been rejected. Others have a visa that has expired, or they have come into the country without having been registered. Some of them are victims of human trafficking. Many of the people who do not have papers are women and children. We have little information about the health status of people in this group. Mental health problems are probably common, and some have serious infectious diseases or chronic health problems. The Institute for Applied Social Science (FAFO) has just started a survey of living conditions.

The Norwegian Board of Health Supervision in the Counties receives both questions and more formal complaints related to this group and their rights – or lack of rights – to receive required health care.

A happy family event – a black day for the family's economy

A young couple's application for asylum was rejected, but they could not be sent back to their home country. The pregnant wife received adequate follow up from the local health services. Everything went well when her baby was born at the local hospital. But a few weeks after coming home, they received a bill from the health trust for NOK 42 731. on the advice of the patient ombudsman and the Norwegian Board of Health Supervision in the County, they complained to the hospital. The hospital replied that the bill had been sent in accordance with current regulations, but that it was waived after an overall assessment of the case. The Norwegian Board of Health Supervision in the County requested the Norwegian Directorate of Health to assess this case in principle. The Directorate of Health concluded that it was not incorrect for the Health Trust to send a bill. Later, Professor Kristian Andenæs has commented on the case, and means that the conclusion of the Directorate is based on a misunderstanding (1).

A complex legal landscape

The story described above illustrates the problems, paradoxes and lack of clarification in an area where there is tension between immigrant policy, health legislation, human rights, professional ethics and human ideals

In accordance with the Municipal Health Services Act, Section 2-1, everyone who lives in the municipality, or is temporarily resident there, has the right to required health care. According to the Communicable Diseases Control Act, Section 6-1, everyone has the right to required health care for communicable diseases. For communicable diseases that are hazardous to public health, this includes the right to free prevention, diagnosis and treatment.

In accordance with the Patients' Rights Act, Section 2-1, everyone has the right to emergency care and required health care. But for specialized health services, health care for people without papers is limited by the Regulations Relating to Prioritization, Section 1, which limits their right to required health care to emergency health care.

According to Article 12 of the UN International Convention on Economic, Social and Cultural Rights, everyone has the right to the best standards of physical and mental health. According to Article 24 of the UN Convention on the Rights of the Child, all children under the age of 18 have the right to "the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". This includes appropriate pre-natal and post-natal health care for mothers.

The present status

Everyone who is resident in Norway shall receive emergency health care. With regard to municipal health services, required health care shall also be provided, not just acute health care.

A main problem is that the right to health care does not give the right to free health care. In one situation, health care shall be free: in the case of measures to control communicable diseases that are hazardous to public health. But apart from this, doctors, out-patient clinics and hospitals can demand full payment for health care. This means that many people do not seek help. In practice, a lot of treatment is provided free, but this is based on philanthropy.

«In relation to western Europe, Norway is late in providing health services for people without papers.»

It is true to say that the Ministry of Children and Equality has stated that children without a residence permit have the same rights as all other children for required health care (2,3). But this is not generally accepted by the health management authorities.
In the autumn of 2009, the Church City Mission, in cooperation with the Red Cross, established a free health service for asylum seekers in Oslo, using voluntary workers.
It is not illegal for health care personnel to provide health services for people without papers. The duty of confidentiality also applies for the police, unless otherwise stated in the law. However, many people are afraid to seek health care, because they are afraid that they will be caught by the police.

In relation to western Europe, Norway is late in providing health services for people without papers. In Sweden, health services for people without papers, run by humanitarian organizations, have been available for many years. In France, health services are provided for this group by the “Aide Médicale de l’Etat”. In the Netherlands, general practitioners, midwives and pharmacists are remunerated from public funds for providing this type of health care (4).

Facts and figures

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 2007–2009 and the result of cases in 2009 according to type of case

	2007	2008	2009						
				Social services			Social security benefits		
Office of the County Governor	Cases dealt with	Cases dealt with	Cases dealt with	Cases dealt with	Reversed	Revaked	Cases dealt with	Reversed	Revaked
Østfold	416	299	248	69	35	10	179	27	29
Oslo og Akershus	1286	857	902	195	81	8	637	110	9
Hedmark	194	221	157	36	11	0	115	19	4
Oppland	169	152	172	28	3	5	138	8	16
Buskerud	366	311	255	62	22	9	190	14	15
Vestfold	258	249	263	43	6	11	211	13	23
Telemark	148	118	154	55	16	4	98	6	12
Aust-Agder	55	50	92	20	2	6	69	5	12
Vest-Agder	161	144	174	44	10	12	122	3	16
Rogaland	319	202	217	48	6	1	161	12	3
Hordaland	531	356	384	130	6	24	234	17	33
Sogn og Fjordane	85	102	63	28	8	7	35	7	1
Møre og Romsdal	174	160	118	53	6	18	61	3	9
Sør-Trøndelag	211	172	267	63	13	19	187	9	10
Nord-Trøndelag	97	89	89	23	1	1	59	2	6
Nordland	212	139	186	71	19	11	102	9	6
Troms	238	173	143	57	13	7	80	8	4
Finnmark	60	71	64	16	1	4	48	0	10
TOTAL	4980	3865	3948	1041	259	157	2726	272	218

Table 1 presents figures for cases in which individuals have complained about a decision that the municipality has taken pursuant to the Social Services Act, and the municipality has not upheld the complaint, but has forwarded the complaint to the Office of the County Governor as the appeals body. More than two-thirds of the complaints are about social security benefits. Examples of such complaints are rejection of an application, 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. 2 726 cases of complaint about social security benefits were dealt with in 2009 (2 809 in 2008).

In 2009, 1 041 complaints about social services were dealt with (882 in 2008). Economic assistance for carers was the service that was complained about most, with 337 cases. Practical assistance came next, with 318 cases, of which 134 were about client-managed personal assistance. There were 174 complaints about respite care and 159 complaints about support contacts.

There has been a slight increase in the number of complaints received in 2009, but there are still few – 4 158 cases in 2009 (3 995 in 2008). The Offices of the County Governors dealt with 8 935 complaints in 1995, but only 3 948 in 2009.

In 2008, the Norwegian Board of Health Supervision introduced guidelines for how complaints abut social services should be dealt with. Among other things, in the

Table 2 Complaints about social services dealt with by the Offices of the County Governors Complains according to the different types of services, 2009

Office of the County Governor	§ 4-2 a	of these: CPA	§ 4-2 b	§ 4-2 c	§ 4-2 d	§ 4-2 e	Other	Totalt
Østfold	22	9	6	12	0	27	2	69
Oslo og Akershus	50	17	49	21	5	70	0	195
Hedmark	14	12	1	3	4	13	1	36
Oppland	10	7	3	6	0	8	1	28
Buskerud	18	14	8	5	2	29	0	62
Vestfold	12	7	4	13	0	12	2	43
Telemark	23	4	4	1	3	19	5	55
Aust-Agder	5	3	6	1	2	6	0	20
Vest-Agder	15	2	13	5	0	9	2	44
Rogaland	8	0	16	2	4	14	4	48
Hordaland	31	15	19	30	4	45	1	130
Sogn og Fjordane	12	4	2	9	0	4	1	28
Møre og Romsdal	17	8	6	11	0	17	2	53
Sør-Trøndelag	30	14	9	6	1	17	0	63
Nord-Trøndelag	7	4	1	6	1	7	1	23
Nordland	15	4	13	21	1	21	0	71
Troms	24	8	12	6	2	12	1	57
Finnmark	5	2	2	1	0	7	1	16
Total	318	134	174	159	29	337	24	1041

* 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 cares

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 – 2007, 2008 and 2009

Provision	Provision regarding	2007[2]	2008[2]	2009	
		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	54	65	82	30
Section 2-1 second paragraph	The right to required health care from specialized health services	212	194	167	41
Section 2-2	The right to an assessment within 30 workdays	14	10	11	8
Section 2-3	The right to a reassessment	7	6	8	3
Section 2-4	The right to choose hospital	18	14	9	4
Section 2-5	The right to an individual plan	6	13	8	7
Section 2-6	The right to transport to health services	390	302	241	55
Chapter 3	The right to participation and information	32	50	48	17
Chapter 4	Consent to health care / the right to refuse health care	5	7	1	0
Section 5-1	The right of access to medical records	38	28	30	19
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	25	33	21	13
Municipal Health Services Act					
Section 2-1	The right to required health care	151	142	146	54
Dental Health Services Act					
Section 2-1	The right to required dental care	0	0	3	0
Other sections that give the right to health services		0	1	7	4
Total number of assessments of specific provisions[1]		952	865	782	255
Number of cases[1]		888	770	693	

[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.
[3] Cases of complaint in accordance with the new Chapter 4a in the Patients' Rights Act, which came into force on 1 January 2009, are not included in the table, but are referred to in a separate paragraph below.

guidelines it was stressed that the Offices of the County Governors should try to make a decision, rather than revoking a decision and sending the case back to the municipality to be dealt with again. Therefore, in Table 1, separate figures are presented for decisions that are reversed and revoked, for decisions which are partly or wholly in favour of the complainant.

The Offices of the County Governors are required to deal with at least 90 per cent of complaints within three months. In 2009, 80 per cent of cases were dealt with within the deadline (87 per cent 2008, 76 per cent in 2007). In 2009, ten of the 18 Offices of the County Governors dealt with over 90 per cent of complaints within three months. At the beginning of 2009, there were 579 cases that had not been dealt with, by the end of 2009 there were 766 cases.

Cases dealt with by the Norwegian Board of Health Supervision

In 2009, the Norwegian Board of Health Supervision received four requests to re-examine decisions made by the Offices of the County Governor regarding complaints. None of the decisions were reversed in favour of the complainant.

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

Cases dealt with by the Board of Health Supervi sion in the Counties

The Norwegian Board of Health Supervision in the County is the appeals body when a person has not received his or her 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.

Up until 2006, the number of complaints regarding failure to meet people's rights to receive health services increased. After 2006, and particularly over the last two years, the number of complaints has reduced. In 2007, 921 new complaints were received (751 in 2009). This represents a decrease of 18 per cent over the last two years.

In 2009, the Norwegian Board of Health Supervision in the Counties completed 765 cases of complaint, of which 693 were dealt with. In 254 of these 693 cases (37 per cent) the complaint was partially or wholly supported, or the decision was revoked because of errors in the way the case had been dealt with, or for similar reasons. This is at about the same level as in 2007 and 2008, when complaints were successful in one way or another in 30 and 36 per cent of cases respectively.

In 2009, 35 per cent of complaints about health services were related to the right to reimbursement of travel expenses for journeys between the patient's home and the place where treatment was provided (Section 2 6, Patients' Rights Act). These complaints are often about relatively small amounts of a few hundred kroner. The number of such

Table 4 Use of coercion and restraint for people with mental disabilities Social Services Act Chapter 4A. Number of decisions etc. 2009

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			Number of dispensations from the requirement regarding the qualifications of staff – Section 4A-9	Number of 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 per 31 December 2009		
Østfold	760	81	20	3	19	18	17
Oslo og Akershus	4 167	294	128	4	123	110	33
Hedmark	233	45	49	0	49	46	4
Oppland	170	29	48	3	48	46	21
Buskerud	4 357	61	39	2	39	234	17
Vestfold	648	35	25	0	25	20	7
Telemark	169	31	17	0	16	13	3
Aust-Agder	253	27	12	0	12	0	6
Vest-Agder	349	52	82	0	53	13	7
Rogaland	2 603	46	69	1	68	60	20
Hordaland	579	145	130	0	110	105	41
Sogn og Fjordane	256	28	26	0	26	20	3
Møre og Romsdal	709	54	56	0	54	53	2
Sør-Trøndelag	811	64	32	1	32	8	9
Nord-Trøndelag	233	25	65	0	28	40	14
Nordland	318	32	46	0	46	37	24
Troms	709	32	38	0	37	14	9
Finnmark	2 989	8	4	2	3	35	9
SUM	20 313	1 089	886	16	788	872	246

complaints has reduced markedly over the last two years, from 390 in 2007 to 241 in 2009. This indicates that the dialogue between the Norwegian Board of Health in the Counties and the health services about these cases has been successful. Better information about who the regulations apply to, and correct decisions with reasons that are easy to understand, leads to fewer complaints.

Cases dealt with by the Norwegian Board of Health Supervision (the central office)
In 2009, the Norwegian Board of Health Supervision dealt with seven requests to re-examine decisions made by the Offices of the County Governor regarding complaints. In 2 cases the decision was partly in favour of the complainant.

The Norwegian Board of Health Supervision dealt with one case in which the Norwegian Board of Health Supervision in the County had rejected the case. The decision was in favour of the complainant.

The Norwegian Board of Health Supervision dealt with one case in which the Norwegian Board of Health Supervision in the County had refused to cover legal fees. The decision in this case was also in favour of the complainant.

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 tasks and reporting during the period 2000-2007 of the Offices of the County Governors are described in the Report of the Norwegian Board of Health Supervision 7/2008.

The municipalities report decisions taken about measures taken to avoid injury in emergency situations (individual situations) to the Offices of the County Governors, pursuant to Section 4A-5 third paragraph, a of the Social Services Act. In 2009, 20 313 decisions were taken (33 805 in 2008), relating to 1 089 persons (1 152 in 2008). The reduction in the number of people may be the result of changes in registration.

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 2009, the Offices of the County Governors authorized 886 decisions. From 2009, the number of decisions and the number of measures are registered separately. One decision can include several measures. This can explain the reduction in the number of decisions from 2008 to 2009. The number of persons with a decision per 31 December 2009 was 788. The total number of measures was 1 293.

Table 5 Use of coercion and restraint for people who do not have the ability to give consent and who refuse health care. 2009

	Number of decision[1]	Number of decisions revoked	Number of decisions reversed	Number of decisions lasting more than 3 months
SUM	1687	125	2	1050

[1] The table includes the number of copies of decisions received by the Norwegian Board of Health Supervision in the Counties

These measures related to:
- measures to avoid injury in repeated emergency situations – 461 decisions
- measures to meet clients' basic needs – 427 decisions
- use of mechanical restraint – 130 decisions (52 pursuant to letter b, 78 letter c)
- use of radical warning systems – 262 decisions (30 pursuant to letter b, 232 letter c)
- education and training – 13 decisions.

The Offices of the County Governors gave dispensation from the requirement regarding the qualifications of staff in 872 cases, which, in Section 4A-9 of the Social Services Act, applies to personnel who shall implement measures according to Section 4A-5, third paragraph b and c. The number of dispensations relates to decisions in cases of application for dispensation.

The Offices of the County Governors made 3 decisions about complaints regarding measures pursuant to Section 4A-5, third paragraph a. One complaint regarding measures pursuant to Section 4A-5, third paragraph b and c was dealt with by the County Committee for Child Welfare and Social Affairs.

On 246 occasions, the Offices of the County Governors carried out local supervision of measures. 207 of these were supervision of use of coercion and restraint, for which the Office of the County Governor has a duty to carry out supervision (pursuant to Section 2-6, first paragraph, second point). Local supervision was also carried out 39 times pursuant to other provisions.

Use of coercion and restraint for people with mental disabilities

From 1 January 2009, the new Chapter 4A in the Patients' Rights Act came into force. This relates to health care for people who do not have the ability to give consent and who refuse health care. The aim is to provide necessary health care to prevent serious damage to health and to prevent and limit the use of coercion and restraint. There are separate regulations for use of coercion and restraint in mental health care, pursuant to the Mental Health Care Act. The health services shall make decisions about use of coercion and

Table 6 Supervision of Social services – Number of system audits carried out by the Norwegian Board of Health Supervision in the Counties. 2007, 2008 and 2009

Office of the County Governor	2007	2008	2009
Østfold	9	9	9
Oslo og Akershus	17	22	22
Hedmark	10	9	9
Oppland	8	6	9
Buskerud	10	11	11
Vestfold	9	9	6
Telemark	8	7	7
Aust-Agder	7	9	7
Vest-Agder	7	9	7
Rogaland	10	12	11
Hordaland	16	14	15
Sogn og Fjordane	8	8	7
Møre og Romsdal	13	12	5
Sør-Trøndelag	13	10	9
Nord-Trøndelag	8	6	7
Nordland	10	11	9
Troms	10	8	8
Finnmark	8	7	6
TOTAL	181	179	164

restraint, and they shall send a copy of the decision to the Norwegian Board of Health Supervision in the County. In 2009, the Norwegian Board of Health Supervision in the Counties received 1 687 copies of decisions, and of these, less than 10 per cent were reversed or revoked. The Norwegian Board of Health Supervision in the Counties examine all decisions, and have authority to re-examine (reverse or revoke) decisions. If there is no complaint about a decision regarding health care, and if the health care continues, 3 months after the decision has been made the Norwegian Board of Health Supervision in the County shall assess whether health care is still required.

Experience from the first year shows that about 70 per cent of the decisions require a response from the Norwegian Board of Health in the County to the municipality/health service, in the form of advice and guidance. Advice and guidance are related to the formalities of the decisions.

The Norwegian Board of Health Supervision in the Counties received 7 complaints about decisions relating to health services. The decision was upheld in six of these cases. In one case the decision was revoked by the health service.

Supervision of Social Services

In 2009, the Offices of the County Governors carried out 164 system audits (see Table 6). 163 of these system audits were supervision of municipalities. One system audit was carried out in another organization. In 134 of the system audits, breaches of laws or regulations were detected. In 104 of the system audits, requirements pursuant to both health and social legislation were investigated. These system audits were carried out jointly by the Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties. 75 of these system audits were carried out as part of countrywide supervision of municipal health and social services for children in residential accommodation and respite care accommodation.

The 89 system audits that were carried out in addition to countrywide supervision included:

- legal safeguards for people with mental disabilities: 18 system audits
- social services for alcohol and drug addicts: 14 system audits
- municipal health services, social services and child welfare services for children: 11 system audits
- temporary accommodation: 10 system audits
- administrative procedures regarding health and social services for people living in their own homes: 9 system audits
- administrative procedures regarding social services: 5 system audits
- support person services and respite care services: 4 system audits
- follow-up of people leaving an institution or coming out of prison: 3 system audits
- health and social emergency planning: 3 system audits.

Other supervision related to: economic counselling, social services administered by the Norwegian Labour and Welfare Organisation, social services and the qualifications of the personnel, services for people with mental disabilities living in shared accommodation, services for elderly people,

Table 7 Supervision of health services Number of system audits carried out by the Norwegian Board of Health Supervision in the Counties. 2007, 2008 and 2009

Norwegian Board of Health Supervision in the County	2007	2008	2009
Østfold	12	15	15
Oslo og Akershus	13	32	33
Hedmark	12	12	12
Oppland	10	16	15
Buskerud	14	13	17
Vestfold	14	20	13
Telemark	13	14	13
Aust-Agder	13	13	13
Vest-Agder	12	14	12
Rogaland	11	20	18
Hordaland	26	26	21
Sogn og Fjordane	11	12	12
Møre og Romsdal	16	17	17
Sør-Trøndelag	16	15	14
Nord-Trøndelag	10	10	13
Nordland	19	16	17
Troms	14	16	13
Finnmark	11	12	11
TOTAL	247	293	279

and services in treatment centres for alcohol and drug addicts.

Per 31 December 2009, there were still open nonconformities (breaches of laws or regulations that had not been corrected) from 44 system audits of social services carried out in 2008 or earlier.

The Norwegian Board of Health Supervision required the Offices of the County Governors to carry out 180 system audits in 2009.

In 2009, the Offices of the County Governors did not issue instructions pursuant to the Social Services Act.

In addition to the 164 system audits, the Offices of the County Governors have also carried out local supervision of the use of restraint and coercion for people with mental disabilities 246 times (see Table 4).

Table 8 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. 2007, 2008 and 2009

Norwegian Board of Health Supervision in the County	Number of completed cases			Percentage of cases that took more than 5 months in 2009
	2007[2]	2008[2]	2009	
Østfold	120	222	177	55 %
Oslo og Akershus	314	392	331	35 %
Hedmark	114	114	122	67 %
Oppland	74	51	50	74 %
Buskerud	94	116	109	61 %
Vestfold	120	62	96	28 %
Telemark	77	62	75	40 %
Aust-Agder	29	42	37	46 %
Vest-Agder	56	64	69	43 %
Rogaland	139	105	101	46 %
Hordaland	153	205	188	37 %
Sogn og Fjordane	42	54	63	11 %
Møre og Romsdal	71	92	130	58 %
Sør-Trøndelag	93	120	111	33 %
Nord-Trøndelag	41	77	72	75 %
Nordland	94	110	82	40 %
Troms	75	92	83	35 %
Finnmark	21	27	62	34 %
Total	1727	2007	1958	45 %
In addition: cases completed without being assessed, by requesting the person who was complained against to contact the complainant in order to find an amicable solution	291	287	285	

[1] The figures are slightly different from previously published figures, because the figures are corrected when inaccuracies are detected.

Supervision of health services

In 2009, the Norwegian Board of Health Supervision in the Counties carried out 279 system audits.

These system audits included:
- municipal services: 189 system audits
- specialized health services: 87 system audits
- private health care personnel: 3 system audits.

In addition, the Norwegian Board of Health Supervision in Rogaland carried out two system audits of health-related conditions in the petroleum industry.

104 of the 189 system audits carried out in the municipalities, investigated requirements pursuant to both health and social legislation. These were carried out jointly by the Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties. 75 of these system audits were part of countrywide supervision of municipal health and social services for children in residential accommodation and respite care accommodation.

In addition, the Norwegian Board of Health Supervision in the Counties carried out countrywide supervision of specialized health services provided at district psychiatric centres (DPS) for adults with mental health disorders. 28 of the 87 system audits of specialized health services were part of this countrywide supervision.

In 215 of the 279 system audits breaches of laws or regulations were detected.

176 system audits were carried out that were not part of countrywide supervision. 114 of these were system audits of municipal services, 59 were system audits of specialized health services, and 3 were system audits of private health care personnel.

The 114 system audits of municipal services that were not part of countrywide supervision included:
- administration of medication in nursing homes: 40 system audits
- other supervision in nursing homes: 22 system audits
- municipal health services, social services and child welfare services for children: 11 system audits
- administrative procedures for health and social services for clients living in their own homes: 9 system audits
- home nursing services: 4 system audits
- emergency services: 3 system audits
- follow-up of people leaving an institution or coming out of prison: 3 system audits
- health and social emergency planning: 3 system audits.
- control of infection: 3 system audits
- environmental health: 3 system audits
- duty to report to child welfare services: 2 system audits
- physiotherapy services: 2 system audits
- rehabilitation: 2 system audits.

Table 9 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. 2007, 2008 and 2009

Legislativ basis	2007[1]	2008[1]	2009
Provisions in the Health Personnel Act			
Section 4. Sound professional standards behaviour	183	247	202
Section 4. Sound professional standards examination, diagnosis and treatment	1543	1519	1712
Section 4. Sound professional standards medication	204	214	229
Section 4. Sound professional standards other	252	277	290
Section 7. Emergency treatment	41	34	39
Section 10. Information	84	83	102
Section 16. Organization of the services	133	199	192
Chapters 5 and 6. Duty of confidentiality, right of disclosure, duty of disclosure	102	117	117
Sections 39–41. Patient records	231	255	233
Section 57. Fitness to practice: alcohol and drug abuse	27	50	44
Section 57. Fitness to practice: other reasons	56	56	64
Provisions in the Specialized Health Services Act			
Section 2–2. Duty of sound professional standards	479	573	576
Other legislative basis for assessment	478	625	579
Total number of provisions as legislative basis[2]	3813	4249	4379
Number of cases assessed[2]	1727	2007	1958

1. The figures are slightly different from previously published figures, because the figures are corrected when inaccuracies are detected.
2. 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.

There were also a few other areas that were the theme for supervision.

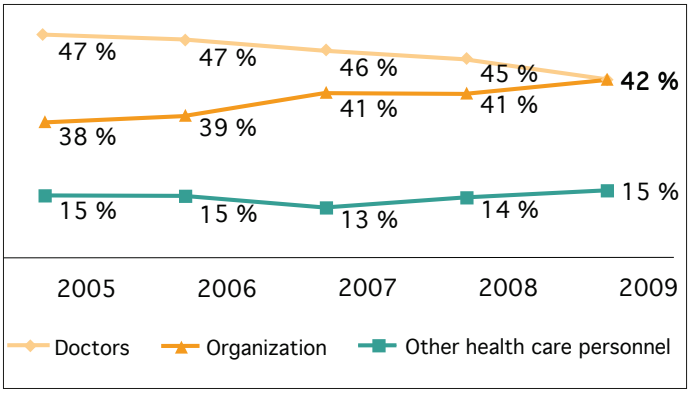
The 59 system audits of specialized health services that were not part of countrywide supervision included:

- emergency services: 14 system audits
- duty to report adverse events to the Norwegian Board of Health in the Counties: 8 system audits
- duty to report about health requirements for having a driving licence: 5 system audits
- services in gynaecology and maternity departments: 4 system audits
- services in intensive care units: 4 system audits
- rehabilitation: 4 system audits
- interdisciplinary services for alcohol and drug addicts: 4 system audits
- duty to report to child welfare services: 3 system audits

The other 13 system audits related to other specialized health services.

Per 31 December 2009, there were still open nonconformities (breaches of laws or regulations that had not been corrected) from 79 system audits of health services carried out in 2008 or earlier.

Figure 2. The object of supervision cases



The Norwegian Board of Health Supervision required the Norwegian Board of Health Supervision in the Counties to carry out 300 system audits in 2009.

Issuing instructions, closing services and coercive fines
In 2009, the Norwegian Board of Health Supervision has not issued instructions to municipalities because of open nonconformities.

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 2009, the number of new cases per 100 000 inhabitants ranged from 33 in Rogaland and 36 in Oslo og Akershus, to 113 in Finnmark. For the whole country, there were 2 437 new supervision cases in 2009: 51 cases per 100 000 inhabitants, 217 cases more than in 2008, an increase of 10 per cent.

The number of supervision cases being dealt with by the Norwegian Board of Health Supervision in the Counties (the backlog) increased from 916 at the end of 2008 to 968 at the end of 2009. This represents an increase of 6 per cent.

The requirement concerning the length of time taken to deal with a case is stipulated in the government budget. More than half of the cases shall be dealt with within five months. This requirement was met in 12 of the county offices in 2009 and 11 in 2008 (Oslo and Akershus count as one office). The requirement was met for the whole country, since 56 per cent of all cases were dealt with in less than five months. This is an improvement from the previous years, when the requirement was only just met. This improvement must also be seen in the light of the fact that the requirement applies for a maximum of 2 000 new cases. In 2009,

Table 10 Number of supervision cases completed by the Norwegian Board of Health Supervision and number of administrative reactions. 2002-2009

	Administrative reaction	No administrative reaction	Completed cases
2002	103	71	173
2003	125	55	172
2004	148	101	237
2005	168	87	242
2006	184	76	252
2007	181	95	271
2008	155	65	224
2009	235	87	301

there were 2 437 – 437 more cases than this maximum – and 10 per cent more cases than in 2008 (2166 cases).

The Norwegian Board of Health Supervision in Oslo and Akershus has contributed most to this improvement in time taken to deal with cases. This is by far the largest county office, and for several years they have had problems with meeting the requirement for length of time taken to deal with a case. In 2009, they met the requirement for 65 per cent 331 cases, and in 2008 for 32 per cent of 392 cases.

Supervision cases are often complex. Table 9 shows that on average each case may have two or three 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 are often serious. In 2009, 86 per cent of these cases were forwarded from the Norwegian Board of Health Supervision in the Counties to the Norwegian Board of Health Supervision to assess whether an administrative reaction should be given. The corresponding figure for all cases was 13 per cent.

When patients complain about the quality of health services, it is often doctors who are complained about. This is understandable, since doctors are the health care personnel who most often take decisions about patient treatment. But health services are not just provided by doctors and other health care personnel individually. The requirement regarding internal control stipulates that management has responsibility for organizing and running services in such a way as to take account of the fact that individuals at any time can make mistakes. Health services shall be organized as robust systems in which mistakes are identified, so that deficiencies at one level are detected and dealt with before they lead to consequences for patients.

Therefore, for several years, the supervision authorities have tried to focus attention on the responsibility that organizations have, and to avoid focussing all attention on the individual who was closest in an adverse situation. Figure 1 shows that the proportion of supervision cases in which the object of supervision was an organization, has increased from 38 per cent in 2005 to 42 per cent in 2009. The

Table 11 Administrative reactions given to health care personnel by the Norwegian Board of Health Supervision according to health care personnel category 2009 (2008 in brackets)

	Warning	Loss of authorization or licence	Loss of the right to prescribe medication in groups A and B	Limited authorization or licence (Section 59)	Limited authorization or licence (new Section 59a)	Loss of authorization as a specialist	Total
Doctor	64 (47)	28 (20)	3 (8)	0 (1)	5 (0)	2 (1)	102 (77)
Dentist	1 (4)	4 (0)					5 (4)
Psychologist	2 (1)	1 (1)					3 (2)
Nurse	6 (7)	44 (21)		1 (0)	1 0)		52 (28)
Auxiliary nurse	1 (1)	19 (10)			2 (0)		22 (11)
Social educator	1 (0)	4 (1)					5 (1)
Midwife	3 (0)	1 (1)					4 (1)
Physiotherapist	1 (1)	0 (1)					1 (2)
Other groups	6 (3)	7 (8)					13 (11)
Unauthorized	4 (6)	0					4 (6)
Total	89 (70)	108 (63)	3 (8)	1 (1)	8 (1)	2 (1)	211 (143)

Table 12 Reason for withdrawal of authorization, according to health care personnel group 2009 (2008 in brackets)

	Nurse	Auxiliary nurse	Doctor	Other	Total
Misuse of alcohol and drugs	38 (15)	11 (7)	10 (10)	7 (5)	66 (37)
Illness			2 (1)	1 (0)	3 (1)
Sexual misconduct with a patient	1 (1)	3 (0)	4 (1)	3 (2)	11 (4)
Behaviour	3 (2)	3 (3)	3 (0)	5 (3)	14 (8)
Unsound professional practice	0 (1)	1 (0)	3 (2)	1 (0)	5 (3)
Failure to comply after a warning		1 (0)	4 (3)		5 (3)
Authorization lost in another countryt	2 (2)		2 (2)	0 (2)	4 (6)
Other			0 (1)		0 (1)
Total	44 (21)	19 (10)	28 (20)	17 (12)	108 (63)

corresponding figures for doctors are 47 per cent in 2005 and 42 per cent in 2009. The proportion of supervision cases for other health care personnel has remained stable at 13-15 per cent during the period 2005 to 2009.

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. 301 cases were dealt with in 2009 (224 in 2008). 235 administrative reactions were given, 24 to institutions and 211 to health care personnel (155 administrative reactions were given in 2008). In 2009, no administrative reaction was given for 87 cases (65 in 2008).

99 health care personnel lost 108 authorizations/licences in 2009 (63 authorizations in 2008). Most cases of withdrawal of authorization were related to misuse of alcohol and drugs, and these cases account for three-quarters of the increase from 2008 to 2009. Most of these cases are initiated by a report from an employer to the supervision authorities.

In November 2008, Section 59a of the Health Personnel Act came into force. This relates to a new type of administrative reaction for health care personnel, which gives the Norwegian Board of Health Supervision authority to limit authorization when the conditions for withdrawing authorization have not been met. In 2009, authorization was limited for eight health care personnel, in accordance with Section 59a of the Health Personnel Act.

21 health care personnel had their authorization/licence suspended while their cases were being dealt with. Suspension of authorization was extended for 3 health care personnel.

In 2009, the Norwegian Board of Health Supervision received notification from 13 health care personnel that they voluntarily renounced their authorization. Four doctors voluntarily renounced their right to prescribe addictive medication.

In 2009, the Norwegian Board of Health Supervision sent 62 cases of complaint to the Norwegian Appeals Board for Health Personnel (33 in 2008). 49 of these cases related to decisions about administrative reactions (of which three involved suspension of authorization), while 10 cases related to loss of authorization because of breach of the conditions for limited authorization. In 2009, the Appeals Board upheld the decision of the Norwegian Board of Health Supervision in 44 of these cases. Two decisions were reversed, one decision was partially reversed and two decisions were revoked. One complainant withdrew his complaint before it had been dealt with by the Appeals Board.

The Norwegian Board of Health Supervision cooperates with the police in a number of cases. We also have authority to apply for prosecution, and this was done in 3 cases in 2009 (7 cases in 2008). We concluded that there were no grounds for applying for prosecution against health care personnel or organizations in 9 cases. In 2009 we reported two health care personnel to the police on the basis of suspicion of a punishable offence (6 in 2008). On request from the police, we gave statements to the police in two cases.

In 2009, the Norwegian Board of Health Supervision received 69 applications for new authorization or limited authorization from health care personnel who had previously lost their authorization (57 applications in 2008). 53 of these cases were completed. 7 health care personnel were granted new authorization without limitations. 12 applicants were granted limited authorization to practice under specified conditions. 32 applications were rejected. 2 applications were rejected and not dealt with because of lack of documentation.

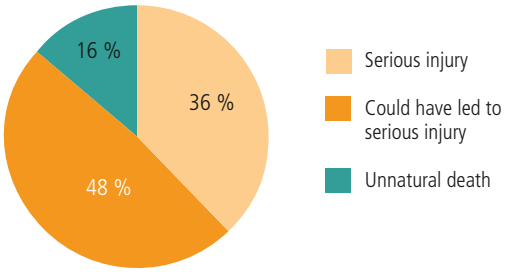
The Norwegian Board of Health Supervision received three applications for the right to prescribe addictive medication from health care personnel who had previously lost this right. We dealt with two applications for the right to prescribe addictive medication in 2009. One of these applications was granted and one was rejected.

In 2009, the Norwegian Board of Health Supervision dealt with 32 cases against institutions (15 cases in 2008). In 24 of these cases, breaches of health legislation were detected, related to inadequate internal organization and management. In 8 cases we found no breaches of health legislation. In most cases, the Norwegian Board of Health Supervision in the Counties complete cases about inadequate organization or management of health services, so the number of cases dealt with by us is relatively small in relation to the total number of completed cases.

In 2009, the Norwegian Board of Health Supervision received 303 new cases (292 in 2008. The median time taken to deal with a case was 5.9 months in 2009 (5.2 months in 2008). Per 31 December 2009, 176 cases were being dealt with (175 per 31. December 2008).

In 2009, the Norwegian Board of Health Supervision requested 21 professional statements from medical experts in 19 cases. In addition, two health care personnel were instructed to have a medical or psychological examination, in accordance with Section 60 of the Health Personnel Act

Figure 2. Reports of adverse events registered in 2008, according to degree of injury



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 Section 3-3 of the Specialized Health Services Act. 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.

1 289 reports of adverse events were registered in the database in 2008 (2 039 in 2007). One-third of the reports (36 %) were reports of serious injury, and one half (48 %) were reports of incidents that could have led to serious injury. 206 reports of unnatural death were registered in 2008 (16 per cent of all reports).

18 per cent of these reports were associated with the use of medication.

8 per cent of reports registered in 2008 were reports of events associated with birth. In 67 per cent of these, the event was associated with the mother, and in 33 per cent the child. There were 17 reports of unnatural death of the child during birth.

17 per cent of reports registered in 2008 were reports of events that occurred in mental health care. 80 reports of suicide, 40 reports of attempted suicide and 21 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.

Use of our web site: www.helsetilsynet.no

In 2009, there were approximately 4.3 million visits to specific sites on our web site (4.8 million in 2008). The most popular sites in 2009 were (number of visits in brackets):

- supervision reports (1 170 000)
- publications (1 100 000)
- the web sites of the Norwegian Board of Health Supervision in the Counties (360 000)
- legislation (310 000)
- news (308 000).

Access to documents

In 2009, the Norwegian Board of Health Supervision received 1 295 requests for access to documents from the media organizations that participate in Electronic Mail Records (1 481 requests in 2008).

Directives from the Norwegian Board of Health Supervision

- IK-3/2009 (17.11.2009). Requirements for applications to be given back the right to prescribe addictive medication. Guidelines for administrative procedures for the Norwegian Board of Health Supervision in the Counties
- IK-2/2009 (28.08.2009). Guidelines for administrative procedures for the Offices of the County Governors for complaints about social security benefits
- IK-1/2009 (02.06.2009). Information for health care personnel who have lost their authorization or who have voluntarily renounced their authorization.

Financial Statement 2006

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

Table 13 Financial statement 2009. Budget chapters 721 and 3721, the Norwegian Board of Health Supervision (NOK 1 000)

Income / expenditure	Budget	Accounts	Difference
Expenditure: fixed wages	49 766	46 335	3 430
Expenditure: variable wages	3 114	6 010	(2 895)
Operating costs (rent, cleaning, electricity, security etc.)	8 360	8 430	(70)
Other expenditure	21 130	18 303	2 827
Total expenditure	82 370	79 078	(3 292)
Income	2 211	2 313	102
Net expenditure / saving	80 159	76 765	3 394

Recommend a candidate for the KARL EVANG AWARD 2010!

The Karl Evang Award (NOK 50 000) will be presented at the Karl Evang Seminar, arranged by the Norwegian Board of Health Supervision 19 October 2009 at Oslo University College. The seminar is free, there is no registration, and is open for everyone. Read more about the award and the seminar at: ...

Send recommendations for a candidate by **20 August** to:

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

Supervision reports

Reports of supervision of health and social services are published at: www.helsetilsynet.no. They can be retrieved, sorted by topic, municipality, county or year.

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