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tilsyn med barnevern, sosial- og helsetjenestene

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Use management systems actively!

Welfare services in Norway are based on the premise that everyone shall have equal access to sound and adequate services. The state, the municipalities and the county authorities have responsibility for ensuring that this aim is achieved. Resources are allocated from central funding through the public budget. Therefore, an understanding of fairness and equity in a Norwegian context is based on the ability and the will to achieve solidarity for all groups in the population in all parts of the country. For many decades, here in Norway there has been political agreement about these main principles.

In order to ensure equal access to services that are sound and adequate, comprehensive legislation has been developed. An important aim of the legislation is that services shall be safe and predictable for clients. Meeting the statutory requirements and providing services within the economic constraints involves two different management principles. In order to succeed, the leadership must be able to understand the principles and requirements that form the basis for Norwegian welfare services, and at the same time provide services in a way that utilizes resources as effectively as possible.

Norwegian legislation contains few requirements about how services shall be organized, but contains relatively strict requirements about the content of the services. Therefore, in order to assess how resources are utilized, it is not sufficient to base management on economic data. Leadership, the municipal councils and the executive committees of the health trusts must have a continuous overview of the quality of the services that they provide. Based on the findings from supervision, we know that there is much to be done in this area.

«An adequate management system must be suitable for daily use, and at the same time it must be anchored in the top leadership and the committee.»

We are particularly concerned that the organizations should have a clear conception of what can be regarded as sound and adequate services. The aim of both planned supervision and incident-based supervision is often to assess whether service providers have planned and carried out their work in such a way as to ensure that the services that are provided are sound and adequate. This is the essence of the concept of quality in order to ensure patient safety.

The management system can just as well be called the internal control system or the patient safety system. But the system must be able to detect new professional and clinical knowledge and ensure that this knowledge is made known and used in the organization. An adequate management system must be suitable for daily use, and at the same time it must be anchored in the top leadership and the committee. It must show what the requirements are and it must be suitable as a basis for sharing experience both within the organization and between different organizations.

The management system is the leaders' tool for ensuring that the requirement to provide sound and adequate services, along with other requirements, is met. It must be based on the requirements laid down in the legislation. But if the system is not based on daily activities, it is not a useful tool. It is important that leaders investigate nonconformities and learn from them. The management system must be continually adapted according to experience gained within the organization and in other organizations. Experience gained from supervision and from adverse events is also useful. It is worth noting that in the documents from the Ministry of Health and Care Services defining the tasks for 2011, the health trusts are directed to learn from adverse events and system failure both at the leadership level and at the committee level. The same challenge can just as well be given to the municipalities.

We see that supervision works. The effect can be even greater if the findings we report from supervision and from the complaints we deal with are also used by other service providers. We are pleased to see the progress being made by the municipalities and the health trusts. A summary of our findings from supervision carried out in 2010 is presented in this publication. More can be found on our web site: www.helsetilsynet.no.

Lars E. Hansen


SÖKNAD OM AVLASTNING

Municipal services for frail elderly people: Are they adequate?

In 2010, as part of our focus on supervision of services for elderly people, we carried out supervision of municipal health and social service. We carried out supervision of nursing homes, the home nursing service, general practitioners, and the administrative routines of the municipalities. We used several different types of methodology. Altogether, we carried out supervision of 294 services. Here, we present a selection of our findings. We will continue this supervision in 2011.

Supervision of municipal health and social services for elderly people with dementia

Many people suffer from dementia, and the prevalence increases with increasing age. Figures from the Norwegian Directorate of Health show that about 17 per cent of people aged 80-84, and about 41 per cent of people aged 90 and over, suffer from dementia. This disease also affects the elderly person's family and friends.

In 2010, supervision was carried out in 48 municipalities. The aim was to identify, investigate and follow up elderly people with dementia living in their own homes, and cooperation with general practitioners. Breaches of the legislation were found in 32 of the municipalities.

Many municipalities lacked adequate routines for identifying patients with dementia, for ensuring that they receive adequate medical care, and for identifying changes in patients' needs. Cooperation with general practitioners was not always adequately planned. When there is no common understanding of how tasks shall be carried out, it is up to the individual how things shall be done. Such a practice leaves things to chance and increases the risk that services are inadequate. The result may be that people with dementia are not identified and investigated as they should be, and that they do not receive the help they need. This can have serious consequences for people with dementia, who cannot express their needs.

People with dementia are particularly dependent on stable and predictable services. Frequent changes in personnel, changes in the time care is provided, and changes in the way personnel provide care, can make clients more confused. We found that some clients had had as many as 26 different service providers in one month. We expect municipalities to introduce measures and arrangements that ensure that the special needs of people with dementia are met. For example, the leadership must evaluate measures to limit the number of care providers. Sound reporting and documentation shall ensure that helpers always know what care each individual client needs and what other colleagues have done, planned and observed.

«Frequent changes in personnel, changes in the time care is provided, and changes in the way personnel provide care, can make clients more confused. We found that some clients had had as many as 26 different service providers in one month.»

Knowledge about dementia is important in order to provide sound services to people with this diagnosis. Several municipalities lacked training plans, and staff training was inadequate in many services. Lack of qualified personnel can result in people with dementia not being identified, changes in needs not being detected, and the quality of the service not being high enough.

The leadership of the municipality has responsibility for planning, organizing and managing services. We found that the leadership did not always fulfil its responsibility. In several municipalities, no risk assessment of the services had been made, and the opportunity to improve the services by learning from adverse events had not been used systematically.

Supervision of management of medication for elderly people living in their own homes

Because of chronic illness and other disorders, many elderly people use a range of medication. According to the prescription register, half of all people over 70 years of age have at least five prescriptions for different types of medication in one year, and one in five more than ten. The risk of side-effects and other medication problems is greater when many different types of medication are used at the same time. Correct administration of medication can be challenging, and many elderly people living in their own homes need help with medication from the home nursing service.

In 2010, 76 municipalities were asked to make a self-assessment of whether their arrangements for management of medication met the main requirements of the legislation. Two-thirds of the municipalities reported that they found deficiencies. In twelve other municipalities, we carried out supervision of home nursing services for elderly people who needed help with medication. In nine of these twelve municipalities we found breaches of the legislation.

Examples of our findings:

- It was unclear who had responsibility for management of medication. The leaders who had responsibility for this lacked the necessary knowledge about medication, and they had not appointed professional advisers.
- Not all the health care personnel who administered medication had the necessary qualifications. The leadership did not assess the qualifications of each individual member of staff, and they did not carry out training programmes. Temporary staff and non-professional staff were not given adequate training.
- Patient record keeping was inadequate, for example recording of diagnoses, medication and cooperation with the general practitioner.
- We identified inadequate procedures that were not updated in accordance with current regulations. The procedures were not reassessed regularly to see whether they needed to be updated.
- The municipalities had not carried out a risk and vulnerability analysis for management of medication, and experience from adverse events had not been used to improve this area.

Management of medication is an area of high risk for adverse events and deficiencies. Patients are often not able to say whether their medication has been administered correctly. Health care personnel must be able to detect any problems that occur, and report them, so that the home nursing service can follow up and ensure that a doctor assesses the situation when necessary. If the municipality does not ensure that there is an adequate number of staff with the necessary qualifications, in the worst case this can be fatal for the patient.

Supervision of general practitioners

In 2010, supervision has included regular general practitioners' assessment and follow-up of patients with dementia, and their management of medication for patients who receive help with their medication from the home nursing service. In 7 cases out of 34, the general practitioners did not meet the relevant legislative requirements. Among other things, we found inadequate patient record keeping, which is particularly unfortunate if, for example, temporary staff need to use the patient records. We found that some patients with dementia were not followed-up systematically, with the risk of serious consequences. For some general practitioners, routines for checking anticoagulation treatment (warfarin) was not in accordance with clinical guidelines. This can mean that patients do not receive effective treatment, or else that there is an increased

risk of serious side-effects such as bleeding. The number of times supervision was carried out was small, but we still obtained a picture of what can go wrong when general practitioners provide care for this vulnerable group of patients.

Supervision of prevention and treatment of malnutrition

It is well known that some elderly people who need care are undernourished or are in danger of suffering from malnutrition. This weakens their resistance to infection, reduces their physical and mental functioning, and increases the risk of complications when they are ill.

In 14 of 21 municipalities, we found that identification, assessment and following up of these patients were inadequate. In nursing homes and in the home nursing service, staff training was inadequate. This can have serious consequences for these frail elderly people.

Supervision of respite care

Many elderly people who live in their own homes are dependent on relatives who provide care and practical help, so that they can live at home as long as possible. This care is very important for the elderly people themselves, but also for the municipality. Many of these private carers are also elderly. The municipal health and social services have responsibility for providing respite care, so that these carers are given a break.

In 2010, the Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties carried out countrywide supervision of how municipalities meet the needs that private carers have for respite care for their relatives. The method used for this supervision was spot checks of documentation from the administrative procedures of the municipalities when they allocate respite care.

«The municipalities had not carried out a risk and vulnerability analysis for management of medication.»

In 48 of 55 municipalities, the supervision authorities found conditions that were not in accordance with sound practice for administrative procedures, as required by the Public Administration Act. We often found that when the municipalities allocated services, they did not investigate and assess the amount of care provided by private carers, the situation, and the need for respite care. In many municipalities little information about respite care was available in the application forms or in brochures. During one year, some municipalities had made very few administrative decisions about allocation of respite care. Very few municipalities had rejected applications for respite care during the same period. When there are so few assessments of the need for respite care, this indicates that many relatives and other private carers do not receive an offer of respite care for their relatives, which they have a right to receive.

Unnotified supervision – a way for finding out what is usual practice

Usually, the supervision authorities notify the services in advance about supervision. However, we can carry out unnotified supervision, in which we give a few hours notice before we arrive and collect the information we require from the service about a specific area at a given point in time. The aim is to obtain a picture of the situation regarding a specific practice in the service.

In 2010, the Norwegian Board of Health Supervision in the Counties carried out unnotified supervision of municipal services for elderly people on 24 occasions. Several different themes were chosen, based on a risk assessment of the local situation.

«Shall we let people go out in the middle of winter, without enough clothes on?» Examples from the county of Aust-Agder

The Norwegian Board of Health Supervision in Aust-Agder were asked this question when they carried out unnotified supervision of 15 nursing homes in the county to investigate whether residents could move around without restrictions.

Residents in nursing homes have the right to move around without restrictions inside and outside the nursing home if they wish to do so. However, the nursing home has responsibility to assess the health status and safety of each individual resident. The right to restrict residents' freedom of movement is regulated by Chapter 4A of the Patients' Rights Act.

The Norwegian Board of Health Supervision in Aust-Agder investigated the nursing homes' practice regarding locking doors. In 14 of 15 nursing homes, main doors, doors to common areas, doors to the garden and doors in corridors were locked, but no administrative decision had been made in accordance with Chapter 4A of the Patients' Rights Act. The solutions and arrangements were collective, and applied to everyone on the "inside". This type of practice is not in accordance with the regulations.

Regional supervision of specialized health services

In 2010, the Norwegian Board of Health Supervision in the Counties chose areas for supervision for their own health region, based on risk analyses. The results of two of these activities are presented in this article.

In the Western Norway Regional Health Authority, the Norwegian Board of Health Supervision in the Countries carried out supervision of assessment of breast cancer. This was done to follow up a national risk analysis of treatment of cancer, carried out by the Norwegian Board of Health Supervision in 2009.

In the Southern and Eastern Norway Regional Health Authority, supervision of specialists who had a contract with the Authority was carried out. Health services provided by these specialists represent a significant proportion of out-patient specialist mental health services in the region. The experience gained from supervision of specialists can be useful for the supervision authorities in other parts of the country.

Supervision of assessment of breast cancer for women in western Norway

Every year, about 2800 women get breast cancer. For every woman who is diagnosed, there are many more who need to be assessed. The prognosis is extremely good if women get good treatment. There is a relationship between the number of cases of breast cancer treated and the results of treatment. This has resulted in great changes in the provision of treatment over the last few years, and the number of hospitals providing assessment and treatment of breast cancer has been reduced from 60 to 20.

A basic principle in assessment of breast cancer is close cooperation between surgeons, radiologists and pathologists. Clinical recommendations from the Norwegian Breast Cancer Group (NBCG) have provided the standard for assessment of breast cancer. Mammography programmes have led to a significant improvement in services for breast cancer. This has been confirmed by supervision.

«Our recommendation to the regional health authorities is that, when they have a contract with private institutes, this should include full triple diagnosis, in line with clinical consensus.»

Assessment of risk related to treatment of breast cancer

In the autumn of 2009, the Norwegian Board of Health Supervision carried out a national assessment of treatment of cancer. 24 qualified specialists participated in choosing areas of treatment of cancer where the risk of deficiencies occurring is high. In the opinion of the group, the risk is greatest if diagnosis is delayed. By reviewing the cases dealt with by the Norwegian System of Compensation for Injuries to Patients, it was found that breast cancer is one of the types of cancer where this is a great problem.

Based on this assessment, diagnosis and assessment of breast cancer was chosen as the theme for supervision with the following health trusts: Helse Førde, Helse Stavanger, Helse Bergen and Helse Fonna. Supervision was carried out in the "triple diagnosis units", that is, units that combine surgery, radiography and pathology. Because several private radiography institutes carry out examinations to assess breast cancer, supervision of one private radiography institute in Bergen was carried out.

Supervision works

Through supervision, we found that the recommendations in the mammography programme were followed. In Helse Stavanger, Helse Fonna and Helse Førde, women were assessed in accordance with the national recommendations. At Haukeland University Clinic, Helse Bergen, the waiting time for the results of biopsies from the department of pathology was too long. The waiting time was the longest in the whole country, and was assessed as being an unreasonable burden for patients. Therefore, this long waiting time was noted as a non-conformity. During a couple of months, Helse Bergen reduced the waiting time to an acceptable level, and supervision has been completed. The waiting time for the results of biopsies for other types of cancer was also long, and the hospital is working to reduce waiting time for laboratory tests for all types of cancer. It is encouraging that supervision has contributed to this improvement, not just within the area of supervision, but also within other areas.

Recommendations after carrying out supervision

Three of the health trusts receive many patients who are referred from private radiography institutes. These institutes carry out mammography, but not triple diagnosis. Our recommendation to the regional health authorities is that, when they have a contract with private institutes, this should include full triple diagnosis, in line with clinical consensus.

Another finding from supervision was that the hospitals have different IT-systems to prioritize referred

Themes for regional supervision of specialized health services in 2010:

- Treatment of stroke (Northern Norway Regional Health Authority)
- Communication (Central Norway Regional Health Authority)
- Small maternity units (Central Norway Regional Health Authority)
- Mental health services for children and adolescents (Central Norway Regional Health Authority)
- Diagnosis and assessment of breast cancer (Western Norway Regional Health Authority)
- Private psychiatrists and psychologists in mental health services who have a contract with the Regional Health Authority (Southern and Eastern Norway Regional Health Authority)
- Treatment of fracture of the hip and hip replacement surgery (Southern and Eastern Norway Regional Health Authority)

patients. Referral to departments of surgery leads to normal registration and prioritization. These referrals appear on the hospitals' waiting lists, and the women have rights according to the Patients' Rights Act. If the referral is dealt with by the department of radiography, the patient is registered in another system (RIS). These referrals do not appear on the hospitals' waiting lists, and the patients do not have rights according to the Patients' Rights Act. This has been reported to the Norwegian Board of Health Supervision as a general problem.

Supervision of contract psychiatrists and psychologists

In 2010, the Norwegian Board of Health Supervision in the Counties in the Southern and Eastern Regional Health Authority carried out supervision of private specialists who have a contract with the Authority to provide mental health services. Breaches of the legislation and the need for improvement were particularly common in the following areas: cooperation with regular general practitioners, patient record keeping and storage of confidential information, and assessment of the risk of suicide.

Many people suffering from mental illness are waiting for out-patient assessment and treatment. Private specialists who have a contract with the regional health authority provide about one-third of the total out-patient treatment in mental health services for adults.

«Several specialists did not assess the risk of suicide in a systematic way. In many cases, such assessments were not recorded in the patient records.»

Supervision of specialized mental health services for adults was carried out in 20 practices (one psychiatrist and one psychologist in each county). The themes were: receiving and dealing with referrals, assessment and treatment of patients, cooperation with general practitioners, patient record keeping and storage of confidential information. Three breaches of the legislation and 17 areas for improvement were identified. In nine practices, no breaches of the legislation or areas for improvement were found.

Little cooperation with general practitioners

We found that there was little cooperation with the patients' general practitioner. The psychiatrists and psychologists did not always inform the general practitioner that they had received the referral, or that the patient had been accepted for treatment. In the case of prolonged treatment, the general practitioner was seldom informed about the progress of the treatment. Some psychiatrists prescribed medication, sometimes addictive drugs, without informing the general practitioner. Case summaries were not always sent promptly.

Inadequate documentation

In some practices, there was no adequate system for documentation and storage of information about patients. Some specialists had patient records that were unclear and unsystematic. Some specialists did not always record essential and relevant information.

Lack of a system for assessing the risk of suicide

Several specialists did not assess the risk of suicide in a systematic way. In many cases, such assessments were not recorded in the patient records. National clinical guidelines for prevention of suicide in mental health services were often not familiar or followed.

Other findings

Generally, there was little cooperation between psychiatrists and psychologists and other specialized health services. The skills of these specialists could probably be utilized more effectively if their services were integrated more with the services provided by the health trusts. Psychologists who specialized in services for children and adolescents received few referrals for people in these age groups.

Referrals were sent directly to individual specialists. If the referral was not accepted, or if the specialist had a long waiting list, the patient had to be referred to another specialist. So for many patients and general practitioners, the referral process was inconvenient and time-consuming.

Mixing roles

Roles are mixed when a professional relationship becomes private or when the relationship becomes sexual. The Norwegian Board of Health Supervision regards such mixing of roles as extremely serious, and we usually react by withdrawing the authorization of the health care personnel who is involved. Doctors, psychologists and physiotherapists are over-represented, but the number of non-professional personnel working in mental health services and services for treatment of people with alcohol and drug problems is increasing.

How often does this happen?

In 2009, the Norwegian Board of Health Supervision withdrew the authorization of 108 health care personnel, of which eleven (ten per cent) were because of mixing of roles. During the period 2002-2010, we dealt with 116 cases of mixing of roles. Authorization was withdrawn in 74 cases, and a warning was given in 40 cases. In six cases, the authorization of the health care personnel was limited. The distribution between different types of health care personnel is shown in the table below.

Health care personnel	Number
Doctors	51
Nurses	15
Auxiliary nurses	14
Physiotherapists	10
Psychologists	10
Other groups of health care personnel	8
Unauthorized personnel	8

Compared with the number of authorized health care personnel in Norway, psychologists, doctors and physiotherapists are over-represented in cases of mixing of rolls. Cases involving non-professional health care personnel represent almost ten per cent of cases. This presents a challenge for employers for staff training.

Why is mixing of roles so serious?

Basically, a professional relationship is characterized by an unequal distribution of power. In this relationship, therapists, that is health care personnel, have the skills to help patients with their health problems and patients are often dependent on these skills. This imbalance of power is particularly prominent for patients with mental illness or alcohol or drug problems. These patients are often in a particularly vulnerable situation. Health care personnel have a responsibility not to misuse their professional relationship to meet their own social and/or sexual needs. This applies during treatment, but also in the period after treatment is completed.

The trust that the general public has in health care personnel and health services is related to the expectation that health care personnel provide health services with the aim of giving patients necessary care that is sound and adequate, and not with the aim of meeting their own needs.

In the opinion of the Norwegian Board of Health Supervision, having a private or sexual relationship with a patient is not in accordance with sound professional practice, and represents serious misuse of the trust given to health care personnel by the community and the health authorities.

Management of medication – what can go wrong?

- *«It was a busy day on the ward. There were many patients who needed help. Just before midnight, I disconnected a drip with what I thought was one antibiotic. I discovered that the patient had been given Metronidazole and Cephotaxim together. These two substances should not be mixed, according to the pharmaceutical products handbook».*

Many health care personnel are very busy during their workday. Often there are few staff on duty and there are many patients with comprehensive needs for care. A lot can happen late in the evening or during the night, when doctors and nurses are tired. In these situations, it is important to have good routines and procedures in order to prevent mistakes being made. In this article, we give some examples of reports in MedEvent (the Reporting System for Adverse Events in Specialized Health Services) to illustrate the kind of mistakes that can be made in management of medication.
16 457 reports of adverse events in hospitals were registered in the period 2001 to 2009. 3 733 of these (23 per cent) were reports of adverse events related to management of medication. Types of adverse events that can occur are:

- the patient is given the wrong dose
- the method of administration is wrong
- the patient is given the wrong medication
- the medication is given to the wrong patient
- the medication is given at the wrong time
- the medication has an unexpected effect.

In 25 per cent of the reported events, the patient was given the wrong dose, either too little or too much. For example:

- *«I copied the information about the medication from one page to the next in the patient's medical journal. I wrote: Trileptal 300 mg 2.5 tablets x 2. I should have written: Trileptal 300 mg 2.5 tablets in the morning + 2 tablets in the evening. The person who should have checked that this was correct did not detect my mistake. The result was that the patient was given the wrong dose for 5 days».*

In 14 per cent of the events, the medication was administered in the wrong way, for example: an injection that should have been given intravenously (in the blood) was given subcutaneously (in the skin) or intramuscularly (in the muscle):

- *«An intravenous infusion of hypertonic calcium was given subcutaneously and this led to necrosis of the tissue (the tissue died) in the place where the injection was given».*

In eleven per cent of the reported events, the wrong medication was given to the patient. Some types of medication have names that can easily be mixed up. Some packets look alike, and the nurse can make a mistake:

- *«The patient was given 50 mg Nozinan tablets, which he should not have been given. "Nobligan" was written in the patient's medical journal, but I read it as "Nozinan».*

In eleven per cent of the reported events, the patient was given another patient's medication:

- *«The patient was waiting for a gynaecological operation. She was given the premedication that the patient in the next bed should have been given».*

In nine per cent of the reported events, the medication had an unexpected effect:

- *«The patient had had her tonsils removed. She was given morphine to relieve the pain. This caused itching. She was then given Ketorax. Her uvula swelled up and was the size of a grape. Her face became very swollen, and her lips, throat and arms also swelled up».*

In three per cent of the reported events, the medication was given at the wrong time:

- *«I gave the medicine at 11 o'clock (three hours too late), and did not realise that I had made a mistake until later, because it was not clear in the medical journal».*

Most adverse events related to management of medication (88 per cent) did not result in damage to the patient. However, it is still important to report these events so that hospitals can analyse the causes of the events and learn from the mistakes that have been made. This can prevent mistakes that could cause damage to patients or even be fatal.

33 per cent of patients admitted to hospital are elderly people. They are more vulnerable than younger people to adverse events with medication. For as many as 47 per cent of these adverse events, the patient was 67 years old or older.

Side-effects of medication are reported to the Norwegian Medicines Agency. Adverse events related to management of medication are reported to the Norwegian Board of Health Supervision. Medication includes all types of pharmaceutical products such as tablets, medicines, injections, drops (eye drops, ear drops, nose drops), blood products etc. Management of medication includes all stages from when the medication is prescribed until it is given to the patient.

Health care personnel who cross borders

«On 5 May 2010, the following news report was broadcast on the radio: "The Swedish supervision authorities are investigating Norway's worst doctor, after the Norwegian Broadcasting Corporation reported that she is now working in Sweden.

Since there have been several similar news reports during the course of the year, it is appropriate to ask whether the Nordic countries inform each other about health care personnel who are given an administrative reaction by the supervision authorities.

The doctor referred to in the radio broadcast lost her authorization as a specialist in 2006. The supervision authorities in all the Nordic countries were informed about this when the decision was taken. There is reason to believe that this information was not followed up adequately in Sweden.

For many years, the Norwegian Board of Health Supervision has had routines for informing the authorities in other countries about health care personnel who have lost their authorization, who have been given limited authorization, or who have themselves given up their rights as a health care personnel. We receive this type of information continuously from the other Nordic countries. This cooperation between the Nordic countries is based on an agreement between the countries from 1993 (1). In addition, according to the Health Personnel Act, Section 57 fourth sentence, authorization, licence or authorization as a specialist, given on the basis of the equivalent authorization in another country, can be revoked if the authorization in the other country is no longer valid.

When necessary, the Nordic countries can also exchange information about the reasons why an administrative decision has been made. Experience shows that the countries have somewhat different practice about the type of information that is exchanged. One reason for this is that the countries have different regulations about releasing information that is confidential.

As illustrated in the example given above, it is very important that such information is followed up. The Norwegian Board of Health Supervision has routines for checking information from the other Nordic countries with information in the health personnel register. In 2010, this resulted in nine health care personnel loosing their Norwegian authorization.

For health care personnel from other EEA/EU countries, other European countries, and countries in other continents, corresponding routines for exchange of information have not been established. However, the Norwegian Board of Health Supervision will send information to these countries when it is appropriate to do so.

During the last few years, the Norwegian Board of Health Supervision has given a warning to 60-80 health care personnel each year.

Countries have not previously exchanged information about this type of reaction. But since February 2010, after verbal agreements between the director generals of the supervision authorities in Norway, Sweden and Denmark, the countries intend to exchange this kind of information as well. Therefore, the Norwegian Board of Health Supervision has informed Sweden and Denmark about warnings given to health care personnel since this time. However, up to now we have not received such information from Sweden or Denmark.

«The Norwegian Board of Health Supervision has routines for checking information from the other Nordic countries with information in the health personnel register. In 2010, this resulted in nine health care personnel loosing their Norwegian authorization.»

(1) Agreement regarding common Nordic employment market for certain groups within the health service and for veterinary surgeons. Oslo: Ministry of Health and Social Affairs, 1993.

When deficiencies in the health service affect elderly people and other people with comprehensive needs for care

Every year the Norwegian Board of Health Supervision deals with a series of cases in which patients complain that they have not received sound and adequate care, and in which the behaviour of health care personnel has been unacceptable. Below, we present some examples of complaints from elderly people and other people with comprehensive needs for care.

When patients use health services, they have the right to be treated with friendliness, understanding and respect. In accordance with the Health Personnel Act, Section 4, the Specialized Health Services Act, Section 2-2 and the Municipal Health Services Act, Section 6-3, patients have the right to receive sound and adequate services and diligent care.

As the examples below illustrate, patients do not always receive sound and adequate services.

The Norwegian Board of Health Supervision can react in different ways when health services are not provided according to statutory requirements and when health care personnel act in a way that is incompatible with professional conduct. We can point out to the organization that there has been a breach of the health legislation. If the conditions are not corrected, we can issue the organization with instructions to do so. We can issue a warning to health care personnel. In cases in which health care personnel are shown to be unsuitable to practice their profession, or have behaviour that is incompatible with professional conduct, we can withdraw their authorization.

EXAMPLES OF CASES

Lack of follow up
An elderly lady came to a nursing home after a stay in hospital. There, she was given medication that could cause a high blood sugar level. Therefore, her blood sugar level should have been measured regularly, and she should have been given insulin when needed.

Different people, both nurses and auxiliary nurses, measured the patient's blood sugar level a total of nine times. The measurements showed that the patient's blood sugar level increased from day to day. With one exception, the blood sugar values were not recorded in the nursing journal, but only on a separate sheet of paper. Assessment of the patient's rising blood sugar level was not described in the patient records, and there was no record that the medication could have this side-effect. The rising blood sugar level was not reported to the doctor.

The patient became gradually worse. Six days after she had been admitted to the nursing home, the staff could not make contact with the patient. Her blood sugar level was measured. The level was the highest the instrument could show. The doctor was contacted, and the patient was given insulin, but her condition could not be reversed and she died later that day.
The Norwegian Board of Health Supervision pointed out that none of the people who were involved had reacted or reported the patient's increasing blood sugar level. We assumed that this was because the nursing home did not have adequate routines. We initiated a supervision case against the nursing home, but not against the health care personnel.
After investigating the case, in addition to the failure to check and to report the increasing blood sugar level, we found that the patient's needs when she was admitted had not been adequately assessed and documented, that her nutritional status had not been adequately followed up, and that there were deficiencies in documentation in her patient records and in the care given to her in the terminal phase of her life.
We concluded that the leadership of the nursing home had not established the necessary management systems to ensure provision of adequate and sound treatment and nursing care. This led to the patient receiving treatment that was not of an adequate standard. The deficiencies in management were seen as a breach of the requirement to provide adequate and sound services, in accordance with the Municipal Health Services Act, Section 6-3.

«The result of the mix-up was that the patient had been given strong psychopharmaceuticals that she should not have had, but had not been given her own medication, including heart tablets.»

Adverse management of medication
An elderly patient received help with her medication from the home nursing service.
The system in the municipality was that patients' medication was packed in small bags by a pharmacy, so-called multi-doses, marked with the patients name, type of medication and dose. Multi-doses were delivered from the pharmacy in roles, and then put in dosett boxes for each patient. But in this process, the tables for two patients were mixed up, and the tablets for another patient were put in the elderly patient's dosett box.
On the following three days, the patient was given the wrong tablets from the dosett box, seven times altogether, by three different people from the home nursing service.
The patient became increasingly weak and unwell. The nurse who visited her on the fourth day wondered if the cause of the patient's confused condition could be side-effects of new medicine. The nurse then discovered that the multi-dose in the patient's dosett box was marked with the name of another patient. However, the name of the dosett box was correct. Therefore, the patient had been given the wrong medicine for three days, without anyone discovering the mistake. None of the three people who had administered the tablets had checked that the name on the multi-dose was the same as the name of the patient. The result of the mix-up was that the patient had been given strong psychopharmaceuticals that she should not have had, but had not been given her own medication, including heart tablets.
In addition to the people who had given the patient the wrong medicine, three other people had been involved in putting the multi-doses into the dosett boxes the day when the mix-up had occurred. So at least seven people had been involved in the adverse event. In our opinion, many mistakes had been made, and the municipality's quality control system for management of medication was inadequate. It was also clear that several health care personnel had made mistakes.
After investigating the case, the Norwegian Board of Health Supervision established that there were deficiencies in the following areas:

Routines for management of medication
Several management documents for management of medication were inadequate, imprecise or incomplete.

Also, some management documents were lacking for some vulnerable areas which have a high risk for deficiencies occurring, such as putting multi-doses into dosett boxes.

Ensuring that health care personnel have adequate qualifications and skills
The municipality had a system for training personnel in management of medication. All the health care personnel who were involved had been given training, with the exception of one temporary member of staff. The municipality had not established a routine for checking whether temporary staff had adequate skills. Training of permanent staff was also inadequate.

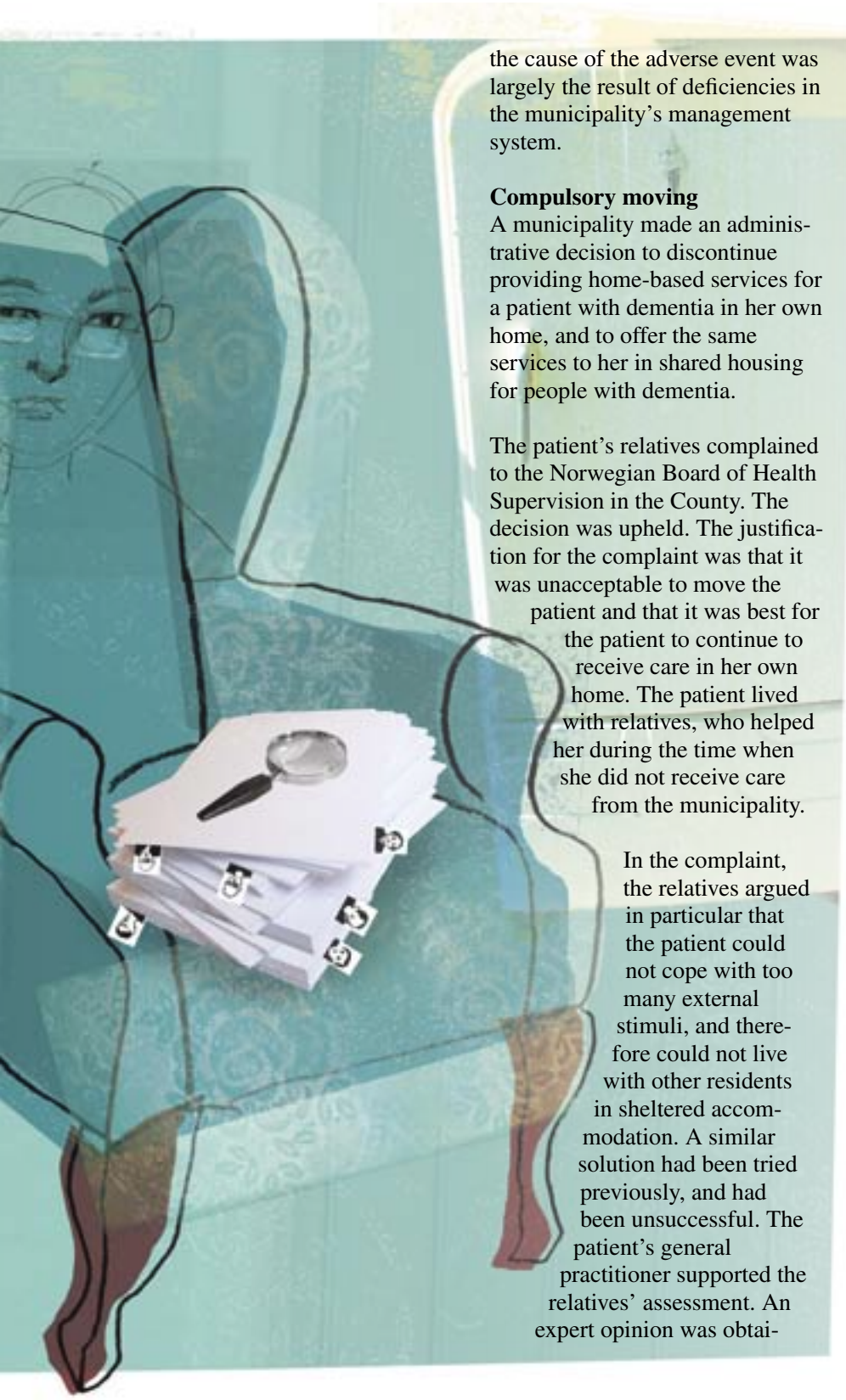
The requirement to document everything in the patient records
The incident was not adequately recorded in the patient records and in other documents. Temporary staff did not have access to patient records, but had to record information in a file for temporary staff. In this case, the municipality could not find this afterwards.

Dealing with adverse events
Health care personnel reported that adverse events with management of medication in the municipality occurred very often, and that they had pointed this out many times. Therefore, the Norwegian Board of Health Supervision asked to see these reports for the last year. The municipality gave us 80 reports of adverse events with management of medication. The adverse events were cases in which patients had not received their medication once or several times, they had been given the wrong dose, they had been given the wrong medication, they had been given other patients' medication, or they had they had not been given all their medication. Mix-up of dosett boxes or multi-doses had also occurred.

The reports lacked an analysis of the cause of the adverse event, recommendations for preventive measures, and whether preventive measures had been implemented or had had the desired effect. Also, the adverse events had not been reported to the involved person's leader.

We were not given written procedures or other documentation that showed how the leaders systematically monitored that procedures had been established and followed up, or whether they functioned as intended. Therefore, we concluded that monitoring of procedures was lacking.

The assessment of the Norwegian Board of Health Supervision
We concluded that there were serious deficiencies in the municipality's management system for home-based services, and that the management system was not adequate to ensure sound management of medication in the home nursing services. Therefore we concluded that there was a breach of the requirement in the Municipal Health Services Act to provide sound and adequate services. We concluded that three health care personnel who had administered the wrong medication to the patient had acted in a way that was not sound and adequate, but they were not given a warning because



the cause of the adverse event was largely the result of deficiencies in the municipality's management system.

Compulsory moving
A municipality made an administrative decision to discontinue providing home-based services for a patient with dementia in her own home, and to offer the same services to her in shared housing for people with dementia.

The patient's relatives complained to the Norwegian Board of Health Supervision in the County. The decision was upheld. The justification for the complaint was that it was unacceptable to move the patient and that it was best for the patient to continue to receive care in her own home. The patient lived with relatives, who helped her during the time when she did not receive care from the municipality.

In the complaint, the relatives argued in particular that the patient could not cope with too many external stimuli, and therefore could not live with other residents in sheltered accommodation. A similar solution had been tried previously, and had been unsuccessful. The patient's general practitioner supported the relatives' assessment. An expert opinion was obtained, which indicated that both solutions were acceptable.

The Norwegian Board of Health Supervision, as the highest authority, reversed the administrative decision. Whether the services offered by the municipality were sound and adequate was not assessed, but the decision was reversed because neither the municipality nor the appeal body had assessed whether they had the authority to demand that the patient should be moved.

Neither the municipality nor the Norwegian Board of Health Supervision in the County had assessed whether the patient was competent to give consent. Even if a patient is not competent to give consent, in a situation in which the patient has the right to receive health care, but does not wish to accept the health care that is offered, the municipality must assess whether the patient can be offered alternative care, or whether the municipality has the authority to demand that the patient must move in order to receive health care.

According to the Patients' Rights Act, patients without the competence to give consent can be admitted to health institutions or kept there if it is necessary in order to provide health care. However, sheltered accommodation, shared housing and similar types of residence are not classified as health institutions. An administrative decision about health care that presupposes that the patient must move to shared housing against her wishes, is therefore invalid.

Sexual violence
An auxiliary nurse who worked in a nursing home sexually abused six patients. Patients and staff who worked at the nursing home reported that the auxiliary nurse spoke to the patients in a way that they regarded as

unacceptable. One patient reported that the auxiliary nurse, four or five times had washed her in a sexual way. Another patient reported that she had been sexually abused when the auxiliary nurse had helped her with intimate hygiene.

The auxiliary nurse denied having done what the patients and the leaders of the nursing home described. She maintained that she had carried out her job and helped patients with washing and showering. We believed the patients' explanations.

We pointed out that health care personnel must be very careful and act in a professional way when they help patients with intimate hygiene. There is a great danger that patients can feel that their dignity has been violated in such situations. We pointed out that helping patients with intimate hygiene, dressing and undressing, and going to the toilet, is part of an auxiliary nurse's basic skills. This type of help shall be provided in such a way that the patient's dignity is maintained. All health care personnel should show respect for individual patients and should be sensitive and considerate.

We concluded that the auxiliary nurse was unfit to practice the profession of auxiliary nurse in a sound and acceptable way. In our opinion, her actions indicated a gross lack of professional insight, and were not in accordance with acceptable professional conduct. We assessed her behaviour to be not in accordance with the practice of her profession as auxiliary nurse. Her authorization was revoked.

Violence – compulsion and rough treatment
A nurse who worked in a nursing home had got into a fight with a patient. The nurse explained that she had tried to take a blood test to measure the patient's blood sugar level, and that the patient had resisted. According to her explanation, she got angry and tried to hold the patient down, and the patient hit her in the stomach. This ended in a fight. The nurse asked an assistant for help, and then took the blood test by force. The same nurse had previously given a patient an injection by force.

The patient said that when the nurse had taken the blood test, the nurse had been brutal. She was frightened of the nurse, and refused to be treated by her.

The same nurse had forced another patient to eat after the patient had said that she did not want any more food. The patient's mouth was full, but the nurse continued to stuff food into her mouth with a spoon. The patient had difficulty in swallowing, and food ran down her face. The nurse was angry and shouted. The nurse was seen to pinch the patient.

We pointed out that nurses are expected to behave in a professional way, and not to be frustrated so that this affects their rational thinking and behaviour, even if the patient's behaviour is challenging, or even if the patient does not seem to be cooperative. We also pointed out that it is important for health care personnel to get help in such situations, and to try to use methods such as motivation, persuasion and negotiation. In one incident, the nurse only called for help after she had hit the patient. In the other incidents she did not ask for help.

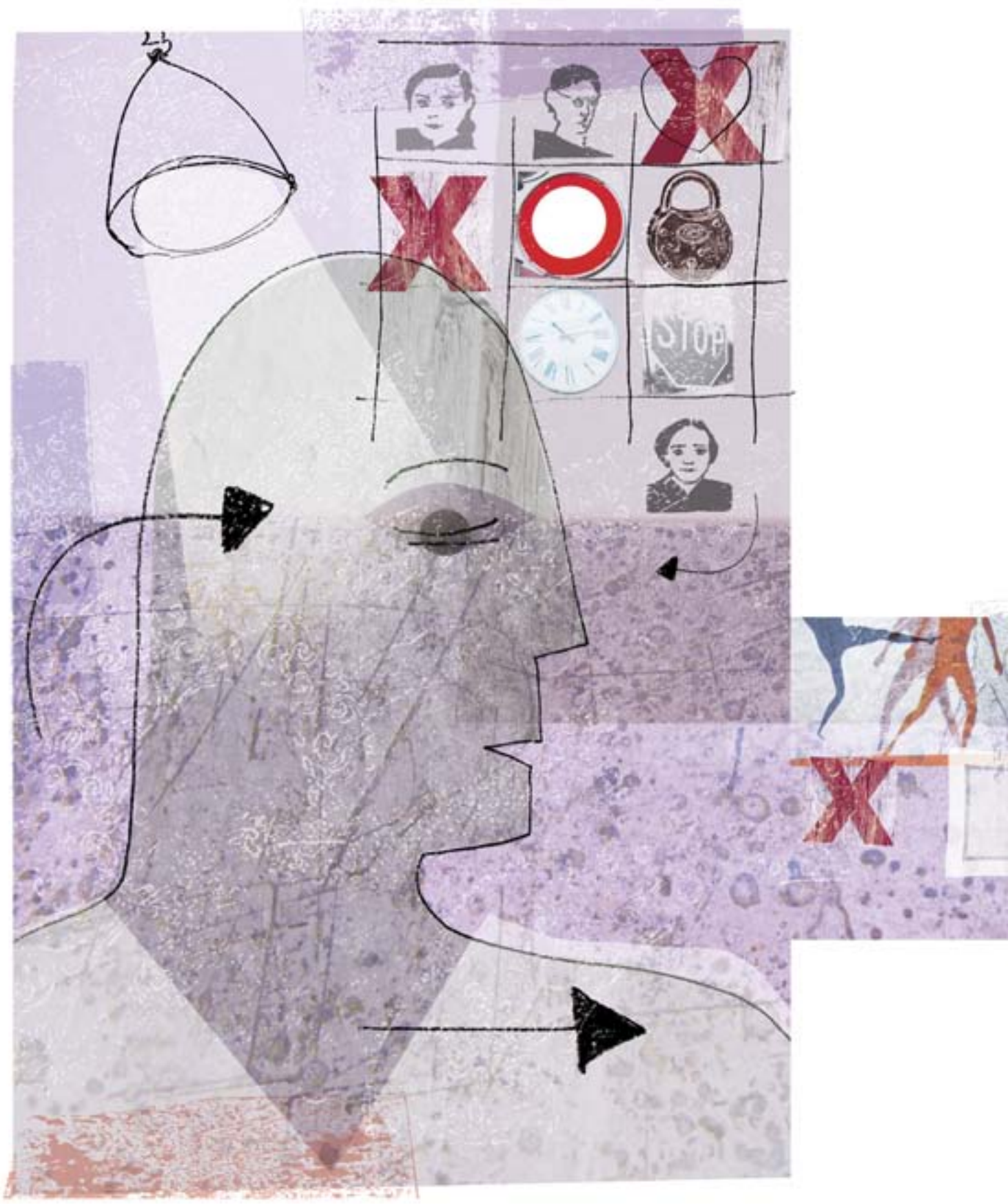
The nurse's use of compulsion and restraint in these situations was regarded as a clear breach of the requirement to provide sound and adequate help and diligent care. In our assessment of the situation in which the nurse had continued to give the patient food against her will, the nurse had shown a lack of ability to show empathy and to put herself in the patient's situation. The nurse was steered by her own needs to carry out her tasks in her own way and at her own speed.

We concluded that the nurse was unfit to practice her profession in a sound and acceptable way, because of unprofessional conduct and gross lack of professional insight. Her authorization was revoked.

Violence – rough treatment
An auxiliary nurse was violent with three patients in a sheltered unit in a nursing home. She had kicked one of the patients, and had hit the other two in the face. She had also been seen to shout at patients and to treat them roughly on several occasions. She explained that she had been very tired at the time, that she had been unable to calm down, and that she became angry.

In our opinion an important task for an auxiliary nurse is to create an environment of professionalism, security and trust. When practising their profession, auxiliary nurses face situations that are complicated, and in which there is a risk of physical and mental pressure. Auxiliary nurses are expected to show control and judgement so that they do not become angry. These are basic norms for human behaviour when dealing with people who are sick and in need of help. Becoming angry, as this auxiliary nurse became, was assessed to be a gross breach of what is expected of an auxiliary nurse and other authorized health care personnel.

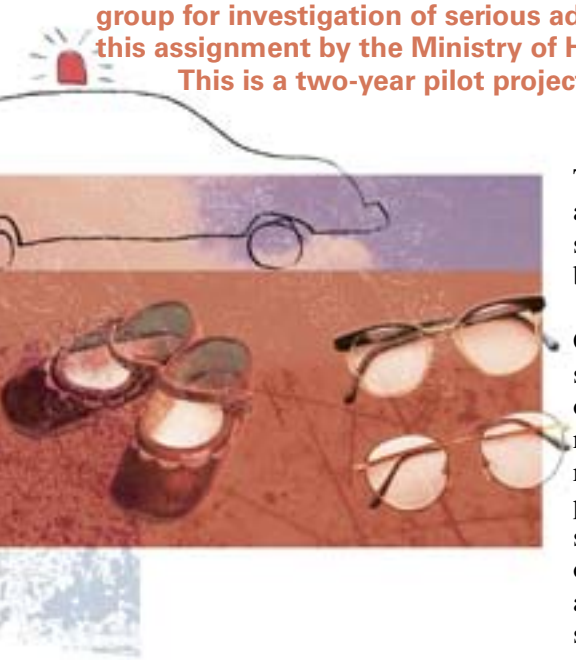
We concluded that by her actions the auxiliary nurse had shown a lack of judgement, a lack of ability to set her own limits and a lack of control of her impulses.We concluded that the nurse had practised her profession in a way that was not in accordance with sound and acceptable practice.
Her authorization was revoked.


STOP

More speedy supervision after unnatural death or serious injury

From 1 June 2010, health trusts are required to report adverse events that have had a serious unexpected outcome immediately to the Norwegian Board of Health Supervision. From the same date, the Norwegian Board of Health Supervision established a call-out group for investigation of serious adverse events, after being given this assignment by the Ministry of Health and Welfare.

This is a two-year pilot project..



The aim of the arrangement is that assessment of these supervision cases shall be made more quickly and shall be more comprehensive.

Cases in which the patient dies or is seriously injured, and in which the outcome is particularly unexpected in relation to the expected risk, shall be reported. This is particularly appropriate if there is an indication that the services were deficient, or if the course of events is unclear or complex. This arrangement does not replace other statutory reporting arrangements for adverse events.

Reports are sent by e-mail to *varsel@helsetilsynet.no.* The e-mail shall only contain the name of the health trust and information about the contact person. The Norwegian Board of Health Supervision is required to contact the health trust in order to get detailed information about the event, no later than the next working day. We then assess the information we have obtained, and decide how to deal with the matter. There are three possible outcomes. We can visit the health trust immediately. The Norwegian Board of Health Supervision in the County can deal with the case as a supervision case. We can decide that the case does not need to be followed up as a supervision case. The Norwegian Board of Health Supervision in the County participates in this process.

When we believe that an immediate visit to the health trust will provide more comprehensive and better information about the case, compared to following the usual written administrative procedures, then we go out without delay. The composition of the call-out team is dependent on what the case is about. The members of the team talk to the involved health care personnel and the management, and the patient and/or relatives are offered a consultation.

Per 31.12.2010, we have received 72 reports. Six have resulted in a call-out and 28 have been dealt with by the Norwegian Board of Health Supervision in the County as supervision cases.

Countrywide Supervision 2011

The aim of supervision is to ensure that services are safe, by examining whether the requirements laid down in the legislation have been met. Planned supervision with child welfare services, health services and social services is mainly carried out by the Offices of the County Governors and the Norwegian Board of Health Supervision in the Counties, both separately and together. Supervision is carried out according to an instruction manual, in order to ensure that the theme for supervision and the way supervision is carried out is standard, and to ensure that the findings are judged in the same way.

The plan of the Norwegian Board of Health Supervision for supervision in 2011 includes child welfare services, social services provided by the Norwegian Labour and Welfare Service, municipal health and social services and specialized health services.

Child Welfare Services

The theme for countrywide supervision in 2011 is how the municipality's child welfare service provides help to children who live at home. The Offices of the County Governors will examine whether the municipalities ensure that cases are assessed and provision of help is evaluated in such a way as to ensure that children and young people receive necessary help and care at the right time. They will also assess whether children are ensured the right to participate, that is to be informed and to give their opinion.

Social services provided by the Norwegian Labour and Welfare Service

In 2011, the Offices of the County Governors will continue with the countrywide supervision that was carried out in 2010 with social services provided by the labour and welfare administration. The supervision authorities will examine whether the municipalities ensure that applicants' rights to receive social security benefits are met, and whether individual assessments are made when applications are dealt with.

In addition, in 2011, preparations will be made for countrywide supervision of the municipalities' use of training programmes.

Compulsory health care in the municipal health service

In 2011, the Norwegian Board of Health Supervision shall carry out supervision of compulsory health care in the municipal health services in accordance with the Patients' Rights Act, Chapter 4A.

The aim of this provision is to ensure that patients who do not have the competence to give consent for treatment, and who refuse to receive treatment, receive necessary health care in order to prevent damage to their health. The aim is also to prevent and reduce the use of restraint and coercion. There are strict conditions for giving health care to patients who refuse health care.

The supervision authorities shall investigate:

- whether the municipalities meet the statutory requirements for assessment of patients' competence to give consent
- whether measures to gain the patient's trust have been tried before compulsory treatment is given
- whether the necessary clinical assessments have been made
- whether an administrative decision has been made when compulsory treatment is to be provided
- whether the need for compulsory treatment is continuously assessed.

Municipal health and social services for elderly people

As part of our focus on supervision of services for elderly people, in 2010 we carried out a wide range of supervision activities in the municipalities. We will continue with these in 2011.

The themes for supervision are:

- how elderly people with dementia living in their own homes are assessed and followed up by the municipal nursing and care services and by their general practitioner
- how municipal services and general practitioners cooperate and follow up elderly people
- how they ensure that management of medication is adequate
- how they ensure that elderly people have adequate nutrition.

Other themes are:

- municipal rehabilitation services for elderly people
- management of medication for frail elderly people
- allocation of respite care for frail elderly people.

Specialized health services for elderly people

In 2011, the Norwegian Board of Health Supervision will focus on provision of specialized health services for elderly people. We will investigate whether the health trusts, through systematic management, ensure that elderly people who have had a stroke or who have fractured their hip receive sound and adequate services.

These areas have been chosen because they are areas where there is a high risk of deficiencies in the service occurring that can have serious consequences for the patient. In supervision of treatment of stroke, we will focus on the following:

- observation, assessment and treatment during the first 24 hours after admission to hospital
- early rehabilitation
- prevention of complications and another stroke.

In supervision of treatment of fracture of the hip, we will examine:

- waiting time from admission to operation
- use of medication
- treatment of confusion
- nutritional status.

The first supervision of the regulations relating to handling human cells and tissue

In 2010, the Norwegian Board of Health Supervision carried out supervision of the three health trusts that carry out corneal transplantations: St. Olavs Hospital Trust, Bergen Hospital Trust and Oslo University Hospital Trust.

Supervision of handling corneas was chosen as the first area for supervision of cell and tissue banks. There are three institutions that are involved in this area.

We wished to have a common theme for supervision of the three institutions. Since removal of corneas from Norwegian donors is only carried out at Oslo University Hospital, we chose to carry out supervision of import of corneas.

The regulations relating to handling human cells and tissues lay down detailed requirements about how human material shall be packed, marked and transported, so that cells and tissues maintain their characteristics and quality, and so that their origin can be accurately traced. Procedures and documentation shall be in writing. Institutions that receive cells and tissues are required to carry out a documented check that the package meets the requirements in the regulations, and that the content of the package is in accordance with the requisition. The theme for supervision was how the leadership of the institutions plan, organize and manage the tasks associated with this.

Lack of written procedures

We found that all three institutions lacked written procedures and routines for documentation to the extent that is required by the regulations.

All the institutions were small, with few staff who had cooperated closely for a long time in this field. Solid professional skills and long experience often leads to sound practice with a small risk of mistakes occurring. Therefore it is understandable that the staff did not perceive the need for written procedures, as required by the regulations.

However, the institutions did not meet the requirements for written documentation as laid down in the regulations. This means that the risk of mistakes is greater than that which is acceptable according to the regulations. We understand that implementation of new regulations takes time, particularly when they are detailed and comprehensive. We believe that the experience we gained from supervision will help the institutions to understand the importance of meeting these requirements.

The results of supervision do not give us cause for concern about the way in which the institutions handle corneas, but we will follow up these health trusts until everything is in order.

The regulations relating to human cells and tissues came into force in 2008. The aim of the regulations is to define standards for quality and safety when handling human cells and tissue for human use, in order to avoid transmission of disease. The regulations involve donation, selection, testing, conservation, storage, coding, marking, processing and distribution. The regulations require the Norwegian Board of Health Supervision to carry out regular supervision in this area, at least once every two years.

In 2010, about 40 institutions in different areas had authorization from the Norwegian Directorate of Health to handle human cells and tissues for human use.

According to the regulations, institutions must have authorization from the Norwegian Directorate of Health to import human cells and tissues from countries outside the EEA. In 2009, 250 corneas were imported from the USA. Corneas from Norwegian donors were only used in 5 corneal transplantations.

References: REG 2008-03-07 No. 222: Regulations relating to requirements for quality and safety when handling human cells and tissues.

An old activity seen in a new light – supervision in 2010 of organizations that are authorized to deal with corneas etc. for human use in Norway: implementation and experience
Report of the Norwegian Board of Health Supervision 2/2011

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.
More information can be found in our annual reports and on our web site www.helsetilynet.no.

Child welfare services

From 1 January 2010, the Norwegian Board of Health Supervision was given overall responsibility for child welfare services. We present figures for 2010 about some of the tasks of the Offices of the County Governors related to child welfare services.

Tabell 1 Supervision of child welfare institutions in 2010

w	Number of child welfare institutions	Number of departments / units	Number of supervisions required	Number of supervisions carried out	Unnotified supervision
Østfold	13	47	117	106	52
Oslo og Akershus	39	67	230	174	87
Hedmark	15	19	63	47	34
Oppland	6	22	26	26	10
Buskerud	5	12	41	42	19
Vestfold	6	8	37	37	15
Telemark	4	14	52	49	23
Aust-Agder	5	12	48	48	29
Vest-Agder	7	25	66	67	20
Rogaland	15	49	113	111	46
Hordaland	23	47	152	108	33
Sogn og Fjordane	4	8	24	32	10
Møre og Romsdal	5	9	21	23	10
Sør-Trøndelag	15	24	73	73	29
Nord-Trøndelag	7	15	29	24	8
Nordland	6	9	25	23	9
Troms	9	20	89	88	25
Finnmark	2	4	10	10	4
Total	**186**	**411**	**1216**	**1088**	**463**

The Offices of the County Governors carry out supervision of child welfare institutions. They are required to investigate whether children receive sound and adequate care and treatment, and whether children are treated in an appropriate way and with respect for their integrity.

In 2010, the Offices of the County Governors carried out supervision of child welfare institutions on 1088 occasions. Of the 186 institutions where supervision was carried out, 74 were state institutions, 18 were municipal institutions, and 94 were private institutions.

The Offices of the County Governors carried out supervision of care centres for asylum seekers under the age of 18 who are alone on 47 occasions. In addition, supervision was carried out in two centres for parents and children.

As part of supervision of institutions and care centres, the Offices of the County Governors assessed the protocols on use of restraint and coercion, and limitation of rights. Table 2 gives an overview of measures of restraint and coercion that the institutions had recorded in the protocols, and that the Offices of the County Governors checked.

The Offices of the County Governors dealt with complaints from residents in institutions or from their relatives: 311 complaints of the use of restraint and coercion and 51 complaints about other conditions. 88 per cent of the complaints were dealt with within three months.

In 2010, the Offices of the County Governors carried out supervision on 20 occasions of municipal child welfare services.

Table 2 Number of measures of restraint and coercion in child welfare institutions and care centres in 2010

Office of the County Governor	Section 14 body search	Section 16 ransacking	Section 17 confiscation and destruction	Section 18 situation of acute danger	Section 19 bringing back after running away	Section 21 limitation of visits	Section 22 limitation of the use of a telephone	Section 23 limitation of freedom of movement	Section 24 urine test	Other	Total
Østfold	6	45	48	199	4	2	9	3	63	0	379
Oslo og Akershus	182	261	107	419	33	0	80	151	595	1	1829
Hedmark	15	57	11	36	3	66	196	147	173	2	706
Oppland	4	35	13	79	10	1	5	5	45	13	210
Buskerud	33	34	28	110	24	0	11	22	68	0	330
Vestfold	97	120	41	74	22	2	42	105	399	2	904
Telemark	28	23	23	88	3	0	1	7	6	0	179
Aust-Agder	18	24	19	62	15	11	11	36	8	0	204
Vest-Agder	14	12	15	26	20	10	19	43	3	0	162
Rogaland	96	146	81	215	19	5	75	58	188	0	883
Hordaland	213	167	75	301	63	16	56	78	289	2	1260
Sogn og Fjordane	6	21	4	4	5	0	22	19	57	0	138
Møre og Romsdal	49	45	16	75	8	2	28	16	84	4	327
Sør-Trøndelag	10	23	25	82	4	0	17	18	6	21	206
Nord-Trøndelag	25	35	27	79	9	0	4	53	54	38	324
Nordland	37	40	31	156	12	1	33	11	12	0	333
Troms	7	37	23	77	8	0	28	46	15	0	241
Finnmark	0	5	6	20	2	2	2	4	15	0	56
Total	**840**	**1130**	**593**	**2102**	**264**	**118**	**639**	**822**	**2080**	**83**	**8671**

Supervision complaints are about conditions in which children, relatives or others complain about child welfare services, or where the Offices of the County Governors decide to investigate conditions in the services. In 2010, the Offices of the County Governors investigated 682 complaints. In about 200 of these cases, breaches of the regulations were found or the child welfare services were given criticism.

Table 3 Number of cases of complaint dealt with against the child welfare service in the municipality 2010

Office of the County Governor	Supervision complaints	Complaints about administrative decisions	Cases dealt with within 3 months	Cases dealt with: longer than 3 months
Østfold	54	9	9	0
Oslo og Akershus	95	63	44	19
Hedmark	31	12	11	1
Oppland	8	0	0	0
Buskerud	49	18	18	0
Vestfold	41	7	7	0
Telemark	12	6	6	0
Aust-Agder	10	0	0	0
Vest-Agder	30	8	8	0
Rogaland	45	7	5	2
Hordaland	73	24	23	1
Sogn og Fjordane	21	3	2	1
Møre og Romsdal	28	4	4	0
Sør-Trøndelag	56	6	5	1
Nord-Trøndelag	25	1	0	1
Nordland	55	10	9	1
Troms	36	10	10	0
Finnmark	13	0	0	0
Total	**682**	**188**	**161**	**27**

Social services

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

The *Act relating to social services provided by the Norwegian Labour and Welfare Service (Nav)* came into force on 1 January 2010. This Act provides the legislative basis for complaints about social security benefits, training programmes and provision of temporary accommodation. Two-thirds of all complaints regarding provisions in the Social Services Act and the Act relating to social services provided by Nav are about social security benefits.

There has been an increase in the number of complaints regarding provisions in the two acts: 4735 cases in 2010, compared to 4158 in 2009. However, the number of complaints is still low. The Offices of the County Governors dealt with 8935 complaints in 1995.

Complaints regarding provisions in the Social Services Act

Table 4 presents figures for cases in which individuals have complained about a decision that the municipality has taken pursuant to the Social Services Act.

In 2010, the Offices of the County Governors dealt with 1104 complaints about social services (1041 in 2009). Economic assistance for carers was the service that was complained about most, with 388 cases. Practical assistance came next, with 310 cases, of which 156 were about client-managed personal assistance. There were 208 complaints about respite care and 149 complaints about support contacts. In addition, there were 38 complaints about a place in an institution or in sheltered accommodation for people with alcohol and drug problems, and 11 complaints about other social services.

Table 4 Complaints regarding the Social Services Act dealt with by the Offices of the County Governors in 2008-2010 and the result of the cases in 2010. Complaints about social security benefits are not included

	2008	2009	2010		
Office of the County Governor	Cases dealt with	Cases dealt with	Cases dealt with	Reversed	Revoked
Østfold	56	69	85	43	5
Oslo og Akershus	145	195	271	86	8
Hedmark	29	36	36	12	0
Oppland	27	28	22	3	3
Buskerud	63	62	64	21	10
Vestfold	56	43	68	5	16
Telemark	37	55	47	13	9
Aust-Agder	15	20	17	1	2
Vest-Agder	48	44	35	5	11
Rogaland	40	48	60	10	2
Hordaland	89	130	131	12	7
Sogn og Fjordane	54	28	35	6	2
Møre og Romsdal	40	53	39	3	16
Sør-Trøndelag	32	63	37	13	5
Nord-Trøndelag	25	23	32	3	3
Nordland	44	71	43	8	2
Troms	64	57	59	12	6
Finnmark	18	16	23	6	1
Total	**882**	**1041**	**1104**	**262**	**108**

In 2010, the Offices of the County Governors reversed the decisions of the municipalities in 24 per cent of cases (25 per cent in 2009). In ten per cent of cases (15 per cent in 2009), the complaints were revoked, and the cases were returned to the municipalities to be dealt with again. This means that that the Offices of the County Governors' upheld the decisions of the municipalities in two-thirds of cases.

The Offices of the County Governors are required to deal with at least 90 per cent of complaints within three months. In 2010, only 62 per cent of cases pursuant to the Social Services Act were dealt with within the deadline. At the beginning of 2010, there were 421 cases that had not been dealt with, by the end of 2010 there were 335 cases. The Norwegian Board of Health Supervision received one request to re-examine a case of complaint pursuant to the Social Services Act. The decision of the Office of the County Governor was upheld.

Complaints regarding provisions in the Act relating to social services provided by Nav

Table 5 presents figures for cases of complaint regarding social security benefits dealt with by the Offices of the County Governors. In addition, they dealt with 29 cases of complaint regarding training programmes (9 in 2009). Most of the complaints were about rejection of an application for social security benefits, or about the amount, or more specific complaints about expenses for accommodation, clothes, dental treatment, medication, furniture, travelling expenses or other expenses.

Table 5 Complaints regarding social security benefits dealt with by the Offices of the County Governors in 2008-2010

	2008	2009	2010		
Office of the County Governor	Cases dealt with	Cases dealt with	Cases dealt with	Reversed	Revoked
Østfold	236	179	321	32	36
Oslo og Akershus	642	637	684	101	21
Hedmark	182	115	181	30	7
Oppland	123	138	140	8	0
Buskerud	241	190	263	43	21
Vestfold	178	211	202	20	29
Telemark	77	98	95	12	20
Aust-Agder	31	69	78	6	6
Vest-Agder	93	122	124	8	12
Rogaland	157	161	223	9	2
Hordaland	250	234	275	22	20
Sogn og Fjordane	45	35	27	5	1
Møre og Romsdal	117	61	97	6	1
Sør-Trøndelag	135	187	189	19	17
Nord-Trøndelag	60	59	57	2	2
Nordland	87	102	91	15	0
Troms	105	80	131	10	9
Finnmark	50	48	32	8	6
Total	**2809**	**2726**	**3210**	**356**	**210**

Table 6 Number of system audits of services relating to the Social Services Act carried out by the Offices of the County Governors in 2008-2010

Office of the County Governor	2008	2009	2010
Østfold	9	9	3
Oslo og Akershus	22	22	24
Hedmark	9	9	6
Oppland	6	9	6
Buskerud	11	11	9
Vestfold	9	6	6
Telemark	7	7	5
Aust-Agder	9	7	6
Vest-Agder	9	7	6
Rogaland	12	11	8
Hordaland	14	15	9
Sogn og Fjordane	8	7	6
Møre og Romsdal	12	5	11
Sør-Trøndelag	10	9	5
Nord-Trøndelag	6	7	7
Nordland	11	9	7
Troms	8	8	4
Finnmark	7	6	3
Total	**179**	**164**	**132***

* Supervision carried out using different methods than system audits are not included (this is a new in 2010).These are equivalent to the amount of work of 37 system audits. The Offices of the County Governors were required by the Norwegian Board of Health Supervision to carry out 180 system audits in 2010

Table 7 Number of system audits of services relating to the Act Relating to Social Services Provided by the Norwegian Labour and Welfare Service carried out by the Offices of the County Governors in 2010

Office of the County Governor	Number of system audits 2010
Østfold	6
Oslo og Akershus	6
Hedmark	2
Oppland	5
Buskerud	8
Vestfold	6
Telemark	4
Aust-Agder	4
Vest-Agder	4
Rogaland	4
Hordaland	5
Sogn og Fjordane	4
Møre og Romsdal	3
Sør-Trøndelag	6
Nord-Trøndelag	4
Nordland	6
Troms	4
Finnmark	3
Total	**84**

Seven per cent of cases of complaint regarding provisions in the Act relating to social services provided by Nav were reversed, and the cases were returned to Nav to be dealt with again. Eleven per cent of decisions were reversed. This means that the Offices of the County Governors upheld the decisions of Nav in about 4 out of 5 cases.

In 2010, 80 per cent of cases pursuant to the Act relating to social services provided by Nav were dealt with within the deadline of three months.

The Norwegian Board of Health Supervision received one request to re-examine a case of complaint pursuant to the Act relating to social services provided by Nav. The decision of the Office of the County Governor was upheld

Supervision of Social Services

Supervision of social services: the Social Services Act
More than half of the planned supervision of services relating to the Social Services Act carried out in 2010 was part of countrywide supervision of health and social services for elderly people.

Of 132 system audits relating to the Social Services Act, 73 were not part of countrywide supervision.
The themes for these included:

- legal safeguards for people with mental disabilities: 14 system audits
- municipal health services, social services and child welfare services for children: 14 system audits
- social services for alcohol and drug addicts: 11 system audits
- services for people with mental disabilities: 7 system audits
- support person services and respite care services: 4 system audits
- institutions for children and institutions for respite care: 3 system audits

In 99 of the 132 system audits, breaches of laws or regulations were detected.

Table 8 Use of coercion and restraint for people with mental disabilities in 2010. Social Services Act Chapter 4A

	Reports of measures to limit harm in acute situations		Decisions reassessed by the Offices of the County Governors			Number of dispensations granted for the requirement regarding the qualifications of staff	Number of local supervisions
Office of the County Governor	Number of reported decisions	Number of people the reports relate to	Number of administrative decisions approved	Number of measures of restraint and coercion approved	Number of people with an administrative decision per 31.12.2010		
Østfold	250	60	18	21	18	14	9
Oslo og Akershus	3654	295	146	200	139	121	35
Hedmark	296	38	55	83	55	54	15
Oppland	336	45	46	59	46	44	21
Buskerud	1323	63	58	92	58	38	16
Vestfold	822	36	33	43	33	28	4
Telemark	208	34	13	48	13	11	0
Aust-Agder	260	24	8	13	8	4	2
Vest-Agder	242	44	44	69	44	16	4
Rogaland	3123	126	84	105	84	74	16
Hordaland	290	86	130	226	110	87	23
Sogn og Fjordane	554	32	26	37	17	7	9
Møre og Romsdal	4053	45	53	143	51	59	5
Sør-Trøndelag	1110	53	32	46	30	8	9
Nord-Trøndelag	267	10	61	85	36	123	11
Nordland	305	43	46	60	46	35	22
Troms	1618	29	44	58	42	21	12
Finnmark	858	13	5	7	5	29	16
Total	**19 569**	**1076**	**902**	**1395**	**835**	**773**	**229**

Supervision of social services: the Act relating to social services provided by Nav

The Act relating to social services provided by Nav, which came into force on 1 January 2010, includes social security benefits, training programmes and temporary accommodation. This act is a new area of supervision for the Offices of the County Governors.

The Offices of the County Governors carried out 84 system audits relating to the Act relating to social services provided by Nav (Table 7). In 70 of these, breaches of the legislation were found. Twelve system audits were carried out relating to both this act and other acts.

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.

In 2010, 19 569 measures taken to avoid injury in emergency situations were registered for 1076 persons (20 313 for 1089 persons in 2009). These include measures that were not regulated in administrative decisions.

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, before they can be implemented.

In 2010, the Offices of the County Governors authorized 1395 measures, which were regulated by 902 administrative decisions. 36 measures were not authorized.

In 2010, the Offices of the County Governors approved 773 applications for dispensation from the requirement regarding the qualifications of staff. 17 applications were rejected.

Despite the use of restraint and coercion, there are few complaints in this area. In 2010, the Offices of the County Governors dealt with one complaint regarding a measure to avoid injury in repeated emergency situations. One complaint was dealt with by the County Committee for Child Welfare and Social Affairs.

On 229 occasions, the Offices of the County Governors carried out local supervision.

Health Services

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

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

Table 9 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 2008-2010

Provision	Provision regarding:	2008[2]	2009[2]	2010	
		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	65	83	71	32
Section 2-1 second paragraph	The right to required health care from specialized health services	194	168	217	85
Section 2-2	The right to an assessment within 30 workdays	10	11	19	15
Section 2-3	The right to a reassessment	6	8	4	0
Section 2-4	The right to choose hospital	14	10	22	10
Section 2-5	The right to an individual plan	13	8	11	8
Section 2-6	The right to transport to health services	303	244	405	72
Chapter 3	The right to participation and information	50	49	70	25
Chapter 4	Consent to health care / the right to refuse health care	7	1	6	3
Chapter 4A compulsory treatment	admission/prolonged stay in a health institution (new from 2009)	–	6	5	1
Section 5-1	The right of access to medical records	28	30	34	18
Health Personnel Act					
Sections 42. 43 and 44, **pursuant to the Patients' Rights Act, Sectio**n 5-2	The right to correct and delete medical records	33	21	32	15
Municipal Health Services Act					
Section 2-1	The right to required health care	142	148	144	66
Dental Health Services Act					
Section 2-1	The right to required dental care	0	3	3	2
Other sections that give the right to health services		1	7	8	5
Total number of assessments of specific provisions 1		**866**	**797**	**1051**	**357**
Number of cases[1]		**771**	**705**	**911**	
Number of cases rejected[3]		**63**	**71**	**63**	

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 that are obviously groundless or out-dated are rejected.

Health Supervision in the County can assess all aspects of the case, and their decision is final.

Up until 2007, the number of complaints regarding failure to meet people's rights to receive health services increased. In 2008 and 2009 the number of complaints went down by ten per cent each year, but in 2010 there was a marked increase to 1070 new cases of complaint. This is 16 per cent more that in 2007 – the highest year previously.

The Norwegian Board of Health Supervision in the Counties did not manage to deal with the growing number of new cases in 2010. The number of cases waiting to be dealt with increased from 155 at the beginning of the year to 251 at the end of the year.

In 2010, the Norwegian Board of Health Supervision in the Counties completed 974 cases of complaint regarding patients' rights. In 39 per cent of cases 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 2009 (37 per cent) and in 2008 (36 per cent).

In 2010, 44 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 complaints went down markedly in 2008 and 2009, but increased again in 2010.

In 2010, the Norwegian Board of Health Supervision dealt with six requests to re-examine decisions made by the Norwegian Board of Health Supervision in the Counties about complaints. In 2 cases the decision was in favour of the patient.

The Norwegian Board of Health Supervision dealt with three cases in which the Norwegian Board of Health Supervision in the County had rejected complaints about patients' rights. The decision was in favour of the complainant in one of these cases.

Table 10 Supervision of health services. Number of system audits carried out by the Norwegian Board of Health Supervision in the Counties in 2008-2010

Norwegian Board of Health Supervision in the County	2008	2009	2010
Østfold	15	15	6
Oslo og Akershus	32	33	29
Hedmark	12	12	6
Oppland	16	15	12
Buskerud	13	17	10
Vestfold	20	13	13
Telemark	14	13	6
Aust-Agder	13	13	7
Vest-Agder	14	13	7
Rogaland	20	18	16
Hordaland	26	21	20
Sogn og Fjordane	12	12	7
Møre og Romsdal	17	17	15
Sør-Trøndelag	15	14	16
Nord-Trøndelag	10	13	7
Nordland	16	17	11
Troms	16	13	13
Finnmark	12	11	6
Total	**293**	**280**	**207***

* Supervision carried out using different methods than system audits are not included

Supervision of health services

In 2010, the Norwegian Board of Health Supervision in the Counties carried out 207 system audits: 141 in municipalities and 66 in specialized health services (see Table 10). Breaches of the legislation were found in 144 of the 207 system audits.

In addition they carried out other types of supervision on 230 occasions.

Per 31 December 2010, there were still open nonconformities (breaches of laws or regulations that had not been corrected) from 65 system audits of health services carried out in 2009 or earlier.

Issuing instructions, giving coercive fines and closing services

In 2010, the Norwegian Board of Health Supervision issued instructions to municipalities pursuant to the health legislation.

In December 2010, Helse Førde Health Trust was issued with instructions because the ambulance service did not meet the legislative requirements, and they were warned that they would be given a coercive fine if they did not correct the nonconformity.

Vestre Viken Health Trust was warned that they would be issued with instruction if they did not correct breaches of the legislation. The health trust corrected the nonconformities, and it was not necessary to issue instructions.

In addition, instructions were issued to several services that did not reply to the supervision authorities about matters regarding supervision.

Table 11 Use of coercion and restraint for people who do not have the ability to give consent and who refuse health care. 2009 and 2010

Year	Number of decisions[1]	Number of decisions revoked	Number of decisions reversed	Number of decisions lasting more than 3 months
2009	1687	125	2	1050
2010	2075	157	27	1254

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

Use of coercion and restraint for people who do not have the ability to give consent

Chapter 4A in the Patients' Rights Act, which came into force on 1 January 2009, relates to health care for people who do not have the ability to give consent and who refuse health care.

The health services are required to make administrative decisions about use of coercion and restraint, and to send a copy of the administrative decision to the Norwegian Board of Health Supervision in the County. In 2010, the Norwegian Board of Health Supervision in the Counties received 2075 copies of decisions (see Table 11).

Table 12 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. 2008-2010

Norwegian Board of Health Supervision in the County	Number of completed cases			Percentage of cases that took more than 5 months in 2010
	2008[1]	2009[1]	2010	
Østfold	222	179	169	50 %
Oslo og Akershus	392	329	391	45 %
Hedmark	114	122	132	66 %
Oppland	51	52	80	50 %
Buskerud	116	113	129	50 %
Vestfold	62	96	90	20 %
Telemark	62	75	98	27 %
Aust-Agder	42	37	39	51 %
Vest-Agder	64	68	83	29 %
Rogaland	105	103	80	48 %
Hordaland	205	185	227	44 %
Sogn og Fjordane	54	65	58	10 %
Møre og Romsdal	92	130	71	48 %
Sør-Trøndelag	120	112	112	25 %
Nord-Trøndelag	77	72	90	72 %
Nordland	110	86	181	45 %
Troms	92	83	93	38 %
Finnmark	26	63	52	12 %
Total	**2006**	**1970**	**2175**	**43 %**
In addition: cases completed without being assessed[2]	290	289	352	
Number of cases rejected[3]	120	143	193	

[1] The figures are slightly different from previously published figures, because the figures are corrected when inaccuracies are detected.
[2] Cases completed by requesting the person who was complained against to contact the complainant in order to find an amicable solution
[3] Cases that are obviously groundless or out-dated are rejected.

Table 13 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. 2008-2010

Legislative basis Provisions in the Health Personnel Act	2008[1]	2009[1]	2010
Section 4. Sound professional standards: behaviour	247	201	245
Section 4. Sound professional standards: examination, diagnosis and treatment	1522	1716	1670
Section 4. Sound professional standards: medication	215	228	230
Section 4. Sound professional standards: other	279	291	301
Section 7. Emergency treatment	34	38	34
Section 10. Information	83	103	104
Section 16. Organization of the services	199	192	144
Chapters 5 and 6. Duty of confidentiality, right of disclosure, duty of disclosure	117	115	157
Sections 39-41. Patient records	255	233	316
Section 57. Fitness to practice: alcohol and drug abuse	50	44	47
Section 57. Fitness to practice: other reasons	56	67	63
Provisions in the Specialized Health Services Act			
Section 2-2. Duty of sound professional standards	573	587	703
Other legislative basis for assessment	**626**	**583**	**683**
Total number of provisions as legislative basis[2]	**4256**	**4398**	**4697**
Number of cases assessed[2]	**2006**	**1970**	**2175**

[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.

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.

Table 14 Number of supervision cases completed by the Norwegian Board of Health Supervision and number of administrative reactions. 2002-2010

Year	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
2010	255	103	347

Experience from the first two years shows that about 60 per cent of the decisions require a response from the Norwegian Board of Health in the Counties to the municipality/ health service, in the form of advice and guidance.

The Norwegian Board of Health Supervision in the Counties received 21 complaints about administrative decisions made by the health services. The administrative decisions were upheld in 18 of these cases.

Supervision cases (individual cases) in the health services

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

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

In 2010, the number of new cases per 100 000 inhabitants ranged from 29 in Rogaland to 93 in Troms. For the whole country, there were 2781 new supervision cases: 57 cases per 100 000 inhabitants, 309 cases more than in 2009, an increase of 13 per cent.

Table 15 Administrative reactions given to health care personnel by the Norwegian Board of Health Supervision in 2009 and 2010

	Warning		Loss of authorization or licence		Loss of the right to prescribe addictive medication		Limited authorization or licence (Section 59)		Limited authorization or licence (Section 59a)		Loss of authorization as a specialist		Total	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
Doctor	64	53	28	27	3	8		2	5	8	2		102	98
Dentist	1	4	4	3									5	7
Psychologist	2	5	1	6				1					3	12
Nurse	6	11	44	43			1		1				52	54
Auxiliary nurse	1	1	19	23					2				22	24
Social educator	1		4	5									5	5
Midwife	3	2	1	2									4	4
Physiotherapist	1			3				1		1			1	5
Other groups	6	4	7	7									13	11
Unauthorized	4	8											4	8
Total	**89**	**88**	**108**	**119**	**3**	**8**	**1**	**4**	**8**	**9**	**2**	**0**	**211**	**228**

The number of supervision cases being dealt with by the Norwegian Board of Health Supervision in the Counties increased from 990 at the end of 2009 to 1051 at the end of 2010. This represents an increase of 6 per cent.

The requirement concerning the length of time taken to deal with a case is that more than half of the cases shall be dealt with within five months. This requirement was met in 15 of the county offices in 2010 (Oslo and Akershus count as one office). The requirement was met for the country as a whole, since 57 per cent of all cases were dealt with in less than five months.

Supervision cases are often complex, and each case has on average 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.

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. 347 cases were dealt with in 2010. 255 administrative reactions were given, 27 to institutions and 228 to health care personnel. No administrative reaction was given in 103 cases.

114 health care personnel lost 119 authorizations/licences. Most cases of withdrawal of authorization were related to misuse of alcohol and drugs. There was a small increase in the number of health care personnel who lost their authorization because of sexual conduct with a patient: from 11 to 16.

Table 16 Reason for withdrawal of authorization in 2010, according to health care personnel group

	Nurse	Auxiliary nurse	Doctor	Other	Total
Misuse of alcohol or drugs	32	13	10	9	64
Illness	1			3	4
Sexual misconduct with a patient	3	1	8	4	16
Behaviour		7	2	6	15
Unsound professional practice	4	2	2	1	9
Failure to comply after a warning	1		2	3	6
Authorization lost in another country	2		3		5
Total	**43**	**23**	**27**	**26**	**119**

22 health care personnel had their authorization/licence suspended while their cases were being dealt with. Suspension of authorization was extended for 2 health care personnel. Three doctors had their right to prescribe addictive medication withdrawn.

The Norwegian Board of Health Supervision received notification from 19 health care personnel that they voluntarily renounced their authorization. Four doctors voluntarily renounced their right to prescribe addictive medication.

In 2010, the Norwegian Board of Health Supervision sent 76 cases of complaint to the Norwegian Appeals Board for Health Personnel (62 in 2009). The Appeals Board upheld the decision of the Norwegian Board of Health Supervision in 50 of these cases. Fourteen decisions were reversed and one decision was partially reversed.

The Norwegian Board of Health Supervision applied for prosecution in eight cases in 2010. We concluded that there were no grounds for applying for prosecution against health care personnel or organizations in 9 cases. We reported three health care personnel to the police on the basis of suspicion of a punishable offence.

The Norwegian Board of Health Supervision dealt with 60 applications from health care personnel who had previously lost their authorization. 16 health care personnel were granted new authorization without limitations. Six applicants were granted limited authorization to practice under specified conditions.

The Norwegian Board of Health Supervision dealt with five applications for the right to prescribe addictive medication from health care personnel who had previously lost this right. Four of these applications were granted and one was rejected.

In 2010, the Norwegian Board of Health Supervision dealt with 38 cases against institutions. In 27 of these cases, breaches of health legislation were detected. In 13 cases, we found breaches of the requirement to provide information to the supervision authorities. In 11 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 the Norwegian Board of Health Supervision (the central office) is relatively small in relation to the total number of completed cases.

In 2010, the Norwegian Board of Health Supervision dealt with 347 cases (301 in 2009). The median time taken to deal with a case was 5.4 months.

From 1 June 2010, individual supervision cases have been dealt with by a separate call-out group for investigation of serious adverse events.

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.

2059 reports of adverse events were registered in the database in 2009 (1286 in 2008). One-third of the reports (32 per cent) were reports of serious injury, and just under one half (46 %) were reports of incidents that could have led to serious injury. 443 reports of unnatural death were registered in 2009 (22 per cent of all reports).

14 per cent of reports registered in 2009 (298 reports) were associated with the use of medication. Examples of such incidents are incorrect dose, incorrect method of administration, incorrect type of medication, wrong patient, and unexpected effect of the medication.

8 per cent of reports registered in 2009 (155 reports) were reports of events associated with birth. In 46 per cent of these, the mother was injured, and in 17 per cent the child was injured. There were 45 reports of unnatural death of the child during birth or death of the foetus before birth.

24 per cent of reports registered in 2009 (486 reports) were reports of events that occurred in mental health care. 127 reports of suicide and 177 reports of attempted suicide and self-inflicted injuries were registered.

Accounts and personnel

The budget for 2010 for the Norwegian Board of Health Supervision was NOK 95.3 million for expenses and NOK 3.9 million for income. The result was NOK 93.3 million for expenses and NOK 4.1 million for income.

The number of employees, calculated as man-labour years, in the Norwegian Board of Health Administration at the end of 2010 was 102.

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