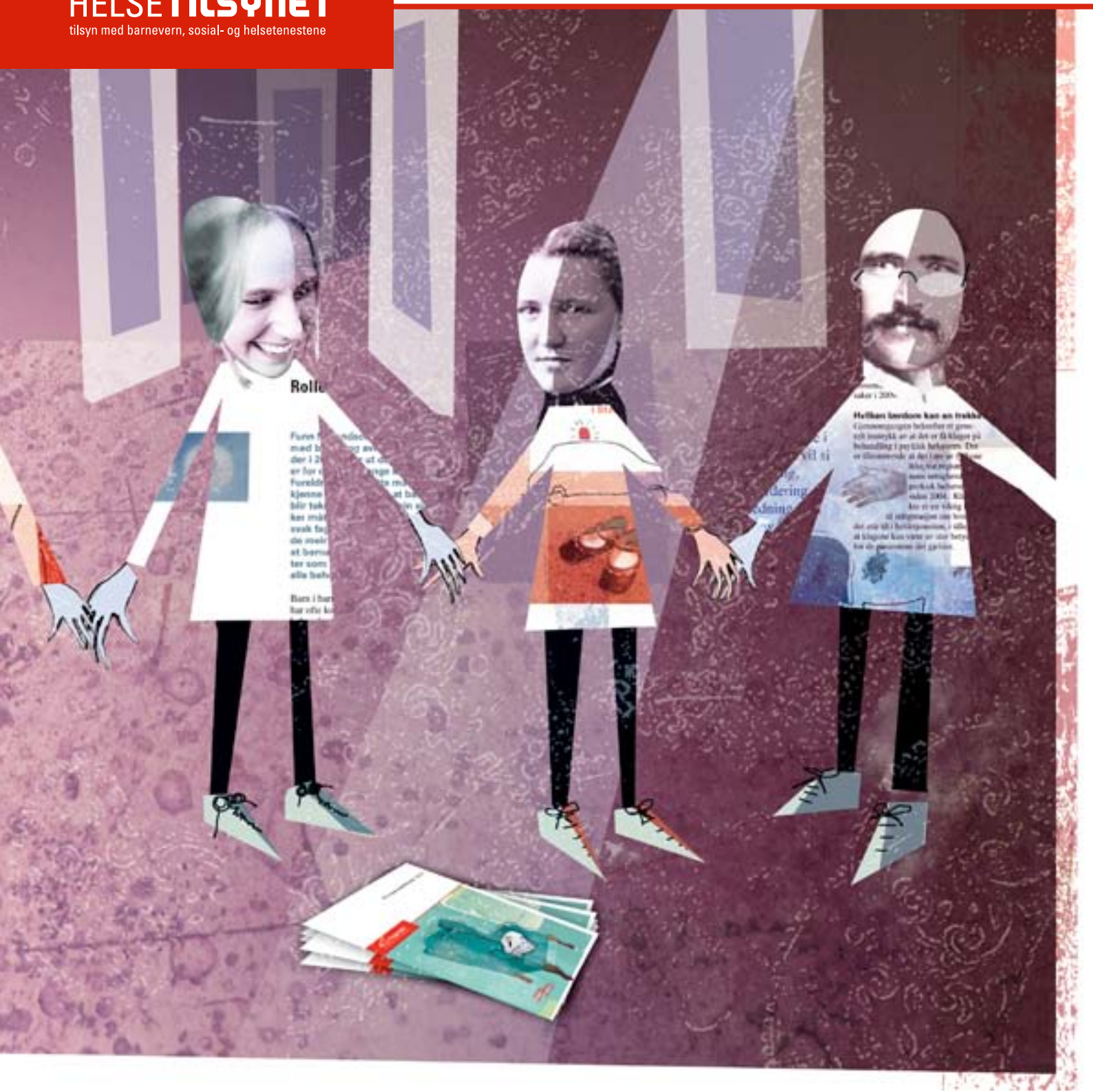
Annual Supervision Report **2011**

HELSETILSYNET
tilsyn med barnevern, sosial- og helsetenestene



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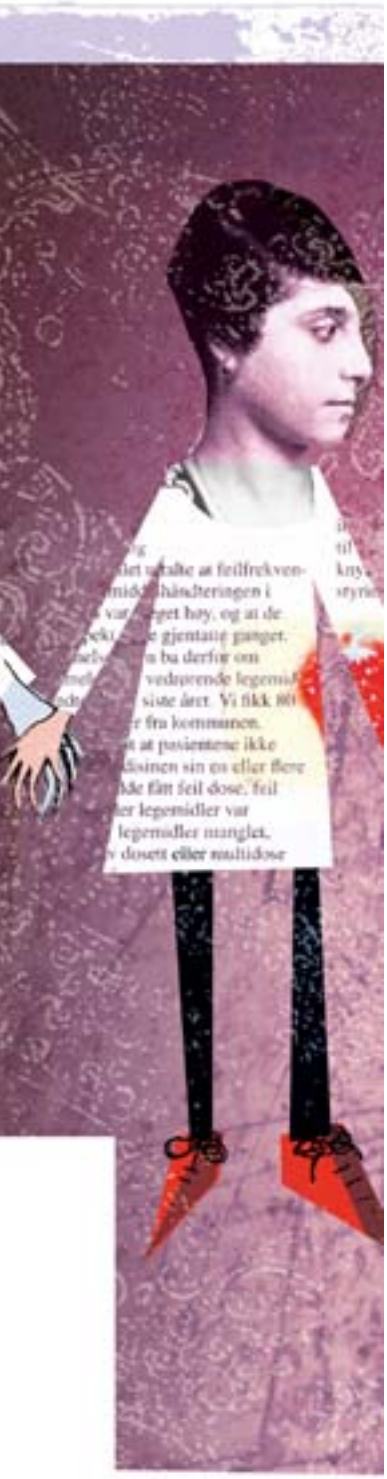

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Living with **conflicts**

Many of the cases we deal with in the Norwegian Board of Health Supervision are controversial. Our work and the decisions we make are discussed in many connections. This is how it should be, if a supervision authority can expect its work to have effect. However, for the Norwegian Board of Health Supervision, 2011 was a rather special year, because much of the public debate was not just about the cases we were dealing with, but also about the way in which we carry out supervision. Much of this was about how clients, relatives and service providers can be involved in our work.

This is an important discussion. On the one hand we shall work to improve safety and to improve the quality of the services that patients and clients receive. This is the core of all supervision activities. Supervision also leads to increased transparency regarding deficiencies in service provision. We believe that, in the long run, this helps to increase the trust that users have in the services.

> "On the one hand we shall work to improve safety and to improve the quality of the services that patients and clients receive."

On the other hand, through our work we shall ensure that personnel have legal protection. This is not only important for personnel themselves, but also in order to ensure that welfare services in Norway have personnel who dare to do their best for clients and patients, even when they are faced with difficult and complicated challenges. Without bold professionals, who daily manage to meet challenges and problems with human warmth and professional skill, the safety and quality of the services would soon be compromised.

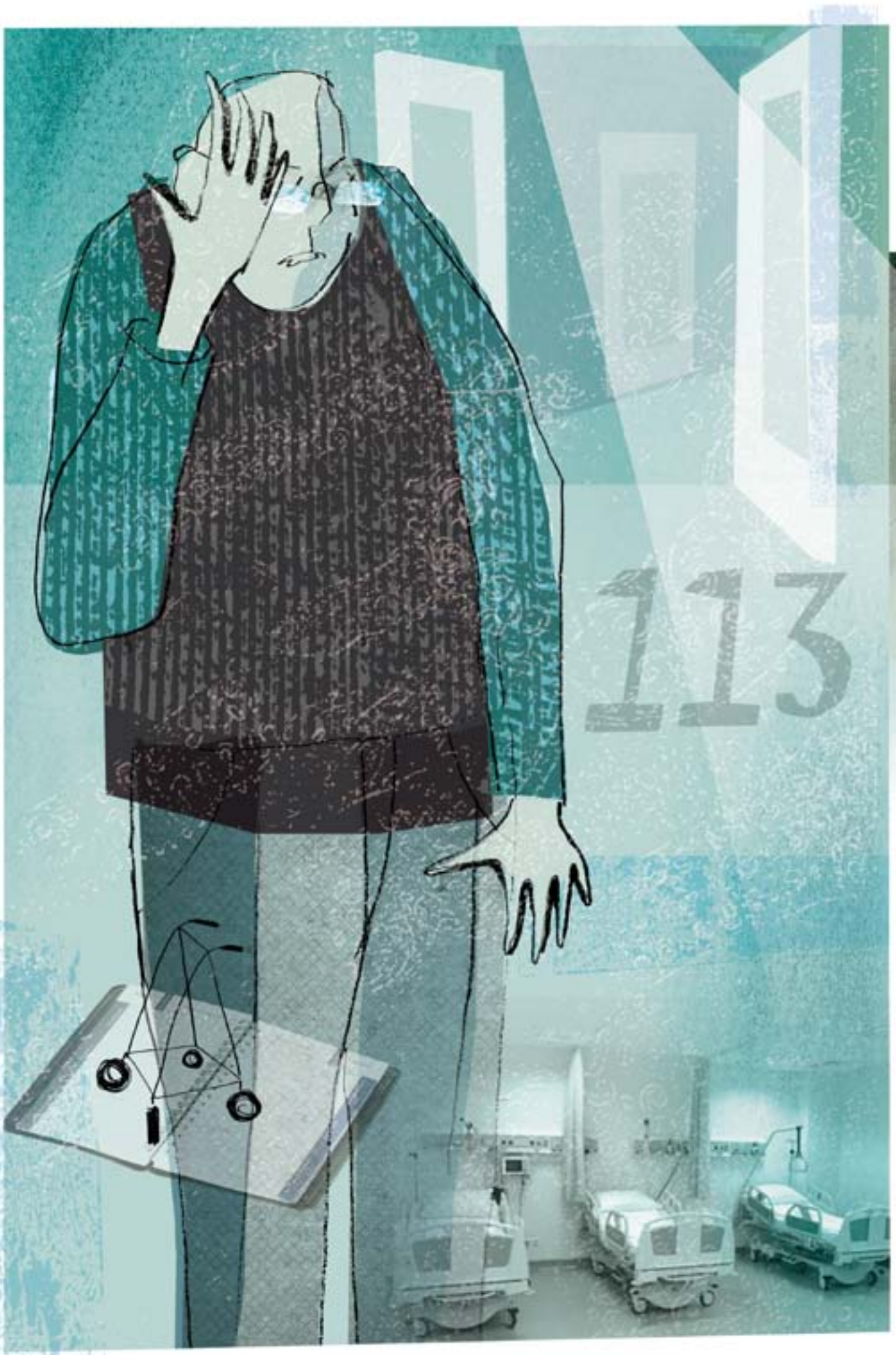
The requirements laid down in the legislation, and the state budget, form the basis for all the work of the Norwegian Board of Health Supervision. In the legislation we find the norms that form the basis for our supervision. The legislation and the annual state budget provide the framework for our activities. We see that much of the previous debate is not only about the kind of supervision we carry out, but also about the expectations that people have of a supervision authority.

From 2012, the requirements relating to provision of health and welfare services have been substantially changed. We are pleased that these changes have made the requirements for sound and adequate services clearer. The requirement to provide sound and adequate services is not just about a minimum standard, but also about guidelines for how services should be. This is important, both for those who are responsible for the services, and for supervision. It also provides a great challenge for the central authorities to clarify what are legitimate expectations of welfare services at any given time. The clearer the requirements are, the clearer and more forceful supervision can be.

Requirements for service provision and supervision are continually changing. The debates in society indicate the direction of these changes. Without doubt, both service receivers and service providers demand to be heard in these debates. However, it is the state authorities that at any given time must decide what patients and clients have the right to receive. This is how it has to be in a democratically governed system for providing services. But we can be fairly certain that tension will always exist between individual demands and collective provision.

In the centre of this field of tension, supervision is seen as a mediator. We take this role seriously, for example by continuously developing supervision so that we always work according to the requirements laid down by the superior democratic bodies. But it is also a role that means that we must live with conflicts around us. Even if we cannot always resolve these conflicts, they give us useful experience to take with us in developing our activities.

Lars E. Hanssen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When elderly people have a stroke: do they receive **adequate treatment?**

Since 2009, the Norwegian Board of Health Supervision has focussed on supervision of services for elderly people. Treatment of patients over 80 years of age who have had a stroke was therefore chosen as a theme for countrywide supervision of specialized health services in 2011.

Adequate treatment of frail, elderly patients with acute disease demands a comprehensive approach, with a thorough assessment of their medical needs, nutritional status, level of functioning, coping and need for assistance. While they are receiving acute treatment, early mobilization and other appropriate rehabilitation must be initiated. Systematic inter-disciplinary cooperation is therefore essential in all phases of treatment. Studies, including studies from Norway, have shown that such an approach in the case of acute disease increases the chance that patients will survive, that their functioning is restored, and that they manage to cope in their own home.

A basic principle for treatment of stroke is that rehabilitation and training must be initiated at the same time as acute observation, assessment and treatment.

In order provide adequate care for frail elderly people who have had a stroke, inter-disciplinary treatment in all phases of treatment is necessary. Usually the following types of health personnel are needed: senior consultant (neurologist, geriatrician, specialist in internal medicine), nurse (stroke nurse), physiotherapist, occupational therapist and speech therapist. The level of staffing must be adequate for the tasks that need to be performed, 24 hours a day, in holiday periods and on public holidays. If other members of staff need to take over the tasks of staff with special qualifications or skills, they must receive adequate training.

We investigated whether specialized health services are managed in such a way that elderly patients who have had a stroke receive adequate treatment. We focussed on areas which can have serious, negative consequences for this group of patients if services are inadequate.

> "Early mobilization is very important for the survival of patients who have had a stroke"

Altogether, 17 health trusts and 29 health institutions, including one private hospital, were included in the supervision. The reports of this supervision are available on our website: www.helsetilsynet.no.

We found breaches of the legislation in nine health institutions. We did not find breaches of the legislation in the other 20 health institutions, but we identified areas with potential for improvement in eight of them.

These findings may be an indication that not all vulnerable, elderly patients who have had a stroke receive adequate hospital treatment.

Observation and assessment during the first 24 hours – a critical phase

The first 24 hours are the most critical for many patients who have had a stroke, and there are many things that must be observed, assessed and investigated. Therefore, hospitals must have routines for allocating responsibility for different tasks and for ensuring that different health personnel cooperate with each other. For example, the following must be monitored and assessed: vital bodily functions, blood supply to the brain (using CT/MR), neurological status, swallowing function, and language and speech.

We found that many stroke patients were not followed up quickly enough by specialized personnel when they had to wait a long time in the emergency unit or in other units before being transferred to the stroke unit. In the stroke unit we also found that routines for distribution of tasks were lacking, and that observation and investigation were not adequately carried out. For example, vital functions were not assessed systematically. It was not clear who should examine neurological status. Standard methods for examination were not used. Swallowing was not assessed systematically. In many units, language and speech were not adequately followed up because of lack of qualified personnel, unclear allocation of responsibility, and inadequate routines for referral.
The following are examples of our findings:

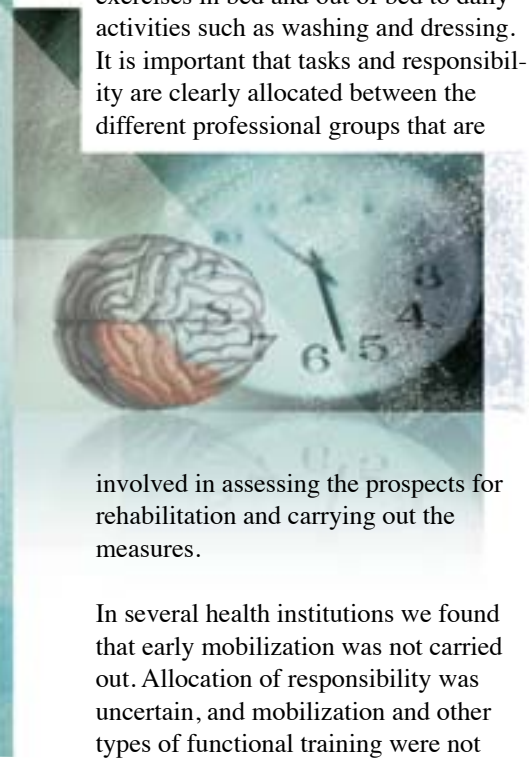
"It is not clear how often blood pressure, pulse, temperature and oxygen saturation should be measured in the unit."

"Testing of swallowing and documentation of this are not always carried out in line with standard procedures."

"At the moment the hospital does not have a speech therapist. There is no system for ensuring that the needs of patients who have speech difficulties are met".

Early mobilization and rehabilitation are important for future quality of life

Early mobilization is very important for the survival of patients who have had a stroke, and is the first measure in the rehabilitation process. The hospital must have a programme for mobilization of patients, which can be adapted to each patient's individual situation, and which can be carried out at weekends, in holiday periods and on public holidays. Early mobilization can range from simple exercises in bed and out of bed to daily activities such as washing and dressing. It is important that tasks and responsibility are clearly allocated between the different professional groups that are involved in assessing the prospects for rehabilitation and carrying out the measures.



In several health institutions we found that early mobilization was not carried out. Allocation of responsibility was uncertain, and mobilization and other types of functional training were not carried out inadequately at weekends and in holiday periods, because of lack of capacity and too few personnel with the relevant skills.

Examples of our findings:

"Early mobilization is not carried out routinely and is at times dependent on when the patient is admitted. The number and availability of staff with relevant skills for carrying out early mobilization varies a lot in holiday periods and on public holidays."

"We were told that staff do not have time to carry out adequate mobilization and task-related functional training."

Is it important how treatment of stroke is organized?

The health trusts organized treatment of elderly people with stroke in different ways. We investigated whether the health trusts ensure that elderly stroke patients receive adequate treatment and rehabilitation, independently of whether they were treated in a stroke unit or in another department.

Our findings showed that for patients who were not admitted to a stroke unit, either because of lack of capacity, or because the health institution did not have a stroke unit, there was a risk that health care was not adequate. Among other things, in several places it was pointed out that personnel in other departments had not received adequate training in several of the standard procedures for observation and assessment of stroke patients, and that several types of examination were not carried out. It was also pointed out that early mobilization was not focussed on in the same way, and that inter-disciplinary cooperation was inadequate. The leadership had not assessed the risk of patients receiving inadequate treatment if they were admitted to other departments.

Stroke units

In the national guidelines from the Norwegian Directorate of Health, a stroke unit is defined in the following way:
organized treatment of stroke patients in a separate unit with permanent beds, manned by inter-disciplinary, specially qualified personnel, and with a standard programme for diagnosis, observation, acute treatment and early rehabilitation.

Facts about stroke

The World Health Organization (WHO) defines stroke as "an acute disturbance in the functioning of the brain, caused by interruption of the blood supply, that lasts more than 25 hours or leads to death. About 85 % of strokes are caused by cerebral infarction (interruption of the blood supply to the brain) and about 10 % by cerebral haemorrhage (bleeding in the brain)

65 % of the 15 000 cases of stroke in Norway each year affect people over 75 years of age. Stroke is the third most common cause of death and the most common cause of functional disability among elderly people.

Mortality during the first month is 15–20 %. About one third of those who survive have a serious functional disability, which makes them dependent on help with daily tasks. Later effects of stroke can be lameness in different parts of the body, speech difficulties and mental confusion.

Treatment of stroke in 2011: Much is positive, but this is still a vulnerable area in some health trusts

In two thirds of the health institutions, no breaches of the legislation were found. This indicates that specialized health services generally provide adequate treatment for elderly stroke patients. Experience from supervision indicates that many health trusts give sufficient priority to this vulnerable area. The work of professionals in this area may have contributed to this, for example, the development of national guidelines.

Acute treatment of stroke is demanding. Many professional groups need to cooperate, and many measures must be implemented and followed up at the same time. In order for all stroke patients to receive adequate treatment, some health trusts need to increase the capacity for specialized treatment of stroke, and to ensure that inter-disciplinary cooperation functions better. This requires stronger management. Relevant information must be obtained to assess the risk of inadequate health care and to evaluate it.

Coercion when providing health care in nursing homes

Many patients in Norwegian nursing homes have dementia or other types of cognitive disorder. This may mean that they cannot manage to assess their own needs for health care, and they may refuse to accept health care. In many nursing homes, much is done to ensure that patients receive the care they need, but we have found that managers and staff lack basic knowledge about what they should do if patients refuse help.

In 2011 the Norwegian Board of Health Supervision carried out countrywide supervision of the use of coercion when providing health care for patients in nursing homes, in accordance with the Patients' and Consumers Rights Act, Chapter 4A. This provision gives rules for when coercion can be used to provide somatic health care, and how this can be done.

> "The risk of taking wrong decisions can be reduced"

When patients in nursing homes refuse to accept health care, the staff must assess whether the patients understand the consequences. Many patients who live in nursing homes are not always able to understand this, and may not be capable of giving informed consent. Therefore, the nursing home staff must assess whether the regulations relating to the use of coercion apply for the residents. The aim of the legislation is to ensure that patients who are not capable of giving informed consent, and who refuse to accept health care, receive essential health care, and are not exposed to unlawful coercion.

The use of coercion to provide health care is an area of special risk, because the consequences of the assessment and the decisions that are taken are important for each patient. Wrong decisions can have serious consequences: either that unlawful coercion is used, or that patients do not receive essential health care. The risk of taking wrong decisions can be reduced if the nursing home and health care personnel are prepared for different situations.

In 2011, we carried out supervision of nursing homes in 43 municipalities and urban districts throughout the whole country. We investigated whether the municipalities ensure that services in nursing homes are provided, managed and improved in accordance with the statutory requirements. Supervision was not about how health care personnel carry out their work. Supervision will continue in 2012, and a national report will be published early in 2013.

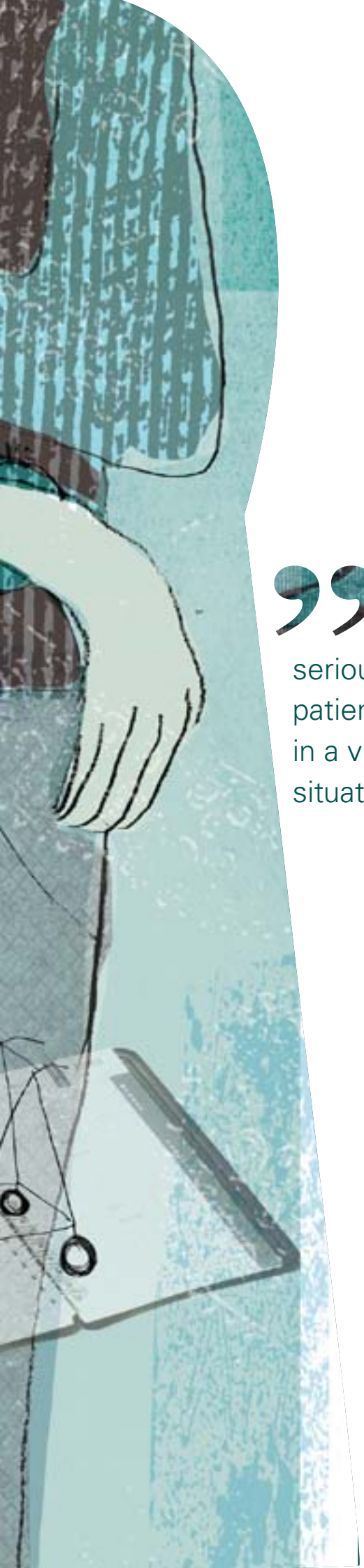
We investigated whether the municipalities ensure that the nursing homes:

- identify patients who refuse to accept health care, and assess their capability to give informed consent
- use measures to gain the patients' trust before they use coercion to provide health care
- assess whether appropriate health care can be provided using coercion.

The findings from supervision

We found that nearly all the managers and staff in the nursing homes lacked knowledge about the legislation. They thought that the legislation was complicated. They were also uncertain about what informed consent is, and whether the capability to give informed consent is permanent, or something that must be assessed all the time. In many nursing homes, the staff did not know how to assess capability to give informed consent, or who was responsible for doing this.

In nursing homes in which staff training was provided, the training was either not adequate, or was not carried out for all of the staff. In many cases, the managers did not have an overview of the knowledge and skills of the staff in this area, or whether information that they had been given had been understood. In some



nursing homes, necessary training had not been given. The theme coercion was rarely discussed in staff meetings or in other relevant meetings. In one nursing home, we were told that it was often up to each individual member of staff to find out how the regulations relating to use of coercion should be followed.

Staff in most of the nursing homes tried to avoid using coercion, and they spent a lot of time on measures to increase patients' confidence so that use of coercion should not be necessary. At the same time, not all the staff knew that essential health care must be provided if it is necessary to avoid damage to health, even if the patient resists treatment.

> "This is serious for patients who are in a vulnerable situation"

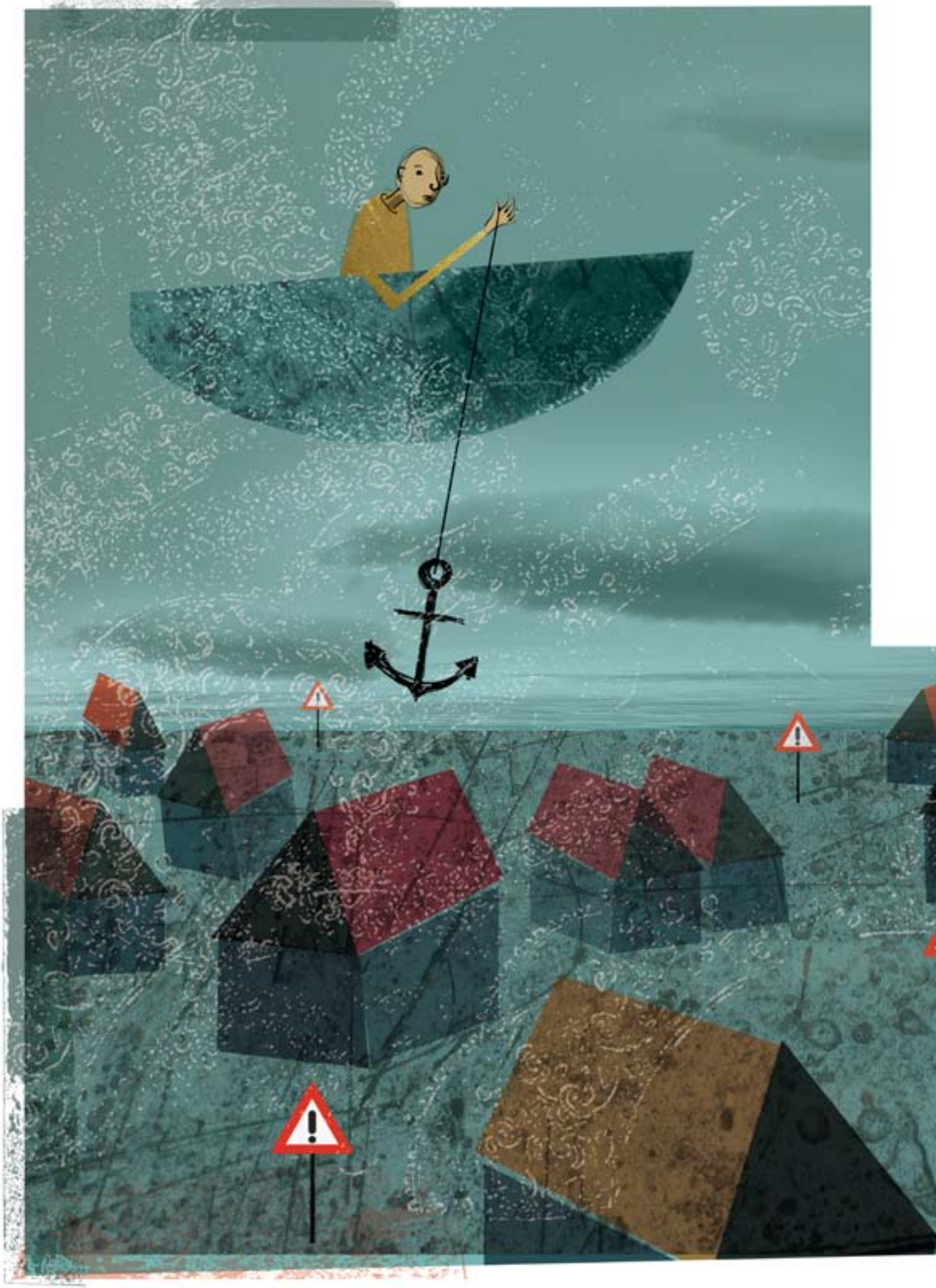
The result of lack of knowledge about the regulations was that in many nursing homes coercive measures were used even though an administrative decision had not been taken. In some nursing homes, alarm systems were used without consent, and without an administrative decision being taken. We found that pills were crushed up in food, sedatives were given to patients who resisted help with personal care, and bedrails were used, without checking whether these measures complied with the regulations.
An important aim of this supervision was to find out whether the municipalities managed and controlled the services in such a way as to ensure that requirements for legal safeguards, patient safety and adequate services were met. Important factors to prevent deficiencies in the services are: clear allocation of responsibility, adequate numbers of qualified staff, clear routines that are known by the staff, arrangements to detect vulnerable areas, and adequate follow-up by the management.

The Norwegian Board of Health Supervision in Rogaland summarized supervision in one of the municipalities in the county in the following way:

«In several cases, health care is provided despite resistance from the patient, without an administrative decision having been taken. Use of coercion is not always recorded in the patient records. Deficiencies are not detected by the municipality's quality control system or by other internal control measures. Therefore, measures to correct these deficiencies are not implemented.»

Supervision will continue in 2012

The area we investigated is an area in which there is a high risk of deficiencies occurring, as shown by the many breaches of the legislation that we detected. This is serious for patients who are in a vulnerable situation. The potential for improvement is therefore correspondingly high when the deficiencies are corrected. There is also potential for improvement in municipalities where supervision was not carried out, if they examine whether coercion is used and how it is done in their nursing homes. Supervision will continue in 2012. The Norwegian Board of Health Supervision encourages the municipalities to examine their services, and to be willing to learn from the mistakes of others.



Children receiving child welfare services **are not heard**

A finding from countrywide supervision in 2011 of municipal child welfare services was that children are given too few opportunities to talk with the staff. In many municipalities, whether or not staff had conversations with children, and how this was organized, was left to chance.

On 1 January 2010, responsibility for general supervision of child welfare services was given to the Norwegian Board of Health Supervision. In 2011, the Offices of the County Governors and the Norwegian Board of Health Supervision carried out countrywide supervision of child welfare services.
The aim of supervision was to examine whether a sample of Norwegian municipalities (44 municipalities) organized and managed child welfare services in such a way as to ensure that services were provided in accordance with the requirements in the Child Welfare Act. This included investigation, evaluation of the services provided, and opportunities for the child to participate – in other words that children were given information and the opportunity to express their views and opinions.

The child is the main person and has the right to be consulted

It is important that children are given the opportunity to talk about themselves and how they experience their situation. This can provide the child welfare services with a better insight into the child's situation, and make it easier to find appropriate measures to help the child.

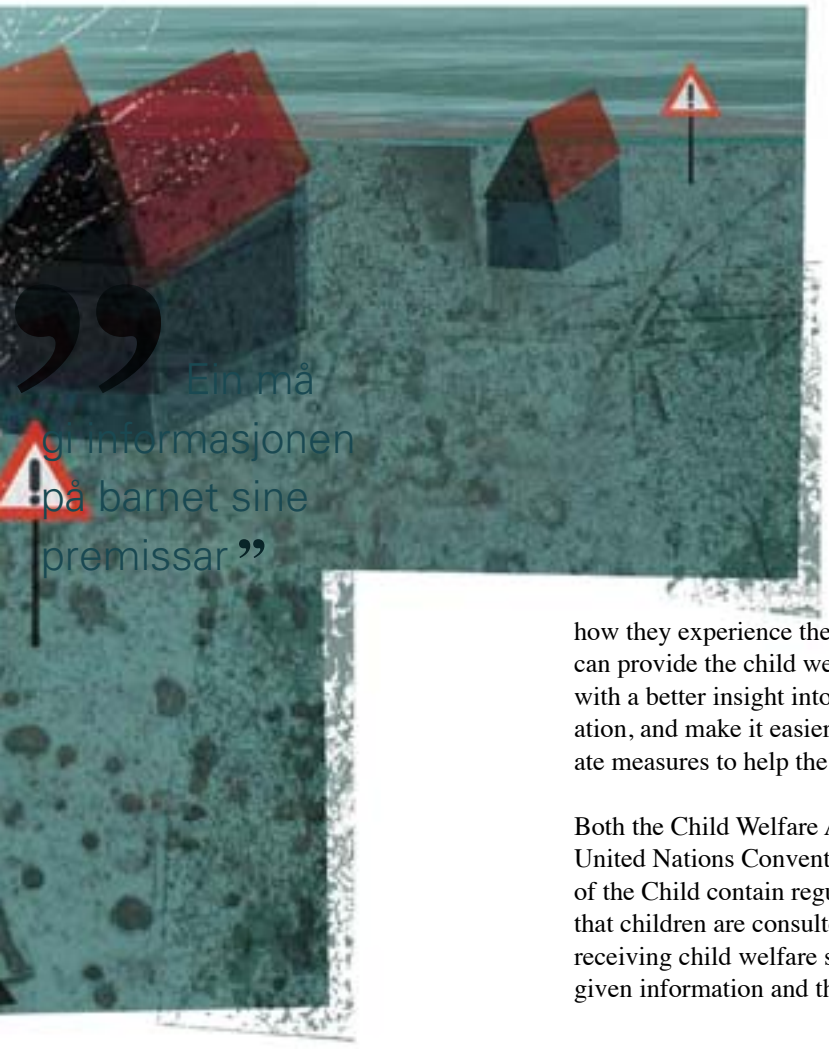
Both the Child Welfare Act and the United Nations Convention on the Rights of the Child contain regulations to ensure that children are consulted. Children receiving child welfare services must be given information and the opportunity to express their views and opinions, both when they are being assessed and when measures to help them are being evaluated. It is not compulsory for children to express their views, but they must be given the opportunity to do so, before decisions are taken about them. This applies to children from the age of seven, and to younger children who are able to form their own opinions. Child welfare staff must inform children about their rights, provide information in a way that is appropriate for the child's age and maturity, and assess the need for talking to children in a private room.

> "Child welfare staff must inform children about their rights, provide information in a way that is appropriate for the child's age and maturity, and assess the need for talking to children in a private room."

Not all children are consulted

The Offices of the County Governors found breaches of the legislation or areas with potential for improvement in 40 out of 44 municipalities.

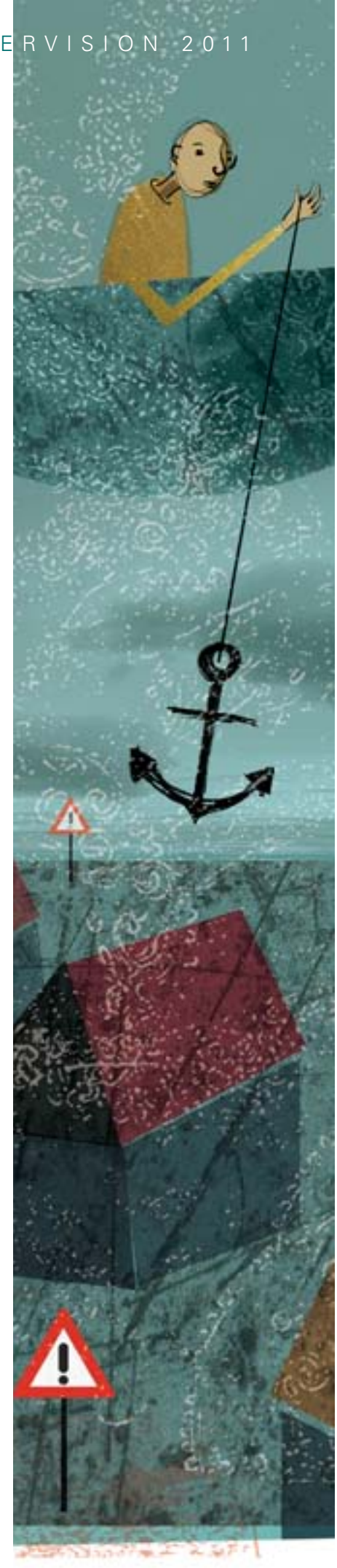
For example:
- the child welfare services lacked routines for talking to children
- they had routines, but did not follow them
- they talked to the children, but did not record the results
- the managers did not ask about whether staff had talked to the children
- the staff lacked knowledge about children's right to participate.



We do not actually know how many children were consulted. Vague formulations are used in the supervision reports, such as: children were not consulted *in all cases, some* conversations were carried out with children, *in many cases* it was not recorded whether children were asked about how they experienced the measures that were provided to help them.

Assessment of supervision

We are very concerned that some of the most vulnerable children are not adequately informed, and that they are not consulted about their own case. Their right to participate has not been adequately met. Whether children are given the opportunity to participate or not, is often up to individual members of staff. We do not know why staff in the child welfare services do not consult children, but the supervision reports give some indications about the challenges that the municipalities face in this area.



Investigation
A child welfare case is initiated when the child welfare services receive a report from a person or from an organization about concern for a child. According to the Child Welfare Act, the child welfare services must as soon as possible, and at the latest within one week, go through the reports that they have received, and decide whether the reports shall be followed up. If there are reasonable grounds to believe that measures are needed, they shall assess the case.

Evaluation of measures to help a child:
The child welfare services shall help each child to have good living conditions and the opportunity to develop, by giving advice and guidance, and by implementing measures to help the child. Examples of such measures are: providing a support person, a place in a day nursery, respite care, help in their own home and economic help. The child welfare services shall evaluate the measures regularly to ensure that they are adequate.

Facts and figures

Contents

This chapter in the Annual Supervision Report presents an overview of the most important tasks that the Offices of the County Governors and the Norwegian Board of Health Supervision carry out as supervision authorities and appeals bodies. The Offices of the County Governors took over the tasks of the Norwegian Board of Health Supervision in the Counties from 1 January 2012. However, we refer to the Norwegian Board of Health Supervision in the Counties in this chapter, because we present statistics for 2011 and earlier.

Child welfare services

Table 1 Supervision of child welfare institutions in 2010 and 2011

	Number of child welfare institutions		Number of departments / units		Number of supervisions required		Number of supervisions carried out		Number of unnotified supervision		Number of consultations with children	Number of children
Office of the County Governor	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2011	2011
Østfold	13	14	47	44	117	116	106	105	52	53	107	341
Oslo og Akershus	39	52	67	66	230	230	174	176	87	87	157	546
Hedmark	15	11	19	22	63	67	47	51	34	23	127	227
Oppland	6	6	22	23	26	25	26	24	10	9	33	166
Buskerud	5	3	12	9	41	34	42	36	19	16	55	86
Vestfold	6	6	8	8	37	38	37	39	15	16	67	177
Telemark	4	4	14	15	52	53	49	49	23	23	47	109
Aust-Agder	5	5	12	15	48	58	48	59	29	24	77	143
Vest-Agder	7	6	25	21	66	65	67	66	20	25	71	116
Rogaland	15	14	49	43	113	107	111	92	46	32	108	229
Hordaland	23	19	47	45	152	132	108	87	33	28	53	250
Sogn og Fjordane	4	4	8	7	24	14	32	10	10	5	39	74
Møre og Romsdal	5	5	9	9	21	21	23	19	10	7	37	115
Sør-Trøndelag	15	15	24	25	73	82	73	81	29	34	128	263
Nord-Trøndelag	7	7	15	13	29	27	24	18	8	10	67	98
Nordland	6	5	9	8	25	21	23	16	9	8	28	106
Troms	9	8	20	26	89	88	88	90	25	39	121	218
Finnmark	2	2	4	4	10	10	10	10	4	4	19	45
Total	**186**	**186**	**411**	**403**	**1216**	**1188**	**1088**	**1028**	**463**	**443**	**1341**	**3309**

The statistics presented in this chapter are from the annual reports of supervision of child welfare services, prepared by the Offices of the County Governors.

In 2011, the Offices of the County Governors dealt with 174 cases of complaint about municipal child welfare services (Table 2). Traditionally, there have been few cases of complaint about child welfare services. Therefore, cases of complaint are a poor source of information about deficiencies in these services. Of the 174 completed cases, 16 (9 %) of the administrative decisions were revoked, and the cases were sent back to the municipalities to be dealt with again. Twenty-three (13 %) of the administrative decisions were changed. The rest of the decisions were either rejected (17 %) or affirmed (61 %). The Offices of the County Governors are required to deal with a minimum of 90 % of complaints within three months and they managed this for 91 %.

The Offices of the County Governors receive information about possible deficiencies in child welfare services from different sources. Requests can come from children, relatives, or other people. They can also get information from planned supervision of the services. In 2011, the Offices of the County Governors dealt with 972 supervision cases against the municipalities. In 115 of these cases, breaches of the regulations were detected.

In 2011, the Offices of the County Governors carried out country-wide supervision of municipal child welfare services. Altogether, 66 system audits were carried out. Breaches of the regulations were detected in 54 cases. In addition, some of the Offices of the County Governors carried out supervision using other methods, or had meetings with the managers about the child welfare services.

Table 2 Number of cases of complaint dealt with against the child welfare service in the municipality 2010 and 2011

Office of the County Governor	Supervision complaints		Complaints about administrative decisions		Cases dealt with within 3 months		Cases dealt with: longer than 3 months	
	2010	2011	2010	2011	2010	2011	2010	2011
Østfold	54	48	9	11	9	10	0	1
Oslo og Akershus	95	208	63	61	44	57	19	4
Hedmark	31	33	12	9	11	8	1	1
Oppland	8	23	0	3	0	2	0	1
Buskerud	49	57	18	14	18	14	0	0
Vestfold	41	69	7	11	7	10	0	1
Telemark	12	16	6	3	6	3	0	0
Aust-Agder	10	19	0	0	0	0	0	0
Vest-Agder	30	62	8	6	8	6	0	0
Rogaland	45	73	7	7	5	4	2	3
Hordaland	73	91	24	14	23	14	1	0
Sogn og Fjordane	21	10	3	4	2	4	1	0
Møre og Romsdal	28	14	4	4	4	1	0	3
Sør-Trøndelag	56	49	6	5	5	5	1	0
Nord-Trøndelag	26	28	1	2	0	1	1	1
Nordland	55	80	10	12	9	12	1	0
Troms	36	53	10	8	10	8	0	0
Finnmark	13	39	0	0	0	0	0	0
Total	**683**	**972**	**188**	**174**	**161**	**159**	**27**	**15**

In 2011, the Offices of the County Governors dealt with 376 cases of complaint regarding child welfare institutions. 322 of these complaints were about measures of coercion and 54 were about other matters. In 71 of these cases, the decision was in favour of the complainant, in 292 cases, the decision went against the complainant and 13 cases were rejected. 92 % of complaints were dealt with within three months.

In 2011, the Offices of the County Governors carried out supervision of child welfare institutions on 1028 occasions (Table 1). 69 of these cases of supervision were system audits, the others were so-called individual supervision, in which the Offices of the County Governors give priority to interviewing children in the child welfare institutions. In 2011, the Offices of the County Governors carried out 1341 interviews with children in child welfare institutions. If all the children who were resident in the institutions at the time of the visits had been present, and if all of them had desired to speak to the staff from the supervision authority, 3309 interviews could have been carried out. The percentage of children interviewed was therefore 41 %.

The Offices of the County Governors carried out supervision in 186 child welfare institutions, which had 403 departments/units. In 443 cases, the supervision was unannounced, in other words, not notified in advance.

The Offices of the County Governors also carry out supervision of reception centres for single, under-age asylum seekers. In 2011, the Offices of the County Governors carried out supervision in ten of these centres, with 27 departments/units. In total, supervision was carried out on 42 occasions, three as system audits and 16 unannounced. The staff of the Offices of the County Governors carried out 151 interviews with children in these centres. If all the children who were resident in the centres at the time of the visits had been present, and if all of them had desired to speak to the staff from the supervision authority, 244 interviews could have been carried out. The percentage of children interviewed was therefore 62 %.

From 2011, the Offices of the County Governors have been required to carry out supervision of centres for parents and children at least once every two years. These are residential centres for parents and children who need help, support and follow-up because there is concern about the child's situation. Examples of reasons for concern are parents with mental illness and parents with drug-related problems. There are 22 registered centres. In 2011, the Offices of the County Governors carried out supervision in five of them.

Social services

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

Table 3 Complaints about social services dealt with by the Offices of the County Governors in 2009-2011 and the result of the cases in 2011

Office of the County Governor	2009	2010	2011		
	Cases dealt with	Cases dealt with	Cases dealt with	Reversed	Revoked
Østfold	69	85	56	29	7
Oslo og Akershus	195	271	298	90	6
Hedmark	36	36	37	11	0
Oppland	28	22	33	13	2
Buskerud	62	64	80	21	14
Vestfold	43	68	86	19	21
Telemark	55	47	37	10	9
Aust-Agder	20	17	26	3	6
Vest-Agder	44	35	33	8	4
Rogaland	48	60	54	9	2
Hordaland	130	131	209	5	14
Sogn og Fjordane	28	35	12	1	3
Møre og Romsdal	53	39	59	8	14
Sør-Trøndelag	63	37	40	5	14
Nord-Trøndelag	23	32	21	0	7
Nordland	71	43	40	6	7
Troms	57	59	49	4	7
Finnmark	16	23	11	4	2
Total	**1041**	**1104**	**1181**	**246**	**139**

* Complaints about social security benefits are not included: see Table 4

2011 was the last year in which the Social Services Act was in force. From 2012, the services referred to below have been regulated by the Health and Welfare Services Act. Table 3 shows cases of complaints in which individuals have complained about administrative decisions taken by the municipality. In 2011, the Offices of the County Governors dealt with 1181 complaints about social services (1104 in 2010). Practical assistance was the service that was complained about most, with 368 cases, of which 177 were about client-managed personal assistance. Economic assistance for carers came next, with 350 cases. There were 239 complaints about respite care and 189 complaints about support contacts.

In 2011, the Offices of the County Governors reversed the decisions of the municipalities in 21 per cent of cases (24 per cent in 2010). In twelve per cent of cases (10 per cent in 2009), the complaints were revoked, and the cases were returned to the municipalities to be dealt with again. This means 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 2011, only 62 per cent of cases pursuant to the Social Services Act were dealt with within the deadline, the same as in 2010. As in 2010, only five Offices of the County Governors managed to meet this requirement, but there were two others that came very close (88 and 89 per cent). At the beginning of 2011, there were 335 cases of complaint that had not been dealt with, by the end of 2011 there were 212.

The Norwegian Board of Health Supervision, as the highest authority, received six cases of complaint relating to the Social Services Act. In four of these cases the administrative decision was upheld. In one case no reason was found to reverse the decision. One of the cases was about interpretation of the legislation.

Table 4 presents figures for cases of complaint regarding social security benefits and job training programmes dealt with by the Offices of the County Governors.

Cases of complaint regarding social security benefits are mainly about economic help for food, accommodation, clothes and other living expenses. In 2011, 3712 cases of complaint of this kind were dealt with, compared with 3210 in 2010, an increase of 16 per cent. Ten per cent of administrative decisions in cases of complaint regarding social security benefits were reversed, and eight per cent were revoked and returned to the municipalities to be dealt with again. This means that over 80 per cent of the administrative decisions that were complained against, and that were not reversed by the municipality, were upheld by the Offices of the County Governors. In 2011, 78 per cent of cases pursuant to the Act relating to social services provided by Nav were dealt with within the deadline of three months, compared with 80 per cent in 2010. Ten of the 18 Offices of the County Governors dealt with at least 90 per cent of cases of complaint within three months, compared with eight in 2010. At the beginning of 2011, there were 642 cases of complaint that had not been dealt with, by the end of 2011 there were 561.

In addition, 44 cases of complaint regarding the job training programme were dealt with, compared with 29 cases in 2010.

The Norwegian Board of Health Supervision, as the highest authority, received no cases of complaint relating to this Act to reassess.

Table 4 Complaints about social security benefits dealt with by the Offices of the County Governors in 2009-2011 and the result of the cases in 2011 and the training programme 2011

	2009	2010	2011			
	Social security benefits					Job training programme
Office of the County Governor	Cases dealt with	Cases dealt with	Cases dealt with	Reversed	Revoked	Cases dealt with
Østfold	179	321	253	31	16	4
Oslo og Akershus	637	684	773	114	27	13
Hedmark	115	181	151	19	8	1
Oppland	138	140	188	7	5	1
Buskerud	190	263	284	36	36	1
Vestfold	211	202	208	8	31	5
Telemark	98	95	147	26	23	2
Aust-Agder	69	78	152	27	12	1
Vest-Agder	122	124	165	12	12	1
Rogaland	161	223	251	3	5	6
Hordaland	234	275	472	27	43	3
Sogn og Fjordane	35	27	32	5	3	0
Møre og Romsdal	61	97	116	14	16	1
Sør-Trøndelag	187	189	152	9	32	0
Nord-Trøndelag	59	57	70	2	10	4
Nordland	102	91	120	5	7	0
Troms	80	131	136	18	9	0
Finnmark	48	32	42	8	9	1
Total	**2726**	**3210**	**3712**	**371**	**304**	**44**

Planned supervision of social services

Supervision of services pursuant to the Social Services Act

In 2011, the Offices of the County Governors carried out 102 system audits (Table 5) and 77 other types of planned supervision of services pursuant to the Social Services Act. Twenty-six system audits and 72 other types of supervision were part of countrywide supervision, as part of the 4-year plan (2009-2012) for giving priority to supervision of health and social services for elderly people.

The themes for the 76 system audits that were not part of country-wide supervision included:

- services and legal safeguards for people with mental disabilities: 40 system audits
- social services for alcohol and drug addicts: 17 system audits
- municipal nursing and care services for elderly people: 7 system audits
- municipal health services, social services and child welfare services for children: 6 system audits.

In 75 of the 102 system audits, breaches of laws or regulations were detected. By 31 December 2011, for 41 of the system audits of social services from 2010 or earlier, breaches of the regulations had not been corrected, compared with 47 for the previous year.

Fifty-nine of the system audits of municipal services were carried out jointly by the Norwegian Board of Health Supervision in the Counties and the Offices of the County Governors, since requirements in the legislation regarding both health and social services were investigated.

The requirement of the Norwegian Board of Health Supervision was that the Offices of the County Governors should carry out 180 system audits. They carried out the equivalent of 143 system audits.

Supervision of services pursuant to the Act relating to social services provided by the Norwegian Labour and Welfare Service (Nav)

In 2011, the Offices of the County Governors carried out 97 system audits relating to the Act relating to social services provided by Nav (social security benefits, the job training programme and temporary accommodation. See Table 6). The requirement of the Norwegian Board of Health Supervision was that the Offices of the County Governors should carry out 100 system audits. In 74 of the system audits, breaches of laws or regulations were detected. By 31 December 2011, breaches of the regulations had not been corrected for 11 of the system audits from 2010 of social services provided by Nav.

Table 5 Number of system audits of services relating to the Social Services Act carried out by the Offices of the County Governors in 2009-2011

Office of the County Governor	2009	2010	2011
Østfold	9	3	3
Oslo og Akershus	22	24	6
Hedmark	9	6	9
Oppland	9	6	5
Buskerud	11	10	6
Vestfold	6	6	7
Telemark	7	5	7
Aust-Agder	7	6	4
Vest-Agder	7	6	6
Rogaland	11	8	4
Hordaland	15	9	9
Sogn og Fjordane	7	6	6
Møre og Romsdal	5	11	7
Sør-Trøndelag	9	5	1
Nord-Trøndelag	7	7	8
Nordland	9	7	7
Troms	8	4	3
Finnmark	6	3	4
Total	**164**	**132**	**102**

Table 6 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 and 2011

Office of the County Governor	2010	2011
Østfold	6	5
Oslo og Akershus	6	12
Hedmark	2	5
Oppland	5	5
Buskerud	8	12
Vestfold	6	4
Telemark	4	3
Aust-Agder	4	4
Vest-Agder	4	4
Rogaland	4	7
Hordaland	5	5
Sogn og Fjordane	4	3
Møre og Romsdal	3	6
Sør-Trøndelag	6	6
Nord-Trøndelag	4	2
Nordland	6	6
Troms	4	4
Finnmark	3	4
Total	**84**	**97**

Table 7 Use of coercion and restraint for people with mental disabilities in 2011. 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 31.12.2011		
Østfold	449	70	24	30	24	20	4
Oslo og Akershus	3142	265	175	257	170	146	31
Hedmark	370	46	67	95	67	63	13
Oppland	660	46	51	62	51	47	15
Buskerud	769	31	70	111	70	49	23
Vestfold	1441	40	30	38	24	22	8
Telemark	128	31	15	22	13	11	4
Aust-Agder	275	21	10	11	10	9	0
Vest-Agder	373	62	60	89	58	12	0
Rogaland	6913	164	90	133	81	82	10
Hordaland	296	84	163	292	138	146	23
Sogn og Fjordane	593	21	11	18	12	8	7
Møre og Romsdal	3814	45	31	74	31	36	3
Sør-Trøndelag	802	49	42	61	40	9	16
Nord-Trøndelag	483	12	32	96	31	84	11
Nordland	507	35	60	138	59	51	32
Troms	2351	27	47	107	51	28	10
Finnmark	792	10	5	6	5	6	12
Total	**24 158**	**1059**	**983**	**1640**	**935**	**829**	**222**

Use of coercion and restraint for people with mental disabilities

There are more than 20 000 people in Norway who are diagnosed as having a mental disability. Previously, the use of coercion and restraint for people with mental disabilities was regulated in Chapter 4A of the Social Services Act. From 2012, these regulations are in Chapter 9 of the Health and Welfare Services Act. Measures of coercion and restraint include both measures that clients resist, and measures that, irrespective of resistance, must be regarded as coercion or restraint. These can be measures to prevent clients from injuring themselves, injuring other people or damaging objects, or measures to meet the needs of the client for food, drink, rest, sleep, dressing, hygiene or personal safety. Examples of measures that are used are alarms, restraint belts and locks on fridges. Thirty-nine per cent of the measures were to prevent injury, and 61 per cent were to meet clients' basic needs. In total, the Offices of the County Governors re-examined 1031 administrative decisions made by the municipalities: 983 of these were approved (Table 7). The approved administrative decisions included 1640 measures (2010: 902 approved administrative decisions, 1395 measures). At the end of 2011, there were valid measures for 935 people (835 at the end of 2010). Forty per cent of the administrative decisions were for women, 60 per cent for men.

In addition, 24 158 measures taken to avoid injury in emergency situations were registered that were not regulated in administrative decisions (19 569 in 2010). The measures were implemented for 1059 persons (1076 persons in 2010). Thirty-seven per cent of these measures were for women, 63 per cent for men.

In 2011, the Offices of the County Governors approved 858 applications for dispensation from the requirement regarding the qualifications of staff who use coercion and restraint. 829 applications were approved (773 in 2010). Seen in isolation, the number of applications tells us little about how many measures of coercion and restraint are used by staff who do not have the required qualifications. The large and increasing number of applications for dispensation from the qualification requirements, seen in relation to the number of administrative decisions, may be an indication that it is difficult to recruit qualified staff in many places.

There are very few complaints in this area. In 2011, there were six complaints regarding measures to avoid injury in repeated emergency situations and two complaints about administrative decisions that were re-examined.

In 2011, the Offices of the County Governors carried out local supervision on 222 occasions (229 in 2010), to investigate use of coercion and restraint, both cases for which there were administra-

Table 8 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 2009-2011

		2009[2]	2010[2]	2011	
Provision	Provision regarding:	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	83	71	70	30
Section 2-1 second paragraph	The right to required health care from specialized health services	168	217	183	45
Section 2-2	The right to an assessment within 30 workdays	11	19	10	6
Section 2-3	The right to a reassessment	8	4	3	0
Section 2-4	The right to choose hospital	10	22	11	5
Section 2-5	The right to an individual plan	8	11	5	4
Section 2-6	The right to transport to health services	244	407	1005	128
Chapter 3	The right to participation and information	49	70	46	14
Chapter 4	Consent to health care / the right to refuse health care	1	6	3	0
Chapter 4A compulsory treatment	Admission/prolonged stay in a health institution	6	5	6	4
Section 5-1	The right of access to medical records	30	33	23	17
Health Personnel Act					
Sections 42. 43 and 44, pursuant to the Patients' Rights Act, Section 5-2	The right to correct and delete information in medical records	21	32	23	9
Municipal Health Services Act					
Section 2-1	The right to required health care	148	144	155	60
Dental Health Services Act					
Section 2-1	The right to required dental care	3	3	2	1
Other sections that give the right to health services		7	8	7	4
Total number of assessments of specific provisions [1]		**797**	**1052**	**1552**	**327**
Number of cases [2]		**705**	**913**	**1462**	
Number of cases rejected[3]		**71**	**64**	**64**	

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.

tive decisions, and cases for which the use of coercion and restraint may not have been regulated by administrative decisions.

Health Services

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

The Office of the County Governor (before 2012 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' and Consumers' Rights Act and certain other regulations. Those who have responsibility for the services (municipalities, hospitals, health trusts etc.) shall have reassessed the case before a complaint is put forward.

The most common cause of complaint was the right to reimbursement of travel expenses for journeys between the patient's home and the place where treatment was provided. There has been a marked increase in the number of such complaints from 244 in 2009, to 407 in 2010, to 1005 in 2011 (Table 8). The number of complaints is not evenly distributed throughout the country. In general there are more complaints about reimbursement of travelling expenses in the counties with a low population density and long travelling distances.

In our view, the most serious complaints are those about the right to required health care and the right to assessment. The number of such complaints has been stable during the last four years, at about 400 per year.

In 2011, 1462 cases of complaint were dealt with. In 327 cases (22 per cent) the decision was in favour of the patient and the administrative decision was either initially reversed, or the case was sent back to the primary authority to be dealt with again because of errors in the way the case had been dealt with. This is a lower percentage than for the previous year. The reason is the increasing number of complaints about travelling expenses. The outcome of these cases is seldom in favour of the complainant, compared to other types of complaint.

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. Two of these cases were received in 2010 and one in 2009. Three cases were about refusal. The decisions in these three cases were upheld. In the other three cases, the decisions were re-examined. One decision was reversed, one case was sent back to be dealt with again, and one decision was upheld.

Planned supervision of health services

In 2011, the Norwegian Board of Health Supervision in the Counties carried out 272 system audits, 129 with specialized health services and 143 with municipal services (Table 9). In addition, they carried out other types of planned supervision on 200 occasions.

Twelve system audits and 36 spot check audits were part of countrywide supervision of frail elderly people with broken hips, and 77 system audits were part of countrywide supervision of treatment of stroke. This was part of the four-year plan (2009-2012) for supervision of health and social services for elderly people. Forty-nine system audits were part of countrywide supervision of compulsory treatment in municipal health services.

The 49 system audits of specialized health services that were not part of countrywide supervision included:

- mental health services for adults (6 system audits)
- mental health services for children and young people (4 system audits)
- interdisciplinary, specialized treatment for people with alcohol and drug problems.

The 58 system audits of municipal services that were not part of countrywide supervision included:

- health and welfare services for elderly people (39 system audits)
- health services for people with alcohol and drug problems (8 system audits)
- health services, social services and child welfare services for vulnerable children (6 system audits)
- health and social services for people with mental illnesses (4 system audits).

Fifty-nine of the system audits of municipal services were carried out jointly by the Norwegian Board of Health Supervision in the Counties and the Offices of the County Governors, since requirements in the legislation regarding both health and social services were investigated.

Breaches of the legislation were found in 156 of the 276 system audits (in 40 system audits of specialized health services and 116 system audits of municipal services). Per 31 December 2011, there were still breaches that had not been corrected from 56 system audits of health services carried out in 2010 or earlier. The corresponding figure for 2009 or earlier was 65.

The requirement of the Norwegian Board of Health Supervision was that the Norwegian Board of Health Supervision should carry out 300 system audits. They carried out the equivalent of 374 system audits. In addition, the Norwegian Board of Health Supervision in Rogaland carried out supervision of the petroleum industry on 8 occasions.

Table 9 Supervision of health services. Number of system audits carried out by the Norwegian Board of Health Supervision in the Counties in 2009-2011

Norwegian Board of Health Supervision in the County	2009	2010	2011
Østfold	15	6	10
Oslo og Akershus	33	29	17
Hedmark	12	6	13
Oppland	15	12	14
Buskerud	17	10	21
Vestfold	13	13	14
Telemark	13	6	11
Aust-Agder	13	7	16
Vest-Agder	13	7	16
Rogaland	18	16	16
Hordaland	21	20	24
Sogn og Fjordane	12	7	17
Møre og Romsdal	17	15	11
Sør-Trøndelag	14	16	15
Nord-Trøndelag	13	7	18
Nordland	17	11	14
Troms	13	13	13
Finnmark	11	6	12
Total	**280**	**207***	**272***

* In addition, supervision was carried out 204 times in 2010 and 197 times in 2011 using methods other than system audits

Issuing instructions, giving coercive fines and closing services
In 2011, the Norwegian Board of Health Supervision did not issue instructions to municipalities pursuant to the health legislation. The University Hospital in Northern Norway was warned that instructions could be issued. The case was that the level of staffing of doctors was inadequate for providing treatment for high risk pregnant women. Instructions were not issued, but the case was followed up by the supervision authority.

In addition, instructions were issued to several services that did not reply to the supervision authorities about matters regarding supervision. In four of these cases, the services were warned that they could be given a coercive fine.

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

Table 10 Use of coercion and restraint for people who do not have the ability to give consent and who refuse health care. 2009 and 2011

Year	2009	2010	2011
Number of decisions received by the Norwegian Board of Health Supervision in the Counties[1]	1687	2075	2367
Number of decisions taken note of	578	1001	1188
Number of decisions answered	1146	1217	1305
Number of decisions revoked	125	157	212
Number of decisions reversed	2	27	24
Number of decisions lasting more than 3 months	1050	1254	1493
Number of complaints	7	18	16

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

Chapter 4A in the Patients' and Consumers' Rights Act 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 Office of the County Governor. In 2011, the Norwegian Board of Health Supervision in the Counties received 2367 copies of administrative decisions (Table 10).

The Offices of the County Governors examine all decisions, and have authority to re-examine (reverse or revoke) decisions. If there is no complaint about an administrative 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.

Sixty-five per cent of the administrative decisions required a response from the Norwegian Board of Health Supervision in the Counties to the municipality/health service: the decisions were either reversed or revoked, or advice and guidance was given. Thirty-five per cent of the decisions were accepted.

The Norwegian Board of Health Supervision in the Counties received 16 complaints about administrative decisions made by the health services. The administrative decisions were upheld in 14 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

Table 11 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. 2009-2011

Norwegian Board of Health Supervision in the County	Number of completed cases			Percentage of cases that took more than 5 months in 2011
	2009[1]	2010[1]	2011[1]	
Østfold	179	168	141	48 %
Oslo og Akershus	329	392	408	57 %
Hedmark	122	132	130	48 %
Oppland	52	82	93	59 %
Buskerud	113	132	130	61 %
Vestfold	96	92	57	26 %
Telemark	75	98	80	30 %
Aust-Agder	37	42	47	36 %
Vest-Agder	68	83	94	24 %
Rogaland	103	85	130	52 %
Hordaland	185	226	247	50 %
Sogn og Fjordane	65	58	62	27 %
Møre og Romsdal	130	71	94	51 %
Sør-Trøndelag	112	113	134	30 %
Nord-Trøndelag	72	90	81	35 %
Nordland	86	181	121	34 %
Troms	83	94	81	35 %
Finnmark	62	53	51	51 %
Total	**1969**	**2192**	**2181**	**46 %**
In addition: cases completed without being assessed[2]	289	354	384	
Number of cases rejected[3]	143	192	174	

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.

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 2011, there were 2752 new cases. This is a small reduction from 2010. The number of cases is unevenly distributed throughout the country. There were fewest cases in Vestfold: 38 per 100 000 inhabitants, and the most in Finnmark: 94 per 100 000 inhabitants. At the end of 2011 there were 1099 uncompleted cases, which is about the same number as for 2010.

The requirement for 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 11 of the county offices in 2010 (Oslo and Akershus count as one office). The requirement was met for the country as a whole, since 54 per cent of all cases were dealt with in less than five months.

Table 12 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. 2009-2011

Legative basis	2009[1]	2010[1]	2011
Provisions in the Health Personnel Act			
Section 4. Sound professional standards: behaviour	201	245	210
Section 4. Sound professional standards: examination, diagnosis and treatment	1715	1689	1835
Section 4. Sound professional standards: medication	227	231	220
Section 4. Sound professional standards: other	291	305	329
Section 7. Emergency treatment	38	36	29
Section 10. Information	103	104	111
Section 16. Organization of the services	191	148	174
Chapters 5 and 6. Duty of confidentiality, right of disclosure, duty of disclosure	126	176	160
Sections 39-41. Patient records	233	320	241
Section 57. Fitness to practice: alcohol and drug abuse	44	47	46
Section 57. Fitness to practice: other reasons	68	64	67
Provisions in the Specialized Health Services Act			
Section 2-2. Duty of sound professional standards	587	706	704
Other legislative basis for assessment	**573**	**670**	**563**
Total number of provisions as legislative basis[2]	**4397**	**4741**	**4689**
Number of cases assessed[2]	**1969**	**2192**	**2181**

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.

Table 13 Number of supervision cases completed by the Norwegian Board of Health Supervision and number of administrative reactions. 2003-2011

Year	Completed cases	Administrative reaction	No administrative reaction
2003	172	125	55
2004	237	148	101
2005	242	168	87
2006	252	184	76
2007	271	181	95
2008	224	155	65
2009	301	235	87
2010	347	255	103
2011	366	283	131

For some cases there is more than one administrative reaction

Table 14 Administrative reactions given to health care personnel by the Norwegian Board of Health Supervision in 2010 and 2011

	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	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
Doctor	53	59	27	24	8	8	2	4	8	1		1	98	97
Dentist	4	11	3	2						1			7	14
Psychologist	5	3	6				1						12	3
Nurse	11	8	43	42				1		2			54	53
Auxiliary nurse	1	2	23	16						1			24	19
Social educator		1	5	3									5	4
Midwife	2	2	2										4	2
Physiotherapist		1	3				1		1				5	1
Other groups	4	5	7	11						2			11	18
Unauthorized	8	15											8	15
Total	**88**	**107**	**119**	**98**	**8**	**8**	**4**	**5**	**9**	**7**		**1**	**228**	**226**

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.

Table 15 Reason for withdrawal of authorization in 2011, according to health care personnel group

	Nurse	Auxiliary nurse	Doctor	Other	Total
Misuse of alcohol or drugs	27	9	11	10	57
Illness	3		1		4
Sexual misconduct with a patient	2		3	1	6
Behaviour	5	7		4	16
Unsound professional practice			2		2
Failure to comply after a warning	1		6	1	8
Authorization lost in another country	4		1		5
Total	**42**	**16**	**24**	**16**	**98**

Supervision cases dealt with by the Norwegian Board of Health Supervision

The Norwegian Board of Health Supervision deals with the most serious supervision cases, which are sent over from the Offices of the County Governors (before 2012 the Norwegian Board of Health Supervision in the Counties). 366 cases were dealt with in 2011 (337 in 2010) (Table 13). 283 administrative reactions were given, 57 to institutions (27 in 2010) and 226 to health care personnel. 131 cases were completed in 2011 without an administrative reaction being given (103 in 2010).

In 2011, 92 health care personnel lost 98 authorizations (119 authorizations in 2010) (Table 14). Most cases of withdrawal of authorization were related to misuse of alcohol and drugs. In 2011, seven health care personnel had their authorization limited.

Thirty-two health care personnel had their authorization/licence suspended while their cases were being dealt with. Suspension of authorization was extended for 7 health care personnel.

The Norwegian Board of Health Supervision reversed one administrative decision from a warning to no administrative reaction.

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

In 2010, the Norwegian Board of Health Supervision sent 84 cases of complaint to the Norwegian Appeals Board for Health Personnel (76 in 2010). Sixty-six of these cases were complaints about administrative decisions to give an administrative reaction (five of these were suspension of authorization). Fifteen complaints were about rejection of an application for new authorization / limitation of authorization, two complaints were about rejection of an application for the right to prescribe addictive medication, and one complaint was about reversal of an administrative decision. The Appeals Board dealt with 79 cases of complaint. They upheld the decision of the Norwegian Board of Health Supervision in 67 of these cases. Ten decisions were reversed, one decision was partially reversed and one complaint was rejected.

The Norwegian Board of Health Supervision applied for prosecution in nine cases in 2011 (8 cases in 2010). We concluded that there were no grounds for applying for prosecution against health care personnel or organizations in 12 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 82 applications from health care personnel who had previously lost their authorization. Twenty-seven health care personnel were granted new authorization without limitations. Eight applicants were granted limited authorization to practice under specified conditions. Thirty-seven applications for new authorization and ten applications for limited authorization were rejected.

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

In 2011, the Norwegian Board of Health Supervision dealt with 79 cases against institutions (38 in 2010). In 57 of these cases, breaches of health legislation were detected. In 18 of these cases, we found breaches of the requirement to provide information to the supervision authorities. In 22 cases, we found no breaches of health legislation. In most cases, the Offices of the County Governors (before 2012 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 is relatively small in relation to the total number of completed cases.

In 2011, the Norwegian Board of Health Supervision asked for a professional assessment in 13 supervision cases. Seven health care personnel were required to undergo a medical or psychological examination.

In 2011, the Norwegian Board of Health Supervision dealt with 366 cases. The median time taken to deal with a case was 5.1 months (5.4 months in 2010). The Norwegian Board of Health Supervision received 353 new cases in 2011 (327 in 2010). Per 31 December 2011, there were 162 uncompleted cases (165 per 31 December 2010).

Reporting System for Investigation of Serious Adverse Events in Specialized Health Services

Health trusts, and organizations that have a contract with a health trust, have a duty to report serious adverse events to the Norwegian Board of Health Supervision. Serious events are death or serious injury to patients, in which the outcome is unexpected in relation to the expected risk. This arrangement was introduced as a pilot scheme from 1 June 2010, and was legally established from 1 January 2012.

In 2011, the Norwegian Board of Health Supervision received 140 reports. Forty-two per cent (59 reports) were from mental health services and 58 per cent (81 reports were from somatic health services. Ten per cent (14 reports) resulted in call-outs, and 48 per cent (67 reports) were forwarded to the Norwegian Board of Health Supervision in the Counties to be followed up.

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. From 1 July 2012, the Norwegian Knowledge Centre for the Health Services will take over responsibility for the arrangement for reporting adverse events.

7756 reports of adverse events were registered in the database in the period 2008-2011 (1286 in 2008, 2059 in 2009, 2265 in 2010 and 2146 in 2011).

One-third of the reports registered in 2011 (34 per cent) were reports of serious injury, and just under one half (46 %) were reports of incidents that could have led to serious injury. 435 reports of unnatural death were registered (20 per cent of all reports).

Fifteen per cent of reports (314 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.

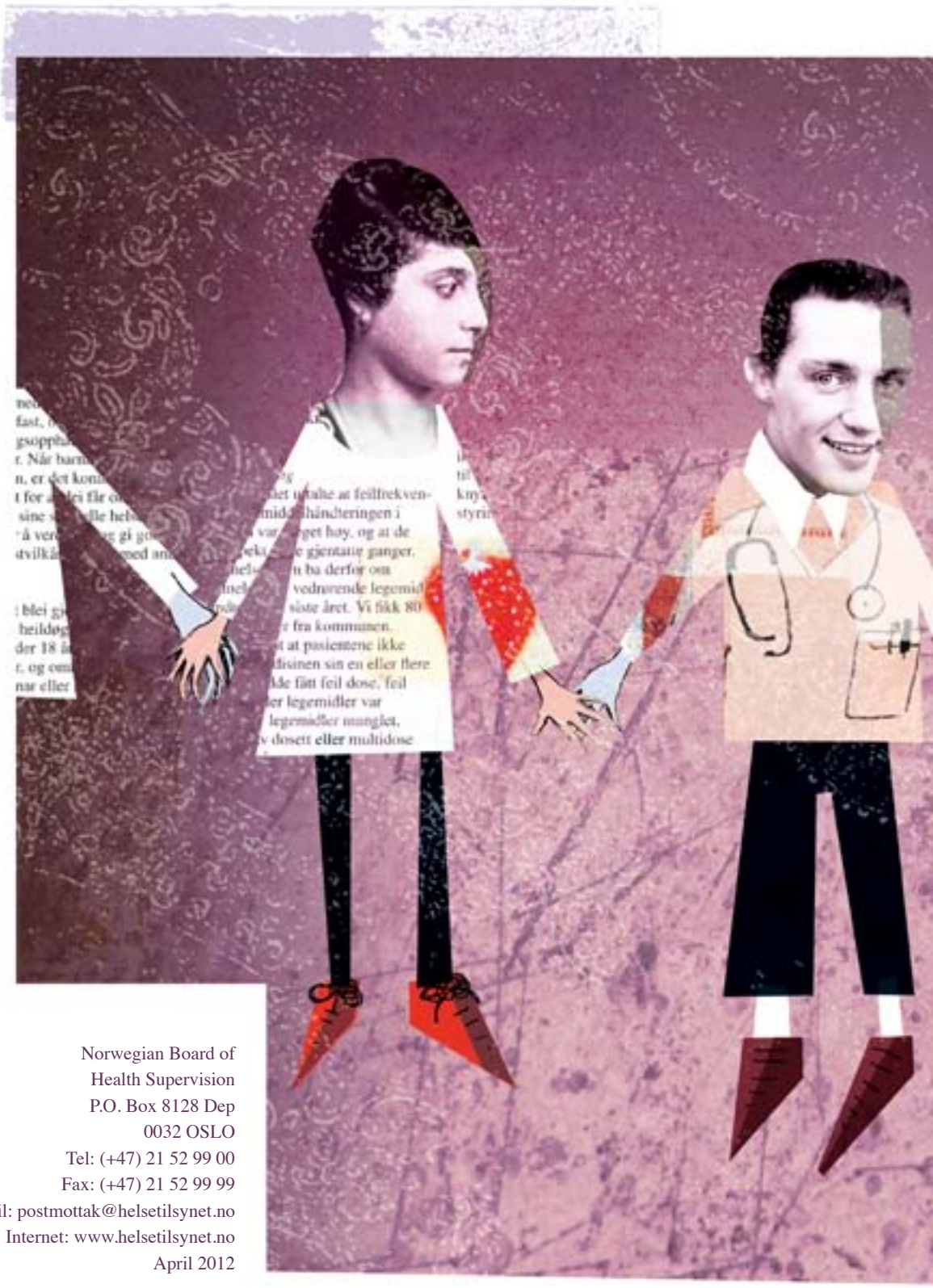
Eight per cent of reports (150 reports) were reports of events associated with birth. In 49 per cent of these, the mother was injured, and in 30 per cent the child was injured. There were 24 reports of unnatural death of the child during birth or death of the foetus before birth.

Twenty per cent of reports (438 reports) were reports of events that occurred in mental health care. 132 reports of suicide and 14 deaths from overdose were registered.

Accounts and personnel

The budget for 2011 for the Norwegian Board of Health Supervision was NOK 96.6 million, The accounts show a result of NOK 97.9 million for expenses and NOK 5.1 million for income.

The number of employees in the Norwegian Board of Health Supervision calculated as man-labour years at the end of 2011was 107.



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