ANNUAL SUPERVISION REPORT **2005**

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tilsyn med sosial og helse

Contents

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Introduction

Supervision is about finding out how things are in the real world, and about weighing up what is found against legitimate requirements for how things ought to be. Central for all supervision carried out by the authorities are the requirements that are laid down in the law. This is the case for supervision carried out by the Norwegian Board of Health (the central office), the Offices of the County Governor and the Norwegian Board of Health in the Counties, when we carry out supervision of health and social services.

We believe that the lookout post we have as a supervision authority provides us with the ideal means for obtaining a comprehensive picture of the situation in the various service sectors. However, the picture we obtain is not representative of health and social services as a whole. Our picture shows areas where there are errors and deficiencies more clearly than areas where conditions are adequate, and where services function in accordance with requirements. Part of the explanation for this is as follows. First, we try to focus our supervision activities on areas where the risk of errors and deficiencies occurring is greatest. Second, our task is to point out conditions that are not in accordance with statutory requirements, so that we can make a contribution to ensuring that such conditions are corrected.

When we point out nonconformities (breaches of laws or regulations), these are usually corrected. Time and time again we see that those who are responsible for the services that we supervise find that the results of supervision provide them with useful information for their management and development work. In 2005 we obtained documentation of this from an evaluation of a previous area of countrywide supervision, carried out by chief county medical officer Helga Arianson. This study is reported on page 14 of this report.

But we would like to see that the results of supervision were used more widely. There is reason to wonder why the same nonconformities are pointed out over and over again, not in the same place, but sometimes in neighbouring municipalities, or in other departments in the same institution. We believe that what we see, and the assessments that we make, are not only useful for the people we have visited. We believe that the results we report from supervision are also useful for others in their management of services. Therefore we try to ensure that service providers are well informed about our work, by making supervision reports and other documentation of our work widely available in the form of published material and electronic publications.

This annual supervision report should be read in the light of the considerations mentioned above. We hope that the relatively short articles presented in the report can whet the reader's appetite, and tempt him or her to take a closer look at the material we present from our supervision.

The Norwegian Board of Health is now nearing the end of the first strategic planning period since reorganization in 2002. We believe that we have consolidated our position as a supervision authority, and have found our role. But we still see the need for further development. We need to develop our cooperation with other public supervision authorities in order to harmonize our approach to the people and the services we supervise, including services provided by the municipalities.

Since the Offices of the County Governors and the Norwegian Board of Health in the Counties make up the operative front-line, conditions are favourable for further development of coordinated and harmonized supervision, not least in supervision of health and social services for children and young people. We also see that there is a greater need for teamwork with supervision in other areas and with other sectors, such as administration of personal information, the working environment and protection of the environment. In the petroleum industry, teamwork is based on a long tradition of formalized cooperation, which can serve as a model for us of teamwork with other sectors.

But in the years to come we will also be faced with new challenges related to supervision of health and social research, and increased activity related to accreditation and certification of health and social services. Much of this work may have a clear international character. These are areas that we have only just begun to investigate.

In this report we present our view of a series of issues that we have confronted in 2005. We hope that the Annual Supervision Report can also stimulate increased interest for the role of supervision. We hope that the Report can promote the view that it is actually both challenging and meaningful to work with supervision in a sector that most people perceive as decisive for experiencing Norway as a safe place to live.

Lars E. Hanssen
Director General of Health

Use of Coercion and Restraint

In 2005, the County Governors carried out countrywide supervision to investigate whether municipalities ensure that services are provided with the least possible use of coercion and restraint for persons with mental disabilities who receive health and social services (according to the Social Services Act Chapter 4A). A particular challenge is to ensure the legal rights of users with reduced ability to express their own needs. In order to ensure that legal rights are met, specific requirements for administrative procedures are laid down in the law. In order to ensure that clients receive services in line with statutory requirements, municipalities are required to establish systematic routines for all stages of the administrative process.

In addition, it was assessed whether services for these clients, such as practical help and training in the home, assistance and a allocation of a personal support person (pursuant to the Social Services Act § 4–2 a-d) are changed in line with changing needs. In particular, the County Governors examined the situation in municipalities where decisions had been taken about use of coercion and restraint, and about use of measures to avoid injury in emergency situations. The aim of supervision was to assess whether municipalities, in a systematic way, ensure that appropriate services are provided, and that use of coercion and restraint for individuals is carried out in accordance with the decisions that have been taken. The County Governors carried out supervision in 53 municipalities, and pointed out deficiencies in 41 of them. Experience gained from supervision in 2003 and 2004 has shown that the risk of deficiencies in this area is high (Report from the Norwegian Board of Health 6/2005).

Changing service provision in line with changing needs

An important aim of statutory regulation of use of coercion and restraint for people with mental disabilities is to ensure that these clients receive services in accordance with statutory requirements, with the least possible use of coercion and restraint. Coercion and restraint must not used to compensate for inadequate services. When carrying out supervision, a central issue was to determine whether municipalities ensure that clients receive services in accordance with statutory requirements when their needs for services change. If the services they receive are reduced, this must be based on an individual assessment of the client, ensuring that the level of services provided is still in accordance with statutory requirements.

In order to ensure that people with mental disabilities receive services in accordance with statutory requirements based on the individual's need for assistance, municipalities need to manage the services in such a way that the right to social services is complied with, for example by implementing systematic routines for planning, organizing and providing services, and for maintaining the level of service provision.

The County Governors found breaches of the law in 21 of the 53 municipalities that were included in the supervision. These breaches related to the duty of municipalities to ensure that the services offered to people with mental disabilities are changed in line with changing basic needs for assistance, in accordance with the Social Services Act § 4–2 a-d. In particular, deficiencies in administrative procedures were detected. Decisions had not been taken, or had not been evaluated or changed. Decisions had not been made for some clients since they had been discharged from HVPU[1] institutions at the beginning of the 1990s. There were still some clients who had not had an individual assessment and some decisions that were not adequately explained and described (as reported in the Report from the Norwegian Board of Health 6/2005). Little documentation was made of systematic evaluation and professional assessment before planning service provision for these clients. The County Governors pointed out deficiencies in ensuring that manpower resources were adequate to meet these clients' needs for services. For example, manpower levels determine the time when clients receive help with getting to bed or getting up. These conditions lead to vulnerability and risk of deficiencies in the services. The quality of the services provided to individual clients can, to a too large degree, be left up to the subjective judgement of individual service providers, with the risk of lack of individual and professional assessment of needs, and lack of predictability and continuity of services for the client.

The County Governors detected deficiencies in routines for reporting and communication, both between employees and leaders of the services, and between service providers and staff who allocate and order services. Those who are responsible for allocating services do not receive information about the need for changes in services provision. Supervision showed that some municipalities have not appointed a person with overall responsibility for the services, and in some municipalities employees do not know who has overall responsibility. The result can be that essential information about clients' changing needs is not passed on to the right person, so that changes in needs are not identified, and service provision is not adapted to clients' needs.

[1]) HVPU refers to the previous county municipal health services for people with mental disabilities, that were discontinued in connection with the reform (HVPU reform) that took place in the 1990s.

Use of coercion and restraint for people with mental disabilities

The municipalities have a duty to ensure that conditions are organized so that the use of coercion and restraint is limited as much as possible, and that these measures are only used when professionally and ethically justifiable. During supervision, it was investigated whether municipalities ensure that use of coercion and restraint are not used contrary to statutory requirements. The municipalities have a duty to provide necessary training, including professional instruction and follow-up when implementing measures relating to the Social Services Act Chapter 4A in general, and in relation to the specific coercion and restraint measures that are used for the individual client in particular.

In approximately three-quarters of the municipalities that were assessed, coercion and restraint were used contrary to the statutory requirements. These municipalities did not adequately ensure that solutions other than coercion and restraint had been adequately assessed in a systematic way. The findings about use of coercion and restraint are, to a large extent, in line with the findings of previous supervision (as reported in the Report from the Norwegian Board of Health 6/2005). Many municipalities lack adequate management and control in planning, organizing and providing services that involve use of coercion and restraint for people with mental disabilities.

The County Governors point out that coercion and restraint are often used when a decision about use of such measures has not been taken, and without writing a report. Examples of such use of coercion and restraint are locking kitchen or bathroom doors, limiting access to food, water or personal possessions, and regular and planned use of restraint when a decision about such measures has not been taken. Supervision also detected several cases of use of restraint of people with mental disabilities to prevent injury in emergency situations, without sending a report about this. In some cases employees were not familiar with internal routines and procedures about how to use coercion and restraint in such situations. Systematic measures to ensure that other solutions had been tried before using coercion and restraint had not been used. Supervision showed that employees' knowledge about and understanding of the concepts of coercion and restraint varies. Examples of this are ambiguity about what is defined as coercion and restraint, what the limits of coercion and restraint are according to the legislation, and lack of knowledge about the legislation that regulates the services. Many municipalities have not ensured that adequate instruction in the legislation that regulates these services has been given.

In several reports, the challenges that the municipalities face in relation to personnel resources and manpower situation are described. The impression that is gained about the municipalities varies. Some municipalities manage to organize things so that the personnel situation is stable, with few members of staff, and a high level of professional competence. Other municipalities have a high turnover of staff and many members of staff to cover the shifts. It is particularly challenging to ensure that the necessary resources are available at night. For example, situations were observed when there was only one member of staff present when coercion or restraint was used, even though the decision stipulated that there should be two. The municipalities face challenges in relation to reducing the total number of employees, and organizing more stable relationships between staff and clients. But there are also reports about conditions being altered so that the need for coercion and restraint is reduced, or so that coercion and restraint become unnecessary, for example that the client moves to a new and better-adapted residence, that shift arrangements are changed, or that the number of staff who provide services for the client is altered.

Summary

21 of the 53 municipalities that were included in the supervision did not ensure that services offered to people with mental disabilities are changed in line with clients' changing basic needs. In the opinion of the Norwegian Board of Health, it is unacceptable that many municipalities do not fulfil the statutory requirements relating to administrative procedures. This jeopardizes clients' legal rights, and can mean that many clients do not receive the services they have a right to receive. The Norwegian Board of Health is concerned that many municipalities lack necessary management and leadership of the services. Deficiencies such as deficiencies in administrative procedures, in responsibility, and in reporting and communication between different sectors can lead to vulnerability and deficiencies in service provision.

Supervision detected that municipalities lack an overview over and control of use of coercion and restraint, that can lead to increased use of such measures. The municipalities have not adequately ensured that measures other than coercion and restraint are adequately assessed in a systematic way, before coercion and restraint are used. Situations that can provide information about necessary improvements, both in relation to the individual client and in relation to the services in general, are not detected in many places. In the opinion of the Norwegian Board of Health, it is unacceptable that many municipalities do not fulfil the statutory requirements relating to use of coercion and restraint. This can lead to a situation in which clients' legal rights are not met.

Reference:
Legal use of Coercion and Restraint?
Summary of countrywide supervision in 2005 of use of coercion and restraint for people with mental disabilities.
Report from the Norwegian Board of Health 2/2006.
Oslo. The Norwegian Board of Health, 2006

An adequate number of personnel, with the necessary knowledge and skills in their professional field and area of service, is necessary in order for clients to receive adequate services in line with statutory requirements. Supervision has shown that many municipalities do not ensure that members of staff have adequate knowledge and skills. In the opinion of the Norwegian Board of Health, this situation is unacceptable.

Do Clients with Long-term, Complex Needs Receive Fragmentary and Divided Services?

In 2005 the Norwegian Board of Health in the Counties carried out countrywide supervision in 60 Norwegian municipalities. The aim of supervision was to examine how municipalities ensure that people with complex and long-term needs for health and social services receive comprehensive and coordinated care. It was investigated whether this was the case during all stages of their treatment and care, and whether clients receive adequate services that are in line with statutory requirements.

The target group for this supervision was clients with a broad range of health and social needs. They can have both long-term and short-term needs for health services such as physician services, physiotherapy, occupational therapy and home nursing services. Physical and/or cognitive functional disability can result in them being totally or partially dependent on help from others with daily activities, such as getting up, washing, dressing, eating and drinking, going to the toilet and going to bed, and for carrying out practical tasks in the home, such as making food, cleaning, shopping, clearing snow and heating the house. They are also dependent on others for avoiding isolation and having a meaningful social life. Severe functional disability, chronic illness, and perhaps social limitations, mean that health and social services are essential in order for these people to have a meaningful and dignified life-situation. Hastily implemented measures and short-term efforts are not sufficient. Help must be comprehensive and in line with statutory requirements over a long period.

Because clients in this group often receive help from many service sectors and from many different service providers, clients can experience that the services are fragmented, that cooperation and coordination between different providers is left to chance, and that the possibilities for client participation are limited.

A coordinated and comprehensive approach during all stages of treatment and care

The results of supervision showed that in 21 of 60 municipalities, assessment of service needs, and planning of service provision for these clients, was fragmentary and poorly coordinated. The municipalities had not established management structures that are robust enough to ensure that service sectors, together and in cooperation with clients, carry out an adequate investigation of clients' needs. Such an investigation is necessary in order to plan service provision that fulfils the requirements laid down in the legislation. In the opinion of the Norwegian Board of Health, it is a serious situation that municipalities do not ensure that a multidisciplinary assessment and investigation is carried out for clients who have complex health care and social needs. Deficiencies in one or several service sectors influence the comprehensiveness of the services that are offered, and whether the services are in line with statutory requirements.

The Norwegian Board of Health wishes to stress the importance of the municipalities having a systematic, well-planned and proactive approach to this client group. Such an approach is important because many of these clients have wide-ranging needs for assistance throughout their life. They may have chronic illnesses, with different rates of progression, and with effects that differ in how noticeable they are. They may have long-term physical disabilities resulting from injury. Their needs may not be predictable, and their functional abilities may be reduced gradually. In order to detect changes in needs for services, it is important to establish routines that ensure that adequate time is available for thorough assessment of needs during all stages of treatment and care. The results of supervision show that municipalities do not adequately ensure that systematic assessment is carried out, either of changes in needs for services, or of whether the services provided function optimally over time and as anticipated.

46 of the 60 municipalities that were included in the supervision lacked the structures and process that are necessary to ensure that clients receive coordinated and comprehensive services during all stages of their treatment and care. Service sectors assess clients' needs individually and not collectively. The different sectors implement measures and follow them up without ensuring systematic communication with other sectors and with the clients. The supervision authorities have pointed out both failure to meet the statutory requirements in these municipalities, and

the risk of deficiencies in relation to the requirements laid down in the law relating to the rights of clients to receive comprehensive and coordinated services. Some multidisciplinary cooperation and coordination occurs through informal contact, but it was difficult for the supervision authorities to find any trace of routine and systematic communication in many of the municipalities that were examined.

The regulation relating to an individual plan was formulated to address the special challenges faced by individuals with long-term and complex needs for services supplied by municipalities and other service providers. The aim of the regulation is to establish a procedure that ensures that clients' needs are seen in an overall context, and that the services clients receive are comprehensive and specially adapted to meet their individual needs.

The results of supervision show that the municipalities' work with individual plans has begun, but that the work seems to lack overall planning and management. In over half of the sectors, the supervision authorities found that work with individual plans for this group of clients was inadequate in relation to the statutory requirements. Many clients did not have a plan, had not been offered a plan, or had not been informed about their right to have a plan. In these municipalities, the supervision authorities were unable to ascertain that the intentions in the regulation had been met in other ways.

The challenge of meeting social needs

When assessment of service needs is inadequate, and when planning of service provision is fragmentary and in some cases inadequate, then it is reasonable to assume that the services offered and the specific measures that are provided, may not be adequately organized and adapted to clients' needs. The results of supervision support this assumption.

For many clients, a support person can be of great importance to avoid isolation and in order to ensure that the client has meaningful social contact with other people. It is therefore of concern that support person services were inadequate in several of the municipalities that were assessed. For example, the results of supervision show that it can take a long time to establish support person services, and these services do not seem to be part of the system of other municipal services. In other words, support persons were often not included in discussions about the individual client's needs and wishes. Support persons did not receive systematic guidance and instruction about their responsibilities and tasks. Certainly, the results of supervision show that municipalities have problems in recruiting support persons, and this makes it difficult to meet statutory requirements. The results also give cause to question whether the municipalities are sufficiently active with recruitment and with establishing measures that can compensate for the lack of support persons. In the light of these findings, in the opinion of the Norwegian Board of Health there is reason to question whether clients have received services in line with statutory requirements, that also meet the individual client's need for social contact, fellowship and participation.

Management for ensuring provision of services in accordance with statutory requirements

During supervision, the services must be able to document that they meet the requirements of internal control. Internal control is about systematic management of the services, in such a way that the requirements laid down in health and social legislation are met, so that people receive their rights in practice. Internal control is also about leadership planning and having an overview over the services, so that adverse situations and events do not occur. Leadership must also have an overview of the long-term and short-term needs of the population and of clients. Systematic management and leadership are also basic prerequisites for improving the quality of services.

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The results of supervision show that the municipalities have a great potential for improvement, in relation to ensuring that clients with long-term complex needs receive coordinated and comprehensive services in line with statutory requirements, both at the sector level and at the overall level. People who need services shall meet a system that carries out a thorough, multidisciplinary assessment of level of functioning and need for help, and that plans and provides services that are adapted to each person's needs and life situation, continually in close contact and communication with clients and their relatives. In the same way, services shall be coordinated in such a way that clients know who is going to come, when they are going to come, and what they are going to do. It is also important that services are systematically assessed and evaluated according to clients' changing needs over time. This is necessary in order to ensure that clients receive services that meet their needs and rights according to statutory requirements.

Reference:
Fragmentary and Divided Services? Summary of countrywide supervision in 2005 of municipal health and social services for adults over 18 years of age with complex and long-term needs for services.
Report from the Norwegian Board of Health 3/2006 Oslo.
The Norwegian Board of Health, 2006


SÅÅÅ...
HVA har
Vi her da...?

Serious deficiencies in confidentiality and patient record keeping in hospital departments of gastrointestinal surgery

Communication between health care personnel and patients is unsatisfactory when consultations concerning sensitive matters take place when uninvolved people are present. Within surgical health services, the system of allocating patients a doctor with special responsibility for them does not function, and in many places the recording of patient records by surgeons is inadequate. These are some of the results of countrywide supervision of communication related to gastrointestinal surgery that was carried out last year.

The Norwegian Board of Health is concerned that because of limitations in the physical surroundings and because of high pressure of work, confidential consultations between patients and doctors take place in wards with several beds or in corridors. Such conditions can lead to a breach of confidentiality. The system of allocating patients a doctor with special responsibility for them does not function adequately most places. The organization of doctors' work does not take account of the fact that patients shall have contact with a doctor who is allocated specifically to them during their hospital stay. This problem has not been properly addressed, and finding a solution has not been given priority. In many hospitals patient record keeping by surgeons is inadequate. It is not unusual for surgeons to omit to record significant changes in a patient's condition and treatment. Inadequate patient records increase the risk for deficiencies and inappropriate treatment, and reduced safety in health services.

In 2005 the Norwegian Board of Health in the counties carried out countrywide supervision in health trusts that provide surgical treatment for patients with acute diseases and cancer in the gastrointestinal tract. The theme for supervision was communication between different health care personnel, and between health care personnel and patients. In the five health regions, supervision was carried out in 23 health trusts. The areas for supervision were:

- Communication between health care personnel while the patient is in the ward
- Informing the responsible doctor about the results of radiographic examination and laboratory tests in urgent cases
- Communication between health care personnel when the patient is in the intensive care department
- Training new health care personnel and temporary staff
- Communication between health care personnel and patients.

Communication between health care personnel while the patient is in the ward

In order for treatment of surgical patients to be in accordance with sound professional practice, information relating to observation of, assessment of and decisions about patients must be available for the health care personnel who are involved in the treatment of the patient. This requires continuous exchange of verbal and written information between doctors, nurses and other personnel.

Some health trusts lack routines for verbal exchange of information between doctors going off duty and doctors coming on duty. In one health trust there was too little time for verbal exchange of information between the doctors starting and ending their shifts. Some places lacked routines for exchange of information between doctors and nurses during the time from the first examination by the doctor until the time when the completed patient record was available. In one place it was found that communication between the doctor and the nurse during the visit and before the visit was interrupted. In several health trusts it was found that nurses did not have access to electronic patient records. Lack of analysis of risk and vulnerability of exchange of information between doctors and nurses, was noted on several occasions.

Informing the responsible doctor about the results of radiographic examination and laboratory tests in urgent cases

In the case of results of tests that demand immediate action, routines are necessary for informing the doctor who is responsible for the treatment. When laboratory and radiology departments send such results by telephone to the ward, the member of staff who receives the results can have varying ability to assess the degree of urgency. An important issue is then whether doctors are informed about urgent results quickly enough. Widespread problems in informing the right people about the results of such tests were not detected by supervision. However, in several places there were no clear routines about which test results should be sent to others immediately, and about who had responsibility for dissemination of such information. Deficiencies in routines were in laboratories, radiology departments and wards.

…. and information is given to patients while other patients are present.

Communication between health care personnel when the patient is in the intensive care department

Patients who are admitted to intensive care units receive treatment for failure in the functioning of one or several vital organs. Several different specialists are often involved in the treatment of an individual patient

in intensive care. When the need to call for qualified help is urgent, good routines for communication are essential. Arrangements that regulate routines for cooperation and allocation of responsibility between health care personnel in different departments can be very useful in the daily work and particularly when the different people involved have different opinions. In intensive care units, communication between anaesthetists and surgeons is mostly verbal, but also written. Serious deficiencies in communication between health care personnel in intensive care units were not detected by supervision. Adequate verbal communication seems to be the main reason why such deficiencies do not occur.

Training new health care personnel and temporary staff

Treatment of patients in hospital in line with sound professional practice demands adequate teamwork from all the involved health care personnel. Adequate knowledge and skills in communication are essential prerequisites. The staff must have knowledge about and practical skills in verbal and written communication, and they must be able to use appropriate technical aids. In addition, health care personnel must have the necessary professional skills, and they must be familiar with internal routines and allocation of responsibility. Professional authorization is a form of public guarantee that health care personnel fulfil the formal requirements for education and experience that is demanded in order to be allowed to practice their profession. However, such a guarantee has its limitations. This means that every employer, in addition to checking that the health care worker has valid Norwegian authorization, must also ensure that the health care worker has the necessary professional knowledge and skills, and in other ways is suitable for the job. Knowledge of the Norwegian language is not a requirement for obtaining Norwegian authorization. However, clinicians must have adequate language skills so that they can communicate with patients and cooperate with health care personnel in a safe way. The employer has responsibility for ensuring this.

It is not unusual for surgeons to omit to record significant changes in a patient's condition and treatment.

Serious problems in communication between health care personnel, caused by lack of language skills, were not detected by supervision. In several departments, deficiencies in providing training for permanent and temporary staff in use of electronic communication tools and documentation systems were detected by supervision. In three departments, deficiencies in routines for training newly appointed doctors were detected. In one department, temporary nurses were not given a password, and had to borrow a password from other members of staff in order to gain access to patient records.

Communication between health care personnel and patients

Safe communication between health care personnel and patients is a prerequisite for providing treatment that is in line with sound professional standards. This is particularly important before an operation, when a patient is discharged, and when information is given and consultations about serious illness are held. Patients need to have confidence in health care personnel in order to be able to receive information and to ask questions. In many hospitals, patients are in wards with several beds, and information is given to patients while other patients are present. Experience indicates that many patients do not know that they have the right to ask for a confidential consultation in private surroundings.

In more than one third of the departments, it was found that the physical surroundings were unsuitable to allow patients to communicate and to receive relevant and essential information confidentially. The reason for this was that consultations took place in rooms with several beds or in corridors, and that there were no consultation rooms close by. No serious deficiencies were detected in the content of the information given to patients before they had an operation or before they were discharged. In one department, lack of routines for giving information to patients before an operation were noted, and in another department pre-operative consultations were not always carried out.

In many departments the system of allocating patients a doctor with special responsibility for them did not function as intended. The reason for this was either that a responsible doctor was not allocated, or that the doctor who was allocated was not available, or that the patient was not informed about which doctor had been appointed to have special responsibility for them.

Patient record keeping

Lack of documentation or inadequate documentation in patient records about the information given to patients was detected in more than two out of three departments. Lack of information about the doctor allocated special responsibility for the patient and the person responsible for the patient record was detected in one-third of departments.

In addition, in two out of three departments, serious deficiencies were found in recording of patient records by the surgeons. This was also the case for patients in intensive care units. In a large proportion of patient records, information about significant changes in the condition of the patient, and how this had been dealt with, was lacking. In one department, almost a month went by without the surgeon writing in patient records. Apart from the medical history, examination on admission, and description of the operation, surgeons wrote very little in the records. In some departments, it was detected that documentation about transfer from one department to another, documentation about admission and discharge from the intensive care unit, and admission records were inadequate. Inadequate patient records reduce safety in health services by increasing the risk of errors and deficiencies. This can have serious consequences for the patient, such as prolonged illness, injury, permanent impairment or death.

In almost one out of three departments, access to information was difficult because of poorly organized patient records. In two places, lack of follow-up from leadership about the content of patient records was pointed out. Limited access to patient records because of lack of personal computers was found in several places. In one place, it was pointed out that the rules about what should be recorded in the patient records were unclear.

The Norwegian Board of Health in the counties will follow up the findings from supervision, to ensure that errors are corrected by those who are responsible.

Reference:
Documentation and Confidentiality in Hospital Departments of Gastrointestinal Surgery.
Summary of countrywide supervision in 2005 of communication between health care personnel and between health care personnel and patients in health trusts that provide surgical treatment for patients with acute diseases and cancer in the gastro-intestinal tract.
Report from the Norwegian Board of Health 1/2006 Oslo.
The Norwegian Board of Health, 2006

Inadequate patient record keeping

In eight supervision cases in 2005, inadequate patient record keeping was the reason, alone or with other reasons, for issuing warnings to health care personnel. However, patient record keeping has been assessed in many more cases, and instruction in patient record keeping has been given to health care personnel.

All health care personnel have a duty according to the Health Personnel Act section 40 to document their practice. This means that health care personnel shall record their activities with patients in the patient records. The duty to keep patient records is justified on the basis of quality and continuity of treatment, and with regard to checking health care that was provided in the past. Health care institutions must organize their activities in such a way that health care personnel can carry out their tasks, including patient record keeping, in a way that is in accordance with statutory requirements, pursuant to the Health Personnel Act section 16.

A basic requirement of health care personnel is to provide health care that is in accordance with sound professional standards. In order to be able to do this, health care personnel must have an overview of measures that have previously been taken, observations that have been made, and assessments that have been carried out. This requires recording information in patient records.

In addition, patient records are an aid to communication between health care personnel. They also make it possible for the supervision authorities to carry out supervision of health services.

Today, many health care institutions use electronic patient record systems. Systems have therefore been established for adequate recording and archiving of information about patients. However, the Norwegian Board of Health often registers that patient record keeping is inadequate. This situation can have negative consequences for the treatment that patients receive. In a broader perspective, this can lead to ineffectiveness and inefficiency, and can hinder the work of the supervision authorities.

There is probably no simple explanation for why health care personnel are careless with patient record keeping. In many situations lack of time may be part of the reason. Another reason may be that other tasks are given higher priority. However, the most common reason seems to be lack of awareness of the importance of adequate documentation.

Inadequate patient record keeping is seen in all types of supervision cases, but perhaps most seriously in cases relating to mental health care. Since we know that patients receiving mental health care more often require long-term treatment than patients in other groups, it is of particular concern that patient record keeping is inadequate in a way that makes continuity of care difficult.

In in-patient departments, it is most often the patient record keeping of doctors and psychologists that is assessed as inadequate. However, in some of these cases it has been possible to understand what has happened by using the nurses' records. This demonstrates how important it is for all health care personnel to record the health care that they have provided.

The negative culture that inadequate patient record keeping reflects, means that both managers and health care personnel must actively work to bring about a change in attitude. Managers must organize the system so that patient records are adequate and inadequacies are detected. Health care personnel must take more responsibility for recording information.

Suicide despite treatment

Many people commit suicide, even though they are receiving treatment in specialist mental health services. Based on experience gained from individual cases and planned supervision of health services, several deficiencies in health service routines for assessment of suicide risk, in prevention of suicide and attempted suicide, and in follow-up of clients after attempted suicide have been identified.

The health trusts have responsibility for ensuring that health care personnel receive adequate training, so that they are able to practice their profession in line with sound professional standards, according to the Specialized Health Services Act.

In supervision cases, we have pointed out the following situations that health institutions need to correct:

- Health personnel without specialist qualifications make individual assessments of the risk of suicide, without having had necessary instruction.
- Assessment of the risk of suicide is sometimes made without adequate background information, and does not include an overall assessment of all the factors that can affect the patient's mental status. Information from relatives is not taken into account to an adequate extent.
- Patients are admitted for so short periods that there is no opportunity to assess all the relevant factors in line with sound professional practice.
- Protective measures, follow-up and compilation of an individual plan are inadequate. The Norwegian Board of Health has found that this has had serious consequences, particularly in transition phases, such as when a patient is granted leave to go home, transferred to another treatment centre, allocated a new therapist, or discharged.
- Diagnostic assessments have not been recorded in the patient records, and other types of documentation are inadequate.
- Follow-up of the relatives after cases of suicide is inadequate.

Obtaining an overview of the situation

The Norwegian Board of Health has begun to look closer at individual cases that are reported to the Norwegian Board of Health in the counties. We wish to obtain a reliable overview of the number of cases that are reported, and to carry out a quality control of our procedures in supervision cases. This work was begun in 2005 and will continue in 2006. We will write a report and/or develop a guideline for administrative procedures for these cases.

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Hospital occupancy rates that are too high

Occupancy rates in hospital departments can be too high when there is an excess number of patients in relation to capacity, in terms of both physical resources and other resources such as manpower and economy. This is often dealt with by placing patients in corridors, or in other departments that may not have the specialized facilities that the patients need. The consequences of occupancy rates that are too high vary. The situation needs to be assessed in each individual case, in order to determine whether or not the situation is in breach of statutory requirements.

Occupancy rates that are too high, and placement of patients in corridors, can increase the risk of incorrect treatment, accidents and hospital infections. Patients' integrity and dignity can be violated, and the time each member of staff has for each patient can be reduced. It has happened that patients have died in corridors. Occupancy rates that are too high can lead to problems when carrying out examinations and exchanging sensitive information. This can lead to admittance practice being too restrictive, and patients being discharged too early.

The Norwegian Institute of Hospital Research (NIS) has stated that a hospital occupancy rate of 85 per cent is often used as an appropriate level of occupancy when planning departments that have a high percentage of emergency admissions. If the mean occupancy rate during the year is 95 per cent or higher, this may be an indication that the situation is in breach of statutory requirements. Another indication is if the number of beds in the corridor is 10 per cent or more in excess of the number of ordinary beds, on more than 10–20 days during the year (1).

Instructions issued to Sandviken Psychiatric Hospital

When hospital services are provided in a way that is in breach of statutory regulations, such that damage to patients may occur, the Norwegian Board of Health can issue instructions to correct the situation. The Norwegian Board of Health can also issue instructions to close the health institution, and can impose a coercive fine if the requirements laid down in the instructions are not met.

In mental health care, tranquility and protection are often essential in order for treatment to be in accordance with sound professional practice. When providing compulsory mental health care, the patient does not have the possibility to refuse admission.

The Norwegian Board of Health issued instructions to Sandviken Psychiatric Hospital in Bergen, because occupancy rates in acute psychiatric departments were too high over a long period of time. Supervision in 1999 revealed that occupancy rates at the hospital had been too high for several years, and that patients had been placed in corridors. The Norwegian Board of Health first warned Hordaland County Municipality that we were considering issuing instructions to them to correct the situation. The County Municipality initiated measures that led to some improvements at the hospital.

However, after a while occupancy rates went up again, and in 2002 the Norwegian Board of Health issued instructions to Bergen Hospital Trust (Helse Bergen HF) to introduce immediate measure to improve conditions, and to ensure that the running of the hospital was in line with statutory requirements. Despite the fact that Bergen Hospital Trust made several improvements and introduced measures, for example, relating to organization of the services and changes to the physical surroundings, occupancy rates were still too high.

The Norwegian Board of Health could not ignore the fact that occupancy rates were determined by factors outside the control of Bergen Hospital Trust. For example, the population that patients came from had doubled since 1995. Also, transfer of patients between hospital departments and district psychiatric centres, and from district psychiatric centres to municipalities, was unsatisfactory. Bergen Hospital Trust did not have the authority to use resources on the private institutions and private specialists that Western Norway Regional Health Authority had contracts with. Thus in 2004, the Norwegian Board of Health found that the right approach was to make Western Norway Regional Health Authority accept its responsibility. In accordance with the Specialized Health Services Act, regional health authorities have a statutory obligation to ensure that the population is offered specialized health services. The Norwegian Board of Health issued instructions to Western Norway Regional Health Authority to implement immediate measures to ensure that the hospital was run in accordance with statutory requirements. It was necessary to make it clear that Western Norway Regional Health Authority had the main responsibility for this, and not Bergen Hospital Trust.

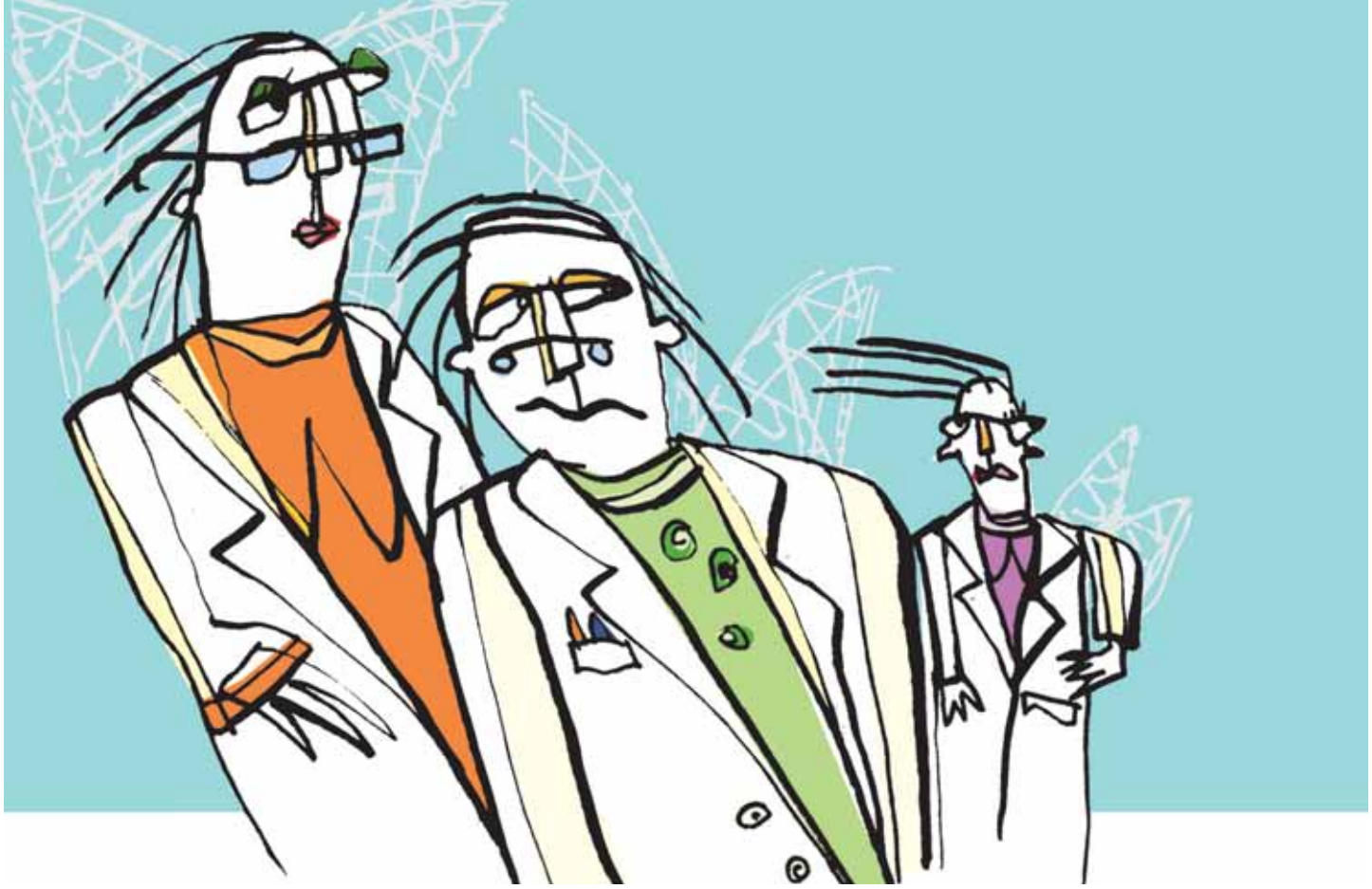
After initiating several measures, such as increasing the capacity of two district psychiatric centres, establishing an acute psychiatric out-patient department, and drawing up contracts between the municipality and private specialists, occupancy rates at Sandviken Psychiatric Hospital are approaching satisfactory levels.

This case has shown that there are several challenges:

- to identify the reasons why occupancy rates are too high, to find out who can do something about the situation, and then to do something about it
- to find the right level to issue instructions to
- to make the regional health authority aware of its responsibility to ensure that adequate services are provide in line with statutory requirements.

The State: The State has overall responsibility for ensuring that the population receives necessary specialized health services.
Regional Health Authorities: Regional health authorities have overall responsibility for the public hospitals and health care institutions in their region, and for ensuring that the population is offered specialized health services. The country is divided into five health regions: Western Norway, Southern Norway, Northern Norway, Eastern Norway and Central Norway.
Health Trusts: Public hospitals and health care institutions in the health regions are organized as administrative units: health trusts. Each region has several health trusts, and each health trust can encompass several hospitals and health care institutions.

Reference:
Guideline for the Norwegian Board of Health for following up hospital occupancy rates that are too high (IK-2730). The Norwegian Board of Health, October 2000



Evaluation of Supervision of Maternity Units

Chief County Medical Officer in Hordaland, Helga Arianson, has carried out an evaluation of countrywide supervision of maternity units in 2004. She examined how the supervision was experienced by health care personnel and leaders, using a questionnaire and interviews.

The study included all leaders and health care personnel who were interviewed during the supervision. This part of the study included 208 persons. Eighty-nine per cent answered the questionnaire. The experiences of the supervision of the leaders and health care personnel were used as an indirect measure of how the supervision team had carried out their work. It was assessed whether the way in which the supervision had been carried out, as perceived by the study participants, was in line with the procedures laid down by the Norwegian Board of Health. It was thus also assessed whether the implementation of this supervision could be regarded as a kind of "gold standard".

The study showed that countrywide supervision of maternity units was well received both by leaders and by health care personnel. Those who responded expressed the view that the supervision teams had mainly carried out the supervision in line with the procedures for the areas that were investigated. The results show that the conclusions that the supervision authorities presented to the maternity units were regarded as correct by most of the people involved. The maternity units have reported many changes that have been made as a result of supervision. The number of changes that have been made is independent of whether non-conformities (breaches of laws or regulations) were pointed out or not. It thus seems that supervision in itself leads to improvements, and that this specific supervision has contributed to improving maternity care in the institutions that were involved.

However, some of the findings of the study give the supervision authorities reason to take a closer look at some aspects of their practice:

- There are many regional differences, which seem to be the result of differences in the way the supervision teams work
- It seems that it is of great importance that the supervision authorities act considerately, in order for the supervision teams to gain the trust of the people involved. The way in which the teams behave seems to have importance for how the supervision is accepted, but not for the extent of the changes that are made.

Who are the recipients of compulsory mental health care?

What characterizes clients who receive compulsory mental health care? Are there still differences in use of compulsory treatment in Norway, according to region and institution?

SINTEF Health Research has analysed data on compulsory admission and treatment for the Norwegian Board of Health in cooperation with the National Directorate for Health and Social Affairs. The data were collected for the whole country on one day in 2003 (in-patients) and over two weeks in the autumn of 2004 (out-patients). There is almost no missing data. Data were collected for all patients receiving treatment from mental health care services on the days of the study period. The analyses include all forms of compulsion regulated by the Mental Health Care Act: compulsory admission, compulsory treatment and use of restraint.

Compulsion and poverty

The main requirement for compulsory admission to mental health care is serious mental illness, according to the Mental Health Care Act section 3-3. These clients are people who are seriously ill. The results of the study show that compulsion is closely related to problems of poverty – economic, educational and social. Only two per cent of patients who are admitted under compulsion to mental health care support themselves from their own work, about 30 per cent do not have their own home, or do not have suitable accommodation according to the therapist's assessment, and less than 10 per cent are married or have a partner. Whether illness leads to poverty, or whether poverty leads to illness, was not investigated. But this study provides evidence that people who receive compulsory mental health care are in a much worse situation to take care of themselves than people in general, because of their economic, educational and social situation. Thus, ensuring the legal safeguards of these clients demands extra vigilance on the part of service providers, the control commission and the supervision authorities. Continuous monitoring of use of compulsion and of administrative procedures for dealing with complaints is essential.

Some of the aims of the Development Plan for Mental Health are: to ensure that people with mental illness have adequate accommodation, to help them to establish and maintain social networks, and to help them find employment. This study gives reason to question whether these aims are being met, and whether the groups of people most in need of help are those who receive help.

Different interpretations of the legislation?

The study showed that there are great differences in use of compulsory mental health care in the different health trusts. The rate for compulsory admission is several times greater in the health trusts that use compulsion most than in the health trusts that use compulsion least.

There is also great variation in how long clients are under compulsory care. For the country as a whole, almost one in three clients who had been admitted under compulsion had been under care for more than one year. In some health trusts, there were no clients who had been under compulsory care for more than three months, while in others, more than 80 per cent of clients had been under compulsory care for over one year.

Some types of compulsory treatment are used much more often in some health trusts than in others.

There also seems to be a relationship in the use of the different types of compulsion (admission, treatment and restraint). Frequent use of out-patient care is related to frequent use of institutional care, and frequent use of restraint or protection is related to frequent use of compulsory admission and treatment.

We do not believe that the great differences in use of compulsion according to region and health trust can be fully explained according to differences in the patient population and the organization of the services. The Norwegian Board of Health will therefore continue to monitor the situation and see whether the differences are partly the result of different interpretations of the legislation.

Reference:
Use of Compulsory Admission and Treatment in Mental Health Services.
Report from the Norwegian Board of Health 4/2006 Oslo.
The Norwegian Board of Health, 2006

Little leeway in nursing and care services

In the report "Nursing and Care Services Under Strain - comparison and analysis of findings and experience from supervision of services in 2003 and 2004" the Norwegian Board of Health points out some vulnerable areas where there is a high risk that deficiencies in provision of municipal nursing and care services may occur.

In particular, the report focuses on special challenges for the municipalities related to clients and the nursing and care services that they receive. In some municipalities, there is reason to believe that the challenges are so great that the system is approaching bursting point. The risk of deficiencies occurring in some areas is high. From the perspective of supervision, this means that there is a danger that services are not provided in accordance with statutory requirements.

Extent and diversity

Many clients with diverse needs for nursing and care provide a challenge for the municipalities in terms of managing the services. This is a vulnerable area. All clients have the right to receive individually adapted services. They have this right, irrespective of their age, gender, housing situation and reasons for needing nursing and care services. In order for service supply to meet statutory requirements, it is necessary for the municipalities to have a management system that ensures that each individual client's needs are thoroughly assessed. Clients and relatives shall be given the opportunity to participate in the assessment, make suggestions and express their wishes. The system must also be organized in such a way as to ensure that changes in needs are detected, so that service supply can be adjusted. Clients' needs shall determine the services they receive, and not vice versa.

During the last few years, because of extended areas of responsibility, the municipalities have been facing extra challenges related to new client groups with complex and extensive needs for help and support. Meeting the needs of some of these clients may require different solutions than those that have been used previously. Examples of new client groups are people with mental disabilities and people with mental illnesses.

The supervision reports give the impression that the municipalities, as far as possible, organize the services to meet the individual needs and wishes of clients, for example in relation to daily routines. However, it seems that it is more difficult to ensure predictability and continuity of services. This can lead to vulnerability, for example in relation to ensuring that clients receive their medication, in cooperation with doctors, other health care personnel and other services, and in relation to use of coercion and restraint.

Vulnerability seems to be particularly associated with manpower: ensuring that the manpower situation is stable, and that health and social workers have adequate skills to meet the demanding professional challenges that they often face. Lack of time is also often a problem. Health and social workers often have too little time with each client. Experience gained from supervision suggests that manpower and time factors can cause services to be vulnerable in terms of meeting clients' basic needs and ensuring that services are in line with statutory requirements.

Teamwork

Based on the experience gained from supervision, it seems that teamwork and cooperation between different sectors of health and social services are vulnerable areas. Cooperation is often essential for ensuring provision of adequate services to clients with complex needs, for example when administrating medication. In the opinion of the Norwegian Board of Health, it is serious that many health care institutions do not have adequate routines for administering medication.

Management and leadership

Systematic management and leadership of the services are essential in order to provide health and social services that meet statutory requirements, and to ensure that the people receive services they need and have the right to receive according to health and social legislation. This is the responsibility of the municipalities, and presents a great challenge when seen in the light of the diversity that characterises municipal nursing and care services.

Many municipalities can document that they are working steadily with quality improvement and development of the services, in order to ensure good management. However, there is still much to be done in most municipalities in putting plans into action and in informing the staff about management systems and routines. In particular, systems for dealing with nonconformities need to be improved. Dealing with nonconformities entails learning from mistakes and adverse events. Experience gained from supervision of

Reference:
Nursing and Care Services Under Strain
Comparison and Analysis of Findings and Experience from Supervision of Services in 2003 and 2004.
Report from the Norwegian Board of Health 7/2005
Oslo. The Norwegian Board of Health, 2005

nursing and care services, and from other health and social services, has shown that service providers are not adequately systematic in checking areas where the risk of mistakes occurring is high, and where the consequences of deficiencies are particularly serious. Not enough attention is given to what can and aught to be done to avoid deficiencies.

Area surveillance

The report "Nursing and Care Services Under Strain" was produced as part of the Norwegian Board of Health's area surveillance. Area surveillance is supervision with an overall perspective. The aim of area surveillance is to collect information from different sources, both our own and others, in order to assess the relationship between the health and social needs of the population and the services clients receive. The supervision authority also needs this information to assess risk and vulnerability, and in the process of making decisions about which areas should be given priority for supervision, both at the county level and at the national level..

Plans for health and social emergency preparedness shall be followed up in the counties

In cooperation with the Offices of the County Governor and the Norwegian Board of Health in the Counties, the Norwegian Board of Health (centrally) has continued its work related to municipal plans for health and social emergency preparedness. During 2005, many municipalities developed a plan, but by 31.12.05 there were still 42 municipalities that had not completed this work. However, many of these 42 municipalities had plans that were ready to be approved in January 2006. In 2006, the Norwegian Board of Health will follow up the municipalities that still do not have plans that are completed and approved.

However, it is not sufficient that municipalities have developed a plan for health and social emergency preparedness. The plans must be based on a risk and vulnerability analysis of the local situation, and they must be regularly updated. They must be adequate to provide a level of preparedness that is appropriate for the purpose, based on the daily running of the municipal services and with regular practices of emergency situations. The plans must be adapted to local conditions, so that the municipality is prepared to provide essential health and social services in the event of a crisis or a catastrophe.

Thus, the Norwegian Board of Health in the Counties, in cooperation with the Offices of the County Governor, have been allocated the task of following up municipal plans for health and social emergency preparedness. For example, in 2005, the Norwegian Board of Health in Aust-Agder, in cooperation with the Department for Emergency Preparedness at the Office of the County Governor, has carried out supervision of health and social emergency preparedness in five municipalities, and found the following:

- Risk and vulnerability analyses are lacking
- The plans are often not fully operative
- Not all the parties that have a role in the plans have been informed
- Practices of the plans have not been carried out. None of the municipalities have practised contacting people on the list of people to be contacted in the case of emergency
- Reports of deficiencies, as indicators of potential vulnerability and failure, have not been used to improve the system
- Integration of the plans with the municipalities' internal control systems is inadequate
- There is more focus on plans for control of communicable diseases than on other plans in areas of health and social preparedness
- The municipalities have broad experience in establishing psycho-social crisis teams
- There is little coordination with hospitals and plans for emergency medical services
- The municipal leadership expects that plans for health and social emergency planning are integrated in municipal plans for crisis leadership and preparedness
- In the municipalities that have allocated responsibility for emergency planning to one person, the plans have a greater degree of continuity, are of higher quality, and are more coherent than in the other municipalities.

The municipalities admit that work with emergency planning can be given too little priority when other tasks are pressing. Supervision functions both as a control of the work that has been done, and as a reminder of the importance of continuing with the work, and improving the plans. A new and more functional template for plans for control of communicable diseases under the leadership of a district medical officer has been developed. The county governor in Aust-Agder organized a meeting in which this was presented for municipalities.

The Norwegian Board of Health – the agency with overall responsibility for cases of complaint relating to health and social legislation

In 2005, the Offices of the County Governor and the Norwegian Board of Health in the Counties made approximately 6 000 decisions about cases of complaint relating to the Social Services Act, and approximately 700 decisions about cases of complaint relating to health legislation. Such cases range from topics such as the amount of social security benefit provided to whether an elderly lady has the right to a place in a nursing home.

The Norwegian Board of Health is the agency with overall responsibility for these cases. This involves responsibility for helping to ensure that the legislation is practised in a way that is as much as possible equally correct, fair and consistent over the whole country. In special cases, the responsible agency must also assess whether decisions should be reversed, pursuant to the Public Administration Act section 35. Basically, decisions about cases of complaint made by the Offices of the County Governor and the Norwegian Board of Health in the Counties are final, and cannot be appealed, pursuant to the Public Administration Act section 28. Neither do the parties involved have the right to ask for their case to be assessed by the Norwegian Board of Health as the agency with overall responsibility for such cases, pursuant to the Public Administration Act section 35.

The role of agency with overall responsibility is important, because correct, fair, consistent and predictable practice when dealing with cases of complaint is a central element of the legal safeguards of clients and patients.

In addition to continual management and providing advice and counselling, we are currently working on improvements to the reporting and registration system, and on developing a guideline for dealing with cases of complaint. The Norwegian Board of Health in the Counties often have to deal with complicated legislative and professional issues. Also, comprehensive changes have been made to the health legislation during the last few years. Perhaps the most important of these are the changes to the Patients' Rights Act and the implementation of the reform of health and social services for people with alcohol and drug problems. For example, if a complaint is made, the Norwegian Board of Health in the Counties needs to decide whether it is in accordance with statutory requirements to refuse to give a drug addict treatment, or whether a patient has the right to have travel expenses reimbursed.

If, when carrying out our role as agency with overall responsibility for cases of complaint, we identify issues of principle regarding interpretation of the legislation, these issues shall be raised with the National Directorate for Health and Social Affairs, Norway. The Directorate is the agency with authority for interpreting the central acts in the fields of health and social affairs.

Examples of provisions in health and social legislation relating to complaints:
Social Services Act section 8–6
Patients' Rights Act section 7–2
Municipal Health Services Act section 2–4
Dental Health Services Act section 2–3
Communicable Diseases Control Act section 6–1

The right to request an evaluation of possible breach of duty, pursuant to the Patients' Rights Act section 7–4, is not dealt with in this article.

An overview of patients' rights, and regulations for making complaints about health and social services, is to be found on the website of the Norwegian Board of Health.

Supervision of private health services

The Norwegian Board of Health is presently assessing how contract management of private providers of health and social services functions. We will assess whether there is a risk that services are provided in breach of statutory requirements, and whether contract management has an effect on the quality of the services. We will also examine the consequences that contract management has for the public bodies that order the services, in terms of their responsibility for services and follow-up of services.

In 2005, the working group cooperated with the Norwegian Board of Health in some of the counties that have carried out supervision of private institutions: six hospitals and one radiographic institute. All the institutions had, or were about to draw up, a contract with the regional health authorities about the type and amount of services they would provide.

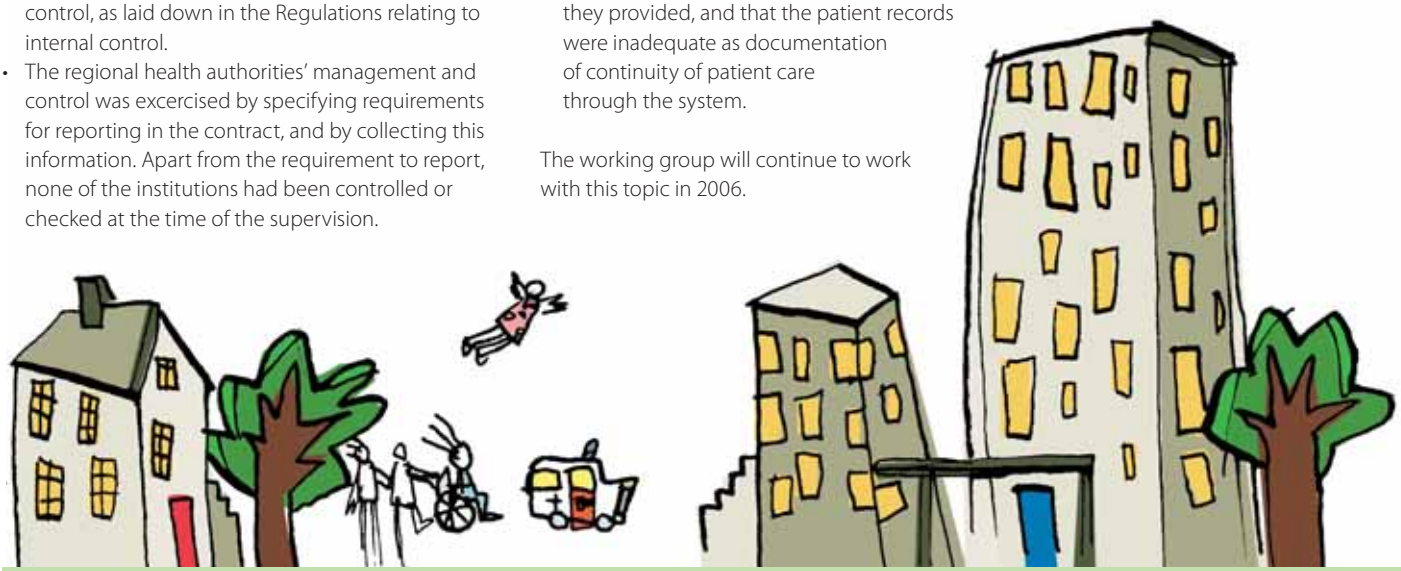
Allocation of contracts is regulated by the Public Procurement Act, which also includes provisions about requirements for administrative procedures, the possibilities to have the case reassessed for those who believe they have been unfairly treated, and sanctions in the case of breach of contract.

Supervision of private hospitals was carried out in Central Norway Health Region. Supervision of the radiographic institute was carried out in Southern Norway Health Region. The supervision reports can be found on the website of the Norwegian Board of Health.

What did we find?

- The tasks of the institutions were clearly defined, both in terms of content and organization. This means that the tasks were more predictable for the institutions' leadership than is the case with public hospitals, which have many functions. Public 24-hour emergency services provide an important supplement to private services, to ensure that service provision is in line with statutory requirements.
- With some exceptions (see point 5) the institutions met the requirements for management and internal control, as laid down in the Regulations relating to internal control.
- The regional health authorities' management and control was excercised by specifying requirements for reporting in the contract, and by collecting this information. Apart from the requirement to report, none of the institutions had been controlled or checked at the time of the supervision.
- The duties that the institutions had related to the tasks specified in their contracts, were mainly duties that are laid down in legislation. Thus the risk of deficiencies in meeting these duties, because of deficiencies in the contracts, was relatively small. Supervision could therefore be focussed on the duty of the institutions as independent bodies, and not on the regional health authorities that order the services.
- Supervision revealed the following:
  The radiographic institute:
  The themes for system audit were patient information and quality improvement in the institution. The institute had not established a quality improvement committee. The institute did not have an adequate system for reporting events involving serious injury to patients, and events that could have led to serious injury to patients, to the Norwegian Board of Health in the County.
  The six private hospitals:
  The themes for system audits were the institutions' management of referrals, discharging patients, documentation of patient-centred services and the hospitals' internal control system. Deficiencies were detected in the routines for ensuring that doctors who had referred patients were informed of the result. This could result in breaches of the legislation, if it led to an increase in waiting time for treatment. At two of the hospitals, the supervision authorities found that nurses did not record the health care that they provided, and that the patient records were inadequate as documentation of continuity of patient care through the system.

The working group will continue to work with this topic in 2006.



Reliable and systematic area surveillance

The supervision authorities' Area Surveillance Project (TOP) is a three-year project, with the aim of ensuring high quality supervision of health and social services through the activities that we call area surveillance. The legislation provides the framework for the activities of the Norwegian Board of Health. Area surveillance is an important supervision activity, and the Norwegian Board of Health wishes to develop sound practice for collection, organization and interpretation of data. Area surveillance is important when the supervision authorities assess the status of health and social services. Information gained from area surveillance is important when deciding which areas should be given priority for supervision, both at the county level and at the national level.

The supervision authorities are expected to have a general overview of the status of health and social services. This includes having information about service supply in relation to the health and social status of the population. In area surveillance, we compare information from different sources, both our own and others. One approach is to use the experience we have gained from supervision together with data from other sources to identify deficiencies in service provision in a defined geographical area. Such information may indicate the need to collect more detailed information from other parts of the country, in order to assess the situation in other places. In addition, the Norwegian Board of Health, in cooperation with other organizations that collect information, shall follow trends in service provision and developments in the population. Examples of relevant areas are social security benefits, poverty and inequalities.

The supervision authorities have many areas to supervise, so it is important to decide which areas shall be given priority, based on an assessment of risk. Risk is about uncertainty in the future, about how systems will function, and about which activities will take place. Risk analysis is based on both experience from supervision and information from other sources, such as public statistics and research reports. Such information can identify vulnerable situations, such as inadequate planning for dealing with adverse events. Information about vulnerable areas that are identified can be used in risk assessment. Risk and vulnerability analysis is a central element of area surveillance. It involves monitoring the right areas at the right time, so that we can identify existing or potential deficiencies in services as early as possible.

You can read more about area surveillance on our website: www. helsetilsynet.no.

AREA SURVEILLANCE
is supervision with an overall perspective, and involves collecting, organizing and interpreting information about health and social services, from a supervision perspective.
(Report to the Storting No. 17 (2002–2003) Public Supervision)

Borghild Haaland

It pays to keep going!

Borghild Haaland, winner of the Karl Evang Award 2005, never gives up, even when she meets opposition. Her approach is to work twice as hard, and to leave no stone unturned: – If I don't manage to get through to people with good ideas in one place, I just try a different approach somewhere else.

– It pays to persevere and to find the right people who get fired with enthusiasm for the task, says the former nurse, midwife and health visitor, who likes to get immediate results.

Borghild Haaland from Arendal is a woman who is enthusiastic about many things, but most of all about the project she is in the middle of at any given moment. When she sees someone who needs a helping hand, she cannot resist doing something.

She is not daunted by her age. At the age of 70 she is starting a new project. This time the topic is family planning and education, and it is the staff and 34 children in a children's home in Toledo, the Philippines, who are benefitting from her efforts. And she has no doubts about what the prize money will be used for:

– Thirty-four children in Toledo have to leave the children's home when they are 18. We will give them the opportunity to have a four-year education after they leave, to prepare them for a successful life as an adult, says Haaland.

And this is totally in line with her thoughts about prevention:

– In order to succeed with prevention, we must start in good time. Health care personnel often begin too late. We must dare to go in as soon as we see that something is not quite right.

– Karl Evang has meant a lot to me since as far back as when he was a lecturer at the health visitor college in 1960. He had a wealth of knowledge to impart. I made up my mind then: this is what I want to go in for, says the retired health visitor, and pulls out her handbag with a well-used copy of Karl Evang's book "Fred er å skape" (Peace is to be Creative).

Borghild Haaland lists up the principles she bases her preventive work on, that are based on Evang's principles:

– The user must always be in the centre. We must create a safe environment for him or her. As health care workers, we must constantly be updated and acquire new knowledge, so that we can do as good a job as possible. It is important to cooperate with as many other people as we can. This also applies to people who work in specialized health services. We must work with prevention in order to avoid suffering, and in order to utilize resources as efficiently as possible. Services must be well organized, of course. With regard to out-reach programmes, we must remember that it is not always those who are first in the queue who are in most need of help. Having a good relationship with the media is also a good idea.

Among other things, Borghild Haaland has been a health visitor in the municipality of Gjerstad in Aust-Agder for many years. Here, she had been the driving force behind preventive measures for all age groups. Examples of her projects are: ballet courses for children, clubs for good nutrition, a health centre for adolescents, anti-smoking clubs and contracts for being alcohol and drug free for pupils in secondary schools, first-aid courses, theme days on asthma and allergy, and health checks for 40-year-olds and long-term unemployed people.

At the award ceremony in October last year, Professor Steinar Westin, who presented the award, said that Borghild Haaland has shown how versatile she can be, and how she has the ability to think untraditionally for the benefit of the clients. He also referred to her indomitable will to keep going, that is needed to put so many good ideas into action.

– I shall keep going as long as I have enthusiasm and good health, as long as I can find new things to do, and as long as I can get things done. Words alone are not enough, they must be turned into action.

What is her recipe for success with projects? According to the prize-winner, the secret is to have empathy, so that one can put oneself in other people's shoes. One must also manage to involve competent people from different professional groups. One must be able to tolerate opposition and work towards a goal. Last but not least, the users of the services must be involved.

Kjell Underlid

Contact with the social security office: the voice of the poor

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In the research project, The Psychology of Poverty[1], 25 clients who were receiving long-term social security benefits in a district in Bergen were interviewed. The focus of the interviews was their experiences of issues related to poverty. Although few questions were basically asked about their contact with the social security office, this topic often came up during the interviews. The social security office turned out to play a central role in their lives.

Many respondents told about specific experiences from their contact with the social security office, that had made them feel insecure, and that had frightened them. This could be criticism and correction, tight control, being "punished" for obtaining extra income, and being given unreasonable demands. Various proposals made by the social security office could lie in the grey area between advice, conditions, requirements, directives and threats. Several clients experienced the social security office as demanding and directly frightening. There could be a lot of waiting and going backwards and forwards. Contact with a complicated, unclear, fragmented and sometimes contradictory help organization could also create insecurity.

The participants in the study reported specific events and experiences that indicated that the social security offices undermined clients' autonomy, or else that clients actually lost their autonomy completely. Examples are rejection of applications that had very negative consequences for clients' development and social contact, and that prevented clients from achieving important aims in life and moving forward.

They experienced that the social security office had a miserly mentality, that they demonstrated their power, made sarcastic, flippant and hurtful comments, were harsh, were suspicious, lacked commitment, were obstructive and complaining, made clients feel ridiculous and pathetic....

Clients who were encouraged to get rid of personal possessions sometimes found that this made it more difficult for them to fulfil central roles in their lives, such as their role as a parent. Some clients mentioned that they were classified in terms of diagnosis, type of client, pathology and psychology, that this was a threat to their autonomy, and that this was used as a means of disciplining them. Having to "fight" against a large, inflexible, bureaucratic system can be interpreted as negative behaviour, and this is something that clients would prefer to avoid.

Many clients experienced that they were looked down on by the social security office, and were treated with little respect. For example, clients told about being "looking down on", so that they felt as though they were not worth anything, and that they were socially inferior. They experienced that the social security office had a miserly mentality, that they demonstrated their power, made sarcastic, flippant and hurtful comments, were harsh, were suspicious, lacked commitment, were obstructive and complaining, made clients feel ridiculous and pathetic, lacked understanding, were insensitive, gave clients the blame for things, and refused to take responsibility for things themselves. It is understandable that such experiences can lead to reduced self-image and self-respect.

The results raise many issues. I will mention some of these, and discuss them briefly.

Do these results give a true and valid picture of the experiences that clients who receive long-term social security benefits have with social security offices? The description given above is not the author's, but the clients'. But clients have different experiences. None of them have experienced all that is described above, but many of them have experienced much of this. The majority of them had negative experiences. A minority of them had neutral experiences or were indifferent.

For them, contact with the social security office was less important than other aspects of their life. Some clients told about social security office employees who had helped them in a positive way, both practically and in the way they had related to them on a personal level. However, nearly all the experiences that the respondents told about were negative experiences.

Some discussion about methodology is relevant. In surveys, one can collect data from a representative sample, either using a postal questionnaire or interview, and one can then generalize to a larger population. The results can be used comparatively, to compare different groups or different points in time. But the response rate for questionnaire surveys of this group of clients is often very low. Many of them do not like filling in forms, some of them are dyslexic. Their mistrust of public agencies can make them suspicious about anonymity and about what the results can be used for. It is difficult to examine things in depth with postal questionnaires. The results can be of little practical value. Are we much wiser if we know that 27.3 per cent answered that they were "fairly satisfied" with the way they were treated at the social security office?

It is not possible to generalize in the same way using qualitative studies. But one can investigate a broader range of topics and examine the issues in greater depth than with postal questionnaire studies. When interviewing people in an atmosphere of trust, one can obtain authentic accounts of complex experiences. One can find out how poverty "smells and tastes". Descriptions are not limited by set questions and responses. Therefore the voices of poor people are heard better. For what they have to say is really worth listening to. When it comes to their experiences of poverty, they are the "experts". However, client's experiences with social security offices need to be studied using both large surveys and qualitative in-depth studies.

Why do clients have such a negative assessment of social security offices?

The insecurity that clients report that they experience when they contact the social security office is a bit of a paradox. Security is just what these offices should create. It is also a paradox that clients feel that their autonomy is threatened by the way they are treated in the social security office. A central role for social workers is to help people in difficult life situations. It is interesting that they do not appear to fulfil this role successfully, since learning how to relate and communicate with people in difficult situations is an important part of their training. But this issue is beyond the scope of a short article such as this. It is not appropriate to search for the causes of the problem at the level of the individual social worker. The causes are to be found at the system level. Social security offices and social services have an equivocal role, in which help goes hand in hand with control. In addition, social services have limited resources.

Social welfare implications

If we accept that security, autonomy, respect and self-respect are important human needs, and that they are central values to aim for from a social policy view, it is serious that clients often experience that these needs are not met during their contact with the social security office. The results presented above, along with other evidence, support the view that drastic changes to social services are needed.

On the one hand, one can argue that a comprehensive reform of social security offices is needed, that there is great potential for improvement, and that there is much that can be done to improve the services provided by these offices. Amalgamation of social services, Aetat (government employment offices) and the National Insurance Service can be an important step in the right direction. There are also good reasons to raise the level of social security benefits, and to ensure that they are standard over the whole country. Social security benefits should also be based more on rights and less on judgement.

The insecurity that clients report that they experience when they contact the social security office is a bit of a paradox. Security is just what these offices should create.

On the other hand, one can argue that the social security office in its present form should be abolished. The present day social security office, in many ways, is a modern version of the old poor relief fund, where ensuring that people had adequate income to support themselves was determined by the judgement of the executive officer. A new model for ensuring that clients have an adequate income, in which social security benefits are organized as a public arrangement, may be more appropriate. Such a system would ensure that people have adequate income, based on statutory norms[2].

From a supervision perspective, it is important that social services are closely monitored, since these clients represent a very vulnerable group. We need a continuous social political discussion about service supply for this group. In this regard, the experiences that social security clients have with social services are important, and their voices must be heard.

[1] Underlid, 2005. Fattigdommens psykologi. Oppleving av fattigdom i det moderne Noreg. (The psychology of poverty. The experience of poverty in modern Norway) Oslo: Det Norske Samlaget

[2] Stolanowski & Tvetene, 2005. Har vi råd, mamma? Om inntektssikring og fattigdom. (Can we afford it, Mam? Ensuring adequate income, and poverty) Oslo: Cappelen Akademisk Forlag

Karina Aase

Siri Wiig

A learning organization – what does it take?

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All organizations have activities and processes that to a greater or lesser extent contribute to learning. This does not necessarily mean that these organizations can be described as "learning organizations".

Organizational learning is a relevant theme within health and social services. For example, recently much attention has been given to adverse events associated with incorrect treatment in Norwegian hospitals. International studies have shown that between 5 and 10 per cent of patients can be injured when in hospital. Without organizational learning from mistakes, it is not possible to see a pattern in repeated events, and it is therefore not possible to reduced these figures. In the reports from the Norwegian Board of Health, we find statements such as: "….experience gained from this supervision must be communicated to teaching institutions and professional groups…", or "….it seems as though we have a long way to go before the establishments become learning organizations, and use available feedback, experience and data for evaluating their own activities….". In order to achieve learning health and social services, it is necessary to learn on many levels and between different parties. It is a huge challenge to ensure that learning take places both within and between health authorities, social authorities, supervision authorities, administrative authorities and primary health services.

During the last decade, the field of organizational learning has exploded. We have few answers to the question about what it takes to be a learning organization. However, we know a lot about what does not work, about underlying assumptions, and about misunderstandings.

Myths

Below we present three common assumptions that can often create unnecessary barriers to organizational learning, or else delay the process.

1. Build an information system and clients will come!

Employees and leaders in organizations focus, to a large extent, on the importance of making knowledge and experience available. They often imagine that knowledge and experience must be collected, recorded and located like goods in a department store. Anyone who needs information or experience can go to the department store and find what she or he needs. The solution is often to develop a central electronic database. This tradition focuses on collection, processing, storing and dissemination of information, but not on utilization of knowledge. Such central databases often generate little enthusiasm among users for registering their experiences and retrieving information. Within health and social services there is a current debate about whether to establish a national register for patient safety. This register will aid analysis of adverse events and learning from experience both locally and nationally. But from a learning perspective, it is not enough just to collect this information centrally. The information must also be channelled back to health and social authorities, and then disseminated further to the services.

2. Technology can replace face-to-face communication!

Bringing people together through training courses, seminars or meetings often results in spontaneous exchange of information, during conversation and sharing of experiences. But at the same time this is costly. Technology provides the possibility for exchange of information without employees having to meet in one place. Studies of such information systems show that the degree of success depends on whether systems that were originally designed as IT-systems are developed to combine IT-support and collective meetings or gatherings. In practice this means that if an IT-support information system is to function, it must also support face-to-face communication, for example through discussion groups, network meeting and follow-up of experience. In health and social services, "Synergi" is being introduced as an IT-based reporting system for adverse events. "Synergi" alone does not create a learning organization, but can provide a basis for learning activities in which employees can discuss their own practice and use relevant information.

3. First we need to create a learning culture!

"In our organization no-one will contribute to learning activities because there is no room or culture for this". Such attitudes reflect the belief that exchange of information only occurs if a learning culture exists, with co-operation and openness. Thus, creating a learning culture becomes an aim before employees can exchange information. But what comes first: a learning culture or exchange of information? For example, health care personnel justify under-reporting of mistakes by saying that "there is no culture for reporting mistakes". This is often just an excuse because creating a learning culture, or in this case a reporting culture, is difficult. It may be better to assume that exchange of information influences the culture. When learning activities are based on important professional issues, the desire to exchange and receive information usually exists.

A model without boxes and arrows

The description of myths given above shows that knowledge and experience that can be expressed in words or in writing only represent the tip of the iceberg. The concept of "tacit knowledge" refers to knowledge that is difficult for us to express directly. The practical application of this concept focuses on how tacit knowledge can be made available and formulated in a concrete way. Often this results in the desire to express tacit knowledge through products, services and systems. This is called "objectification". "Objects" are produced (procedures, tools, regulations) that shall render knowledge and experience visible.

During the last decade, research within organizational learning has focussed on the significance of practice, collective reflection and dialogue. Instead of the desire to express individual tacit knowledge explicitly, focus has been directed more on expressing it collectively. The concept of "collective tacit knowledge" has been launched. In order to understand this perspective of organizational learning, the triple helix model has been developed.

The triple helix model

Event/experience

Creative dialogue

Collective practice

(Swart & Pye, 2002)

Event/experience expresses individual knowledge associated with specific events or experiences. There are many different descriptions of an individual event or experience, which often vary from person to person.

Creative dialogue involves active reflection of the different descriptions of the events/experiences, individually or collectively. In the collective processes it is important that representatives of the different perspectives are gathered together.

Collective practice entails following up aspects of the creative dialogue and changing individual or group practice related to the different events/experiences.

The model shows that learning activities should be developed with all the three "threads" included. For example, approaches that only focus on dialogue without relating this to specific events/experiences, or that only focus on changing practice without linking the change to creative dialogue, have little chance of success.

Concrete approaches to organizational learning?

There are many approaches to organizational learning, but there is no correct answer to what functions or does not function. Both the myths described above, and research in general, indicate that there is a tendency for organizations to develop learning processes that are based on one or two of the elements in the triple helix model. Trade and industry have traditionally focussed on formal measures such as requirements, procedures, networks and databases, that involve "person-to-document" approaches to learning. The opposite is "person-to-person" approaches, and the challenge in many organizations is to find the correct range or balance between these two perspectives.

A series of concrete approaches to learning have been developed and tested in different organizations. The approaches range from story-telling and accounts of learning in the World Bank to collective training and problem teams in nuclear energy. It is important to note that what functions in one organizational setting does not necessarily function in another. It is therefore difficult to copy approaches directly.

Learning health and social services?

So what does it take to be a learning health or social service? Health and social services must avoid the notion that a learning organization can only be built in a rational way with the help of knowledge systems and technology, or that a culture for learning must be developed before knowledge can be shared. The triple helix model should be the basis for work with learning within and between parties. In other words, existing or new learning activities must include all the three threads in the model (experience, dialogue, practice).

At the same time, learning cannot be taken out of context. Today, health and social services are characterized by general conditions that involve continuous changes, cost-cutting, demands for increased productivity, and lack of time. This creates difficult conditions for learning health and social services, and should provide food for thought.

Literature

Dixon, N. (2000). ***Common Knowledge. How Companies Thrive by Sharing What They Know.*** Harvard Business School Press, Boston, Massachusetts.

Hansen, M.T., Nohria, N., Tierney, T. (1999). What's your strategy for managing knowledge? ***Harvard Business Review,*** 77(2): 106–116.

Swart, J. & Pye, A. (2002). Conceptualizing organizational knowledge as collective tacit knowledge: a model of redescription. ***Proceedings OKLC 2002,*** 5–6 April, Athens, Greece.

Wenger, E. (1998). ***Communities of Practice: Learning, Meaning, and Identity.*** Cambridge, Cambridge University Press.

Wenger, E.C. & Snyder, W.M. (2000). Communities of Practice: The Organizational Frontier. ***Harvard Business Review,*** January–February: 139–145.


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Be careful when prescribing

As a consequence of the requirement for responsible conduct laid down in the Health Personnel Act, doctors must have an overview and control of their prescribing. Since the use of addictive medication can lead to a series of problems, doctors must be careful when prescribing such medication. In this context, addictive medication means medication that can lead to intoxication or euphoria, the development of tolerance, or symptoms of abstinence. The most serious danger when prescribing these types of medication is the risk of dependency or misuse. The result can be that the patient may not receive, or may not be motivated to receive, adequate treatment for the original problem.

Guidelines for responsible prescribing

Directive IK-2755, produced by the Norwegian Board of Health in 2001, lays down guidelines for responsible prescribing of addictive medication. According to the directive, doctors shall ensure that there are medical grounds for use of addictive medication. For example, the use of opiates may be appropriate for patients with chronic, non-malignant conditions, or for drug addicts who are on the waiting list for medication-assisted rehabilitation (MAR). However, it is important that such medication is part of a comprehensive, interdisciplinary course of treatment. The appropriate medication, in the right dose, over a defined period of time, can be of great benefit to many patients, on the condition that both the patient and the doctor are aware of the dangers that are associated with use of the medication. The doctor and the patient should have a clear agreement about the dose and the time-scale.

If there is a need for strong pain-killers, the choice should be made on the basis of current knowledge. For example, quick-acting opiates should not be used for long-term treatment, or when the a danger of addiction is great. The dose must be carefully adjusted according to the effect. The medication must not be used longer than is necessary, and if the patient becomes dependent, a plan for withdrawal must be made. Patients who may sell the medication should be identified and appropriate measures taken.

Medicinal products in group B (prescription drugs that are addictive, excluding narcotic drugs), such as benzodiazepines, have clear indications and provide good relief of symptoms when used over a short period of time. However, there is a great danger of addiction, and this danger increases over time, while the effect of the drug can be reduced. This demands vigilance from the prescribing doctor. Use of high doses of medication containing codeine can lead to opiate dependency. Dependency must be dealt with speedily. The decision to prescribe addictive medication over a long period of time should be carefully considered, and not taken under pressure of time or under pressure from the patient. The patient should be referred for appropriate professional help if he or she develops symptoms of addiction.

Revocation of the right to requisition medicinal products – warning

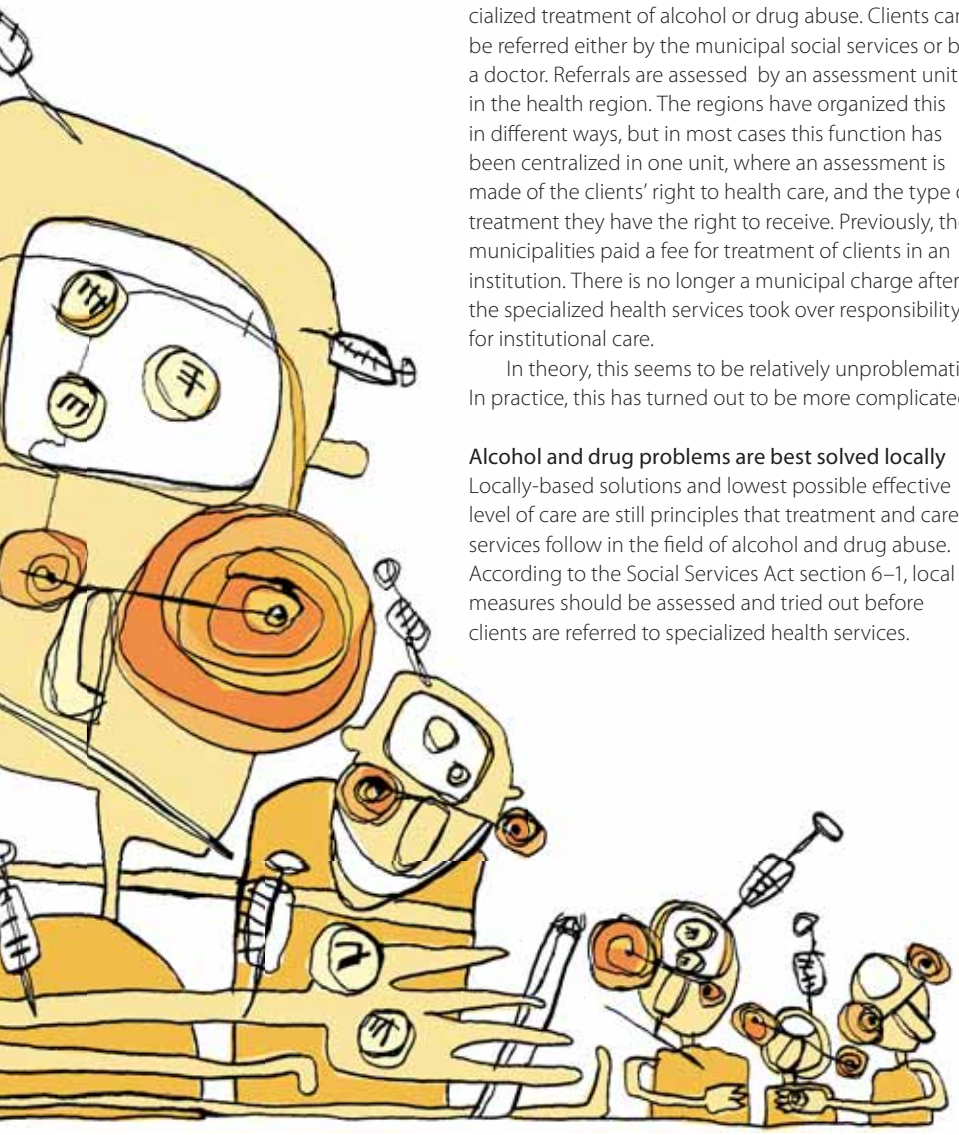
Each year, the Norwegian Board of Health deals with a series of cases, in which doctors are reported for prescribing addictive medication in a way that is not in line with responsible conduct. A common feature of cases that result in a reaction in the form of a warning, or loss of the right to requisition medicinal products, is that the prescribing is not planned and is regulated by the patient. The prescribing appears to reflect the patient's wishes for type of medication, dose, and length of prescribing, without the doctor having made an assessment of the effect of treatment, or the broader context of the case. Often the doctor has not assessed alternative forms of treatment, or has not followed the patient up adequately in relation to unwanted side-effects of the treatment.

In cases in which it can be shown that the prescribing doctor has demonstrated a lack of professional insight, in that the patient has not been adequately assessed before being prescribed addictive medication, or has not been followed up when using this type of medication, then this can lead to revocation of the right to requisition medicinal products. If there are indications for the use of the chosen medication, but follow up has not been planned, or has been regulated by the patient, this can lead to a warning and guidance, as laid down in the directive IK-2755.

In 2004, eight doctors lost their right to requisition medicinal products in group A (narcotic drugs) and group B (prescription drugs that are addictive) (twelve doctors in 2005). Seven doctors were given a warning for irresponsible prescribing (11 doctors in 2005).

Reform of health and social services for people with alcohol and drug problems: a challenge for the municipalities

The aim of the reform of health and social services for people with alcohol and drug problems is to give these people access to treatment, independent of municipal economy and priorities, and independent of their contact with social services. This has previously been a barrier for some of them. Treatment services for alcohol and drug abuse are now part of specialized health services. Specialized health services shall provide multi-disciplinary specialized treatment with a broad approach, and with a focus on the total health and social needs of individual alcohol and drug abusers. These people now also have a statutory right to receive treatment for alcohol and drug abuse. The municipalities still have the same responsibility within the field of alcohol and drug abuse as they had before the reform.



With the reform, there are now two pathways into specialized health services, for multi-disciplinary specialized treatment of alcohol or drug abuse. Clients can be referred either by the municipal social services or by a doctor. Referrals are assessed by an assessment unit in the health region. The regions have organized this in different ways, but in most cases this function has been centralized in one unit, where an assessment is made of the clients' right to health care, and the type of treatment they have the right to receive. Previously, the municipalities paid a fee for treatment of clients in an institution. There is no longer a municipal charge after the specialized health services took over responsibility for institutional care.

In theory, this seems to be relatively unproblematic. In practice, this has turned out to be more complicated.

Alcohol and drug problems are best solved locally

Locally-based solutions and lowest possible effective level of care are still principles that treatment and care services follow in the field of alcohol and drug abuse. According to the Social Services Act section 6–1, local measures should be assessed and tried out before clients are referred to specialized health services.

Because of the special challenges associated with issues related to serious alcohol and drug abuse, there is often strong pressure to find solutions that involve clients coming out of their local environment. This often means treatment in an institution. Examples of such issues are: the burden experienced by the relatives of serious alcohol and drug abusers, fear of collection of illegal debts, homelessness and behaviour that creates problems with buying a home.

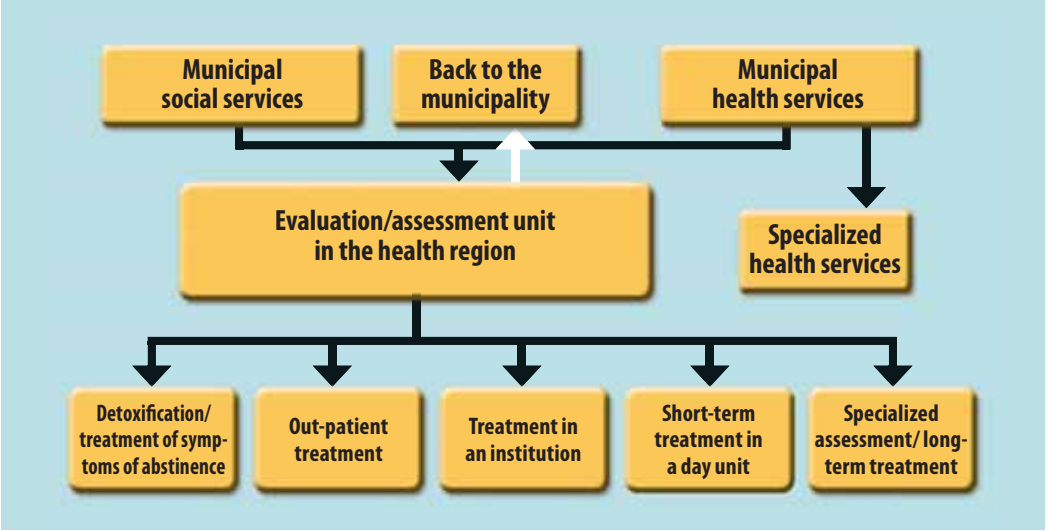
Because of changes in financing of treatment of alcohol and drug abuse in institutions, comprehensive changes have occurred in the relationship between locally-based treatment measures and specialized health service treatment in an institution, seen from the point of view of the municipalities. Before 2004, social workers would have assessed what locally-based treatment measures could be provided for up to kr 12 500 per month (municipal charge), compared to the effect of a stay in an institution. After the reform, the municipalities have a strong financial incentive to refer clients to an institution, since this now involves no cost for them.

Demand for treatment in an institution within the specialized health services has increased.

Demand for places for detoxification treatment is particularly great, even though the health trusts have increased capacity in 2005. The result is that only clients who are assessed as having "the right to essential health care" are given priority. There is a long waiting list for treatment for other clients. At the same time, private institutions report decreasing demand. Several of them are reducing their capacity or closing down.

How is it going?

In the autumn of 2004, the County Governor in Aust-Agder took the initiative on behalf of the health trusts and the municipalities to carry out a survey of referral of clients with alcohol and drug problems. This initiative was taken because of several reports from social services about problems with getting places for alcohol



The pathways to specialized treatment.

and drug abusers in specialized health services. The survey showed that several municipalities have little overview of the clients they have referred. Referred clients have often not been fully assessed for temporary measures, in accordance with the Social Services Act. There is little or no systematic follow-up by the municipalities of clients who have not been assessed as having the right to multi-disciplinary specialized treatment.

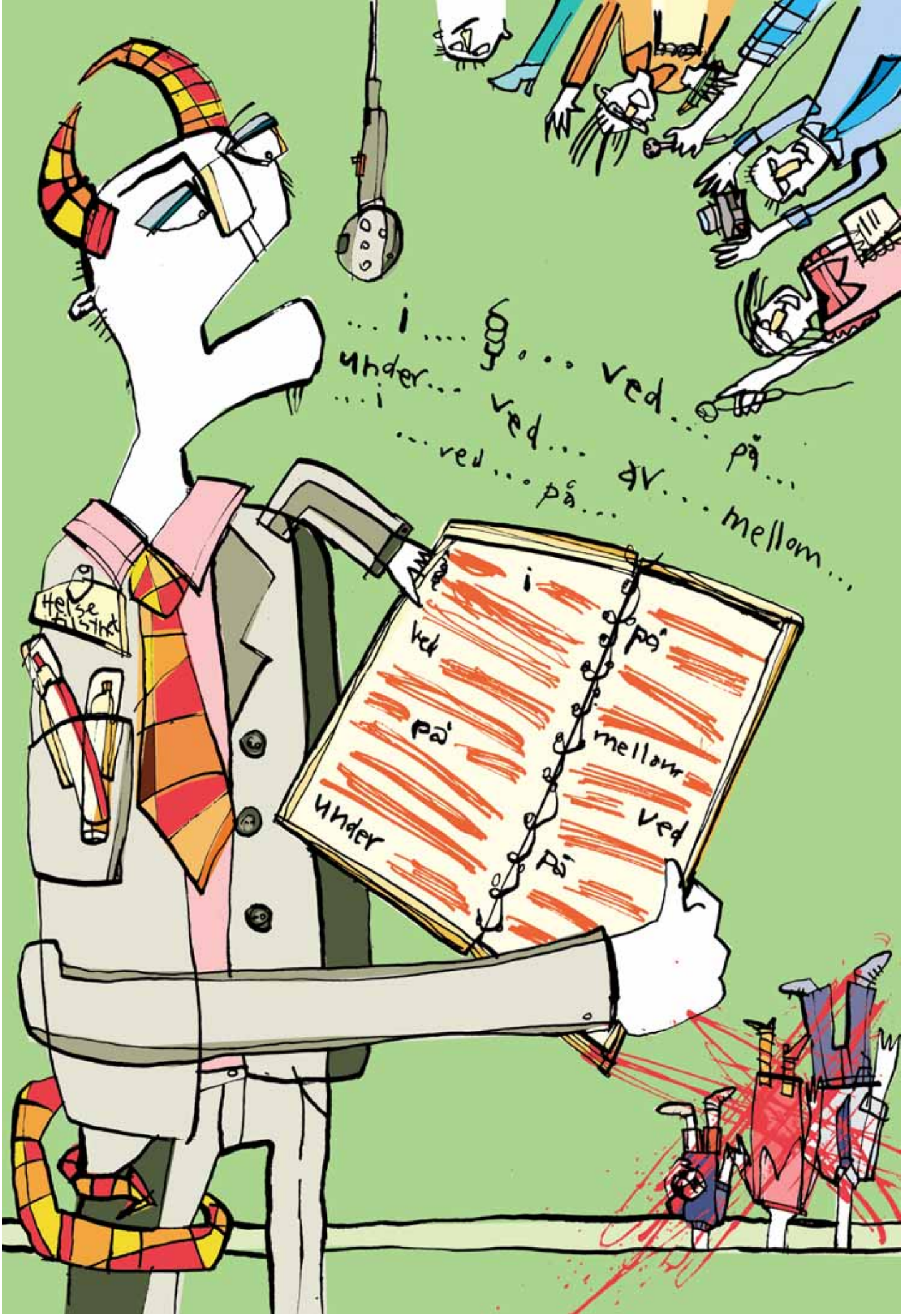
After the reform, several municipalities have significantly reduced their budget for treatment and care of alcohol and drug abusers. This has happened because of changes to block grants after the reform. This has limited the possibilities for the municipalities to consider different temporary measures. This applies in particular to purchase of places in private care and rehabilitation institutions. There is no indication that the municipalities are in the process of building up their own facilities for meeting such needs. It can also be questioned whether the municipalities have adequate competence to run such facilities.

We can wonder whether the municipalities have taken a break in working with alcohol and drug abusers after introduction of the reform. Do the municipalities now define this as the domain of the specialized health services? Do they now only perceive their role to be the referring agency that, at best, follows up clients when they return from the specialized health services as "cured"?

This article is based on the experience of the Office of the County Governor in Aust-Agder.

RELEVANT ISSUES:

- The municipalities have developed 24-hour care services only to a small degree. This affects alcohol and drug abusers who, in the short-term or the long-term, have need of such services.
- Because of the new financial arrangements, municipalities are unwilling to buy treatment places from private organizations.
- It seems that the municipalities have a long way to go in order to achieve more systematic rehabilitation of alcohol and drug abusers. They should perhaps, to a much larger extent, focus on parallel measures between the municipality and specialized health services.
- Supervision should, to a larger extent, focus on parallel measures between the municipality and specialized health services.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The right of access to public documents – but not to everything

Is it in the interests of society that private people who contact the Norwegian Board of Health take the risk that their stories may be broadcast in the media? Do the most important cases, from a supervision perspective, get the most media attention?

Everyone who follows what is in the media from day to day is aware that the press are preoccupied with what happens in the health and social sectors. Nearly every day, the Norwegian Board of Health is the source of major and minor news items in the media. This means that the supervision authority is constantly faced with difficult and necessary decisions about what kind of information can and should be released.

Through its activities, the Norwegian Board of Health gains insight into the most private areas of people's lives. Patients and relatives tell about loss of life and health, about difficult relationships and about setbacks in different situations. Health care personnel experience that both their professional and their private lives are investigated. Information is collected about their professional skills and personal qualities, about their health and their relationship to alcohol and drugs, and about other factors that can illuminate and explain a course of events. Much of the information that the Norwegian Board of Health acquires is obviously not meant to be made public, either in a form in which the person can be identified, or in an anonymous form.

A central principle in Norwegian public administration is that public documents are available to everyone. According to the Freedom of Information Act, the public has the right to see public documents, if no decision has been taken to the contrary. This means that everyone has access to, and can publish, information that is the product of the administrative procedures of public bodies. However, the public does not have access to confidential information and administrative bodies can, after a specific assessment of each document, choose to exempt documents from public disclosure, for example documents containing information about breaches of the law.

As the result of a statement of 8 July 2005 from the Legislation Department in the Norwegian Ministry of Justice and the Police, the Norwegian Board of Health in future will exempt documents from public disclosure less frequently than previously.

Information about personal matters

Confidential information is exempt from public disclosure. This means that information about the health of named persons will always be exempt from public disclosure. However, if personal details are removed, so that individuals cannot be identified, the public will then have the right of access to information. In small places, it will often be necessary to remove more than the person's name in order to ensure that the person cannot be recognised, for example information about age, sex, place of residence, and treatment centre.

Contact from patients and relatives after coverage in the media show that even the release of anonymous information can be unpleasant. For some people, this reflects an aversion to reading about their case in the newspapers. For others, the result of the media coverage is that people who know something about the case have been able to identify the case and find out more about the case than the persons involved would have wished.

Decisions made according to the Freedom of Information Act shall be taken on the basis that public access to information shall be given priority in situations such as those described above. However, it is thought-provoking that private individuals who contact the Norwegian Board of Health cannot do so in the knowledge that their case will not be exposed in the media.

Information about breaches of the law

Many supervision cases are based on criminal offences or other breaches of the law. Traditionally, it has been assumed that information about a person who has committed an offence is exempt from public disclosure. However, today it is generally accepted that there must be very good grounds for exempting information from public disclosure, when the information concerns breaches of the law connected with a person's practice of their profession. This means, for example, that the public may be given access to information about a named health care worker who has been guilty of irresponsible conduct.

However, after a specific assessment of the case, the underlying causes relating to a case, and more detailed information about a case, can still be deemed to be exempt from public disclosure. For example, it would not be appropriate to publicise information that a breach of the law occurred as the result of a health care worker's illness, use of alcohol or drugs, or other personal problems.

Information about breaches of the law that occur outside work may also be relevant to whether a person is fit to be a health care worker. In such a situation, it must be assumed that the duty of confidentiality is more limited than otherwise. For example, it is possible that a health care worker has been guilty of sexual abuse in his or her private time. This is information that can be made public, if consideration to the third party allows this.

The flip side

It is usual to want to keep information such as that mentioned above to oneself. Thus, a consequence of the principle of freedom of information in public administration is that release of information will often occur against the interests and wishes of individuals.

In a democracy it is self-evident that the administrative procedures of public bodies should be transparent for the public. However, it is just as self-evident that the planning, organization and running of health and social services, including the professional conduct of employees, should be transparent for public bodies.

"Worth knowing about" from the counties

"Worth knowing about" reports from the Norwegian Board of Health in the Counties and the Offices of the County Governor provide the Norwegian Board of Health (centrally) with information about local conditions, which is not available in other reports. The reports tell us about observations that are made, and about how local phenomena and events are assessed. The information from one county can be relevant for other counties. Many of the reports are purely informative. Other reports are about conditions that need to be assessed and followed up, through supervision or in other ways, by the Norwegian Board of Health in the County, the Office of the County Governor, the Norwegian Board of Health (centrally) or other authorities. Summaries of a selection of reports are presented below.

The Norwegian Board of Health in Østfold

The role of the Norwegian Board of Health in relation to the outbreak of legionella in the county of Østfold was to assist with finding the source of the infection and making a list of all the water-cooling towers in the county. The Norwegian Board of Health in Østfold was also invited to participate in daily planning and status meetings with the chief municipal medical officer, with Østfold Hospital Trust (Sykehuset Østfold HF), and with the Minister of Health when he visited to area. The Norwegian Board of Health in Østfold reported that the health services in the municipalities that were involved had the necessary competence and resources to deal with the situation.

The Norwegian Board of Health in Oslo and Akershus

The Norwegian Board of Health in Oslo and Akershus reports that it has received a series of complaints about basic patients' rights not being met. This applies to several sections of the Patients' Rights Act, such as the right to be assessed within 30 days, determination of the time limit for receiving treatment, free choice of hospital and the right to transport to health services. It often takes a long time for cases about the right to transport to health services to be dealt with by the national insurance offices. The documentation for these cases often includes many quotes from the legislation, but little assessment of how the facts in the case should be interpreted according to the legislation. The Norwegian Board of Health often has to clarify the facts, and this can take a long time, so that the time taken to deal with such cases is longer than is desirable. There is great variation in how far the different health trusts have come in implementing patients' rights. However, patients know their rights, so complaints will continue to be made. The Norwegian Board of Health in Oslo and Akershus believes that much work remains to be done before all patients' rights are met.

The Norwegian Board of Health in Telemark

The Norwegian Board of Health in Telemark reports that people with mental illnesses who need municipal health and social services do not receive a decision about the services they need based on an individual assessment. Decisions are made less often for these people than for clients who have other types of diagnosis, even though they may need the same types of service.

The Office of the County Governor in Telemark

The Office of the County Governor in Telemark reports that, during the last few years, services in several ROBEK[1] municipalities have been inadequate. For example, the number of places in institutions for people with functional disabilities (to provide relief for carers), and the amount of accommodation for people with special needs (for example, alcohol and drug abusers and people with functional disabilities) have been inadequate. The number of staff in institutions has been reduced. Day care facilities for young people with serious functional disabilities have been reduced. Activities for adults and elderly people have been reduced or discontinued. Night staff have been replaced by mobile teams. The number of places in institutions and residences has been reduced, and people have been given economic support for accommodation instead. Some municipalities take too long to adapt service supply to cuts in the budget.

The Norwegian Board of Health in Aust-Agder

The Norwegian Board of Health in Aust-Agder reports that the duty to provide information in hospitals is not being adequately fulfilled. Patients have a great need for information, and they lack information about illnesses, assessment and treatment. The Norwegian Board of Health in Aust-Agder has dealt with three cases of failure to meet the duty to provide information in hospitals. The coverage in the media also indicates that lack of information can be a problem, and that the duty that hospitals have to inform patients, in accordance with the Patients' Rights Act, is not being fulfilled.

The Norwegian Board of Health in Vest-Agder

The Norwegian Board of Health in Vest-Agder reports that mental health care services request guidance about treatment of patients who are sentenced to treatment. They refer to routines for cooperation between Southern Norway Health Authority and the police, which have been developed locally.

The Norwegian Board of Health in Møre og Romsdal

The Norwegian Board of Health in Møre og Romsdal reports that it has assessed dental services for people with mental disabilities. The matter concerns a mentally disabled patient who had toothache, but who had to wait several weeks for treatment because the treatment needed to be carried out under a general anaesthetic. The treatment was not considered to be emergency treatment. The dental health of people with mental disabilities is vulnerable because of several factors: medical, psychological, nutritional and organizational. Specialized health services face special challenges for this group. These patients need to be followed up with an individually-adapted programme, by people who have special skills in communication, dental hygiene, dental diseases, and prevention. The problems are familiar, but follow-up is not always optimal when there are too few staff and many of them are not professionals.

The Norwegian Board of Health in Sør-Trøndelag

The Norwegian Board of Health in Sør-Trøndelag questions whether information about medicinal products

[1] ROBEK – Register for Governmental Approval of Financial Obligations. The Local Government Act § 60 gives rules about state review and approval of financial obligations. According to § 60 nr. 3, the Ministry of Local Government and Regional Development is required to establish a register of all counties and county municipalities that are subject to approval.

on the Internet is sufficient. The government body responsible for providing information about medicinal products is the Norwegian Medicines Agency, which has mainly provided information in its publication "Medicines News" (Nytt om legemidler), which was sent out regularly to all the doctors in the country. This publication is now only available on the Internet. The Norwegian Board of Health in Sør-Trøndelag is worried that important information about medicinal products may not now reach all doctors. This can have serious consequences for the safety of health services, and can increase the risk of incorrect treatment and damage to patients. Not all doctors use the Internet regularly. This may be because of lack of access to the Internet, health problems associated with working with a data screen, opposition in principle about using data in the office or at home, or lack of computer skills. The chief medical officer admits that he has not looked at the website of the Norwegian Medicines Agency during the last three months, but he is not the only one.

The Office of the County Governor in Nordland

The Office of the County Governor in Nordland reports that it has carried out a survey that shows that half of the municipalities answer no to the question about whether it is possible for clients to have a private conversation, not overheard by other people, when they talk to a member of staff at the counter in the social security office. The County Governor confirms that this is in breach of the law, and will follow up the municipalities concerned. The municipalities must ensure that buildings are designed so that the requirements for confidentiality can be met, when the new employment and social welfare offices are established.

The Norwegian Board of Health in Troms

The Norwegian Board of Health in Troms has asked the two large urban municipalities in the county for a report of nursing home coverage. It requests a report of the number of clients for whom a decision has been made that they shall be given a place in a nursing home, but who are still living in their own homes because a place is not available. It has also asked about the waiting time for getting a place, and what services clients are offered while they are waiting. The reports show that there are large differences. The Norwegian Board of Health is now discussing whether it is possible to formulate minimum requirements for home-based services for patients waiting in the queue for a place in a nursing home. By making the decision to give a client a place in a nursing home, the municipality has made an assessment that the client needs the 24-hour supervision that a place in a nursing home provides. Services provided during the waiting time should include supervision by health care personnel equivalent to that which would be provided in a nursing home, including supervision in the evenings and at night.

The Norwegian Board of Health in Troms

The Norwegian Board of Health in Troms reports the following about psychiatry and the responsibility of the municipalities:

The health trusts have been asked to give a report about patients who have completed their psychiatric treatment, but who are not receiving adequate services in the municipalities. The reports show that there have always been 2–4 patients who have completed their treatment but who are still in special psychiatric departments. Two of these patients had been waiting for 44 days and 520 days. The waiting time is long for some patients, and this reduces the capacity in the department. One of the reasons for this problem may be that the **Regulation relating to municipal payment by the municipalities for patients who have completed treatment** is not applicable to psychiatric patients.

The Norwegian Board of Health in Finnmark

The Norwegian Board of Health in Finnmark reports that seven municipalities in the county report that they do not make a systematic assessment of people who may be suffering from dementia. Four of these municipalities have sheltered accommodation, but do not carry out systematic assessment of the residents.

The Office of the County Governor in Finnmark

In Finnmark, the proportion of employees in nursing and care services who have professional qualifications is decreasing. The County Governor will therefore pay attention to educating more people with professional qualifications. Supervision and continual contact with the services have also shown that more qualified staff are needed in services for people with mental disabilities. The services provide enough care, but the staff do not have enough knowledge. There are enough personnel at the auxiliary nurse/care worker level, and in some cases at the college level, but there are not enough specialists. The municipalities have not adequately assessed their needs for professional staff for services for people with mental disabilities. The County Governor is considering applications for dispensation from municipalities that do not have enough qualified personnel, but wonders how these municipalities can compensate for this to ensure that clients' statutory rights are met.

Through yearly meetings with the leaders of municipal social services and children's welfare services, it has become clear that problems related to alcohol and drug abuse are increasing and now affecting younger people. Alcohol and drugs are becoming more and more easily available. The municipalities are finding it difficult to establish adequate aftercare for these people, and it is difficult to find meaningful employment and activities for them. The municipalities wish to improve teamwork with health services, particularly with doctors who provide treatment in institutions. Some municipalities have established a post for an executive officer with responsibility for services for alcohol and drug abusers.

You can read more about local conditions on the website: www.fylkesmannen.no

The Norwegian Board of Health gives more administrative reactions

In 2005, the Norwegian Board of Health dealt with 242 cases – about the same number of cases as in 2004. However, the number of administrative reactions has increased from 148 in 2004 to 168 in 2005. No administrative reaction was given in 87 cases. Each case can have several administrative reactions.

The reason for initiating a supervision case is usually a complaint from a patient or relative, with the exception of cases that result in loss of authorization. Many of these cases are referred by employers (20 cases) and some of them by prosecuting authorities (7 cases). No cases in 2005 were referred by the patient ombudsman. Information from the media, compensation cases and other reports can also form the basis for supervision cases. When the Norwegian Board of Health in the County means that there can be cause to give an administrative reaction to a health care personnel, the case is sent to the Norwegian Board of Health (centrally), which has authority to give a formal reaction, such as a warning or withdrawal of authorization.

During the last few years, there has been a steady increase in the number of administrative reactions given by the Norwegian Board of Health, from 148 in 2004 to 168 in 2005. This increase may indicate that more serious cases are sent over to the Norwegian Board of Health. In 2005, the Norwegian Board of Health dealt with 242 cases.

In 2005, 46 health care personnel lost their authorization, compared to 60 in 2004. In most cases the reason was alcohol or drug abuse, or other personal reasons, such as a sexual relationship with a patient.

In 2005, well over half of the individual supervision cases that ended with an administrative reaction involved doctors (83 doctors). Fifty-six doctors received a warning, 15 lost their authorization and 12 lost their right to prescribe medicinal products in group A (narcotic drugs) and group B (prescription drugs that are addictive). One doctor had previously lost his authorization in one of the other Nordic Countries, and this was the reason for his authorization in Norway being withdrawn.

Twenty-three health care personnel lost their authorization because of abuse of alcohol or drugs. The largest group was nurses: 12 of the 23 were nurses. Nine lost their authorization because of their behaviour, mainly criminal behaviour, that was assessed as incompatible with practising as a health care personnel, seven because of sexual exploitation of patients, one because of illness and three because they had previously lost their authorization in one of the other Nordic countries. The others lost their authorization because of various serious breaches of the Health Personnel Act.

The increase in the number of administrative reactions may indicate that more serious cases are sent over to the Norwegian Board of Health.

In 2005, 33 complaints against the decisions of the Norwegian Board of Health were sent over to the Norwegian Appeals Board for Health Personnel. Of these, 23 cases were settled. In 21 cases, the decision of the Norwegian Board of Health was affirmed. In one case a warning to a midwife was reversed. One case was rejected.

The Norwegian Board of Health (centrally) gave criticism to twenty institutions for inadequate organi-

zation, for example inadequate internal control system. In most cases, it is the Norwegian Board of Health in the County that gives criticism to the leadership for deficiencies in organization or management of health services. The number of such cases dealt with by the Norwegian Board of Health (centrally) is therefore relatively small in relation to the total number of completed cases.

The time taken to deal with such cases had gone down slightly from 2004. The mean length of time was 5.8 months (2004: 8.2 months), median 4.8 months (2004: 6.3 months). Per 31 December 2005, 144 supervision cases were being dealt with by the Norwegian Board of Health.

Table 1. Number of supervision cases, 2002 to 2005

	Reaction	No reaction
2002	103	71
2003	125	55
2004	148	101
2005	168	87

Table 2. Administrative reactions against health care personnel, given by the Norwegian Board of Health in 2005 (figures for 2004 in brackets)

	Warning	Loss of authorization	Loss of the right to prescribe medication in groups A and B	Limited authorization
Doctor	56 (38)	15 (19)	12 (9)	0 (1)
Dentist	6 (5)	3 (2)		0 (0)
Psychologist	5 (2)	2 (1)		0 (1)
Nurse	10 (4)	18 (25)		3 (3)
Auxiliary nurse	4 (1)	5 (7)		0(0)
Social Educator	0(0)	1 (2)		0(0)
Midwife	2 (0)	0(0)		0(0)
Physiotherapist	1 (2)	1 (1)		0(0)
Other groups	1 (2)	1 (3)		0(0)
Unauthorized	2 (3)			
Total	87 (57)	46 (60)	12 (9)	3 (5)

Table 3. Reason for withdrawal of authorization, according to health care personnel group, 2005

	Nurse	Auxiliary nurse	Doctor	Other	Total
Alcohol and drugs	12	3	7	1	23
Disease	0	0	0	1	1
Sexual exploitation of patient	0	0	4	3	7
Behaviour	3	2	2	2	9
Unsound professional standards	0	0	1	0	1
No improvement after a warning	1	0	0	1	2
Authorization lost in another country	2	0	1	0	3
Total	18	5	15	8	46

The Norwegian Board of Health in the media – literally

The search queries "Helsetilsynet" (Norwegian Board of Health) and "2005" gave approximately 100 000 hits in the search engine Google. For the same period, the search query "Helsetilsynet" is mentioned about 6 000 times in the Norwegian media. The Norwegian Board of Health is, literally, clearly visible in the Norwegian media world.

We have not carried out a thorough review of the reports in which the Norwegian Board of Health is mentioned, but we get the clear impression that the media pay us a lot of attention, both in relation to incident-related supervision and planned supervision. Below, we have selected some of the events that were reported in the media.

In January, NTB reported that the Norwegian Board of Health was concerned about the use of locum doctors. The background for this concern was a risk analysis that was carried out to identify critical areas within primary physician services. In some small municipalities, up to 70 per cent of inhabitants were on so-called "lists without a doctor".

In the Municipal Report (Kommunal Rapport) for February, the Norwegian Board of Health demanded that the municipalities should sort out their services to groups with special needs. This mainly related to alcohol and drug abusers, but also to newly-arrived asylum seekers, people with mental illness and people with mental disabilities.

In March, the newspaper Bergens Tidende reported that patients who were admitted under compulsion to Sandviken Psychiatric Hospital, ran the risk of being allocated a bed in a corridor. The newspaper reported that the Norwegian Board of Health meant that the way in which the hospital was run could lead to injury to patients, and was thus in breach of statutory requirements. The Norwegian Board of Health issued instructions to the hospital to improve their provision of services.

In April, Aftenposten (a national newspaper) reported that the Norwegian Board of Health was concerned that light beers are being squeezed out of the refrigerators in the shops. In a hearing statement to the Ministry of Labour and Social Affairs, the Norwegian Board of Health expressed the wish that shops should be required to allocate as much space in the refrigerators to light beers as they allocate to beers with higher alcohol content.

In May, NTB reported that alcohol and drug abuse was the most common reason for health care personnel losing their authorization in 2004. Sixty health care personnel lost their authorization and 57 were given a warning. The figures were about the same as for the previous year.

Troms folkeblad (a local newspaper in Troms), a series of other newspapers and the broadcast media reported that all municipalities had to check the status of control of water cooling-towers. The Norwegian Board of Health gave the municipalities a time limit of one week to report whether they had an overview of possible sources of infection of legionella, and whether they carried out supervision of these sources, after cases of legionnaires' disease were detected in the county of Østfold. The case continued to be aired in the media until well into the summer.

Throughout the year, the media wrote about individual cases dealt with by the Norwegian Board of Health. In June, we could read in several newspapers that a former surgeon at Østfold Hospital had lost his certificate of completion of specialist training as a surgeon. The surgeon had also worked at Moss Hospital and Nordland Hospital, and had previously been suspended from his job in Bodø.

Municipal plans for health and social emergency preparedness were a recurring theme for much of the summer. Throughout the country, the media had articles about the municipalities that still did not have approved plans, despite having been issued instructions by the Norwegian Board of Health, or having received a warning that instructions would soon be issued if they did not rectify the situation.

In August, at the end of the summer, VG (a national newspaper) reported that Director General of Health, Lars E. Hanssen, was directing his wrath at hospital leadership. The newspaper reported that Lars E. Hanssen was considering whether to give large fines to hospital owners who had not responded after having been issued with instructions to rectified conditions in the hospital to conform with the law. The situation referred to was the problem of excess patients in relation to capacity.

During the year, the Norwegian Board of Health has withdrawn the right to prescribe medication in group A (narcotic drugs) and group B (prescription drugs that are addictive, excluding narcotic drugs) for several doctors who have been too generous in prescribing these drugs to drug addicts. In September, the Norwegian Medical Association stated in Dagbladet (a national newspaper) that these doctors could not reckon with their support. The Association thus supported the practice of the Norwegian Board of Health.

In October the storm over the "doctors' certificates case" blew up in Dagens næringsliv (a financial newspaper). Based on the newspaper article, a supervision case was initiated against a psychologist, a psychiatrist and two doctors. In addition, the psychologist and the psychiatrist were reported to the police. This was clearly the biggest media case the Norwegian Board of Health was involved in, in 2005.

The "doctors' certificates case" continued to be aired in the media in November. The psychologist who was involved had his authorization suspended for six months. The decision was appealed to the Norwegian Appeals Board for Health Personnel.

The media year for the Norwegian Board of Health ended after Christmas with a case in which a patient suffered acute kidney failure and serious damage after taking dangerous herbal medicine. The medicine contained illegal substances, and the Norwegian Board of Health issued a warning to other patients who may have taken the medicine.

And in the opinion of the Norwegian Board of Health…

Below we present a selection of the opinions of the Norwegian Board of Health, taken from hearing statements in 2005. A list of other hearing statements, which are published on our website www.helsetilsynet.no, is given at the end of this article.

New act on administration of employment and social welfare (NAV)

• After the reform, employment and social welfare offices (NAV offices) will have responsibility for national insurance and employment (which before the reform were the responsibility of the state), and tasks related to the Social Security Act (which before the reform were the responsibility of the municipalities). The municipalities and the NAV authorities in the municipalities will be able to decide that the NAV authorities shall only have responsibility for tasks defined in the Social Security Act Chapter 5 (economic support), while tasks defined in the Social Security Act Chapter 4 (social services) shall continue to be administered by the municipality. Administrative tasks dealt with by the NAV offices will then be dominated by economic support. The Norwegian Board of Health means that there is then a danger that clients who do not manage to participate in the labour market, and who have the greatest needs for social services, will be marginalized to an even greater extent by such an organization.

• When large government bodies and municipal services are amalgamated, it is important that it is clear which rules apply to the duty of confidentiality. On the basis of this, we mean that it is necessary to review and harmonize the rules relating to the duty of confidentiality and privacy protection.

• There is a need to define more clearly the authority of the supervision authorities to issue instruction to the state section of employment and social welfare administration, when the municipality has delegated responsibility to them. In order to work effectively, the supervision authorities must be able to exercise their authority directly to the employment and social welfare administration. This also includes areas for which the municipality has responsibility.

• The Ministry should consider whether the duty of internal control should be introduced for agencies and institutions that provide services pursuant to the Social Services Act Chapter 5, and also consider whether there is a need for state supervision of these services.

NOU 2005:3 From piecemeal to comprehensive – a continuous health service (the Wisløff Committee – a new combined act for health and social services)

• The Norwegian Board of Health agrees with the Committee's conclusion that teamwork is often inadequate at the individual level and at the leadership/system level. The experience we have gained from supervision has shown that the area where teamwork most often fails is at the interface between different levels and different services.

• In our opinion, the statutory requirements for provision of services need to be defined more clearly. There should be a clearer focus on the requirement for internal control, and on the responsibilities of service providers.

• The Norwegian Board of Health questions to what degree the municipalities and the regional health authorities utilize their managerial authority, by being able to stipulate conditions and make contracts with regular medical practitioners and private health care personnel.

NOU 2004:18 Comprehensiveness and planning in health and social services (the Bernt Committee)

• In the opinion of the Norwegian Board of Health, a more detailed assessment and discussion is required of some of the interfaces and ambiguities resulting from the recommendations, particularly in relation to specialized health services, the Patients' Rights Act and the Health Personnel Act.

• It is positive that the requirements for documentation are specified more clearly, for example for clients who receive social services.

• The Norwegian Board of Health recommends a legal authority, in order to carry out supervision directly with private bodies.

• The Norwegian Board of Health stresses the need for a supervision authority in the county that is as independent as possible, and in which supervision tasks are collected in one place. In our opinion this should be the Norwegian Board of Health in the County and the Office of the County Governor.

NOU 2005:1 High quality research – better health

• The Norwegian Board of Health agrees with the committee that there is a great need for organizing, harmonizing and clarifying the legislation relating to research, which is currently fragmentary.

• The Norwegian Board of Health agrees that all statutory regulation of medical and health research should be collected in one act, as far as is possible.

• The interface between quality assurance and evaluation of practice exists today, but will become clearer with the legislation that is proposed. The wording of the act gives little guidance about where this interface lies. Statutory regulation of research must not obstruct practitioners from evaluating their own practice as part of normal service provision, without this being defined as research.

• The interface between project work associated with teaching, and social research, must be more clearly defined.

• The relationship between research on and testing of medical equipment seems to have been forgotten in the process.

NOU 2005:11 Public involvement in the area of dental health

• In the opinion of the Norwegian Board of Health, the committee's description of the current situation regarding dental services is general, and lacks both an analysis of the complexity of the situation and a detailed presentation of regional differences in manpower and utilization of resources.

• We agree that one administrative body should be allocated managerial and administrative responsibility for the whole sector in a region. We believe that this responsibility should involve ensuring that everyone has access to necessary dental services in accordance with statutory requirements. What this involves should be clearly described in the legislation.

• The Norwegian Board of Health means that organization of dental services should be seen in relation to organization of specialized health services, and that

they should therefore be organized within the public regional health authorities.
• The committee have only briefly discussed the types of measures that are necessary in order to ensure adequate managerial and administrative responsibility for dental services in the region. We mean that alternative forms of financing dental services should be considered.
• The Norwegian Board of Health agrees with the principle that dental services should continue to give priority to selected groups.

Report from the evaluation committee for the tsunami catastrophe
• The contribution from some sectors and organizations, for example health and social services, is described briefly and with little analysis of their role. This means that the committee's recommendations have limited validity in relation to a more comprehensive assessment of emergency planning in general in the country.
• In its report, the committee assumes that telecommunication within Norway, and between Norway and other countries, functioned satisfactorily. Telecommunication in crises should be evaluated further.

Directive for requisition of centrally-stimulating medication as part of the treatment of children, adolescents and adults with attention-deficit/hyperactivity disorder (AD/HD) and narcolepsy
• It is appropriate that guidelines for applications for permission to requisition centrally-stimulating medication for treatment should be simplified and coordinated. At the same time, updated and evidence-based guidelines should be developed as aids to decision-making and as part of quality assurance of the diagnosis and treatment of AD/HD.
• In the treatment guideline, clear requirements should be laid down for assessment by a specialist in relation to confirming the diagnosis and initiating treatment with centrally-stimulating medication. It is then unproblematic for a regular medical practitioner or another doctor to continue the treatment under the guidance of a specialist.

Specialist training in community medicine
• There is a gap between supply of and demand for skills in community medicine.
• The Norwegian Board of Health stresses the need for a speciality in community medicine to ensure professionalism, legitimacy, authority, status and recruitment. The focus of the speciality should be extended to include other arenas for community medicine activities in addition to the municipalities.
• In the opinion of the Norwegian Board of Health, there is a need for a separate speciality for doctors, that combines medicine and social studies, in order to ensure that adequate skills are available, and in order to develop competence in this field. Continual professional development in the field of medical practice has traditionally taken place through defined professional specialities.

Other hearing statements from the Norwegian Board of Health

Regulations relating to control of communicable diseases in health and social services
Changes to the Patients' Rights Act – provision of treatment to patients who are not able to give consent for treatment themselves
National risk and vulnerability analysis in the health sector
The responsibility of the County Governor for the safety of the community and emergency planning
Regulations relating to municipal tasks pursuant to the Child Welfare Act
Changes to the Mental Health Care Act and the Patients' Rights Act
Changes to the Regulations relating to internal control in health and social services and in the Regulations relating to the Social Services Act Chapter 3
Changes to the Regulations relating to the Alcohol Act
Changes to the Patient Injury Act
Establishment of the Norwegian Patient Register as a health register with personal data that is individually identifiable
Discontinuation of the arrangement of marking medicinal products with a warning triangle
Regulations relating to health care personnel's right to receive gifts, commission, services or other types of payment during execution of their duty
Regulations relating to collection and processing of personal health data in the Norwegian Defence Forces' health register
Regulations relating to individual client-based nursing and care statistics (IPLOS register)
The requirement for a police certificate of good conduct for health care personnel and social workers
Criteria for notification, definition of cases and list of notifiable diseases
National clinical guidelines for examination of children's sight, hearing and language
NOU 2003:21 Crime control and privacy protection
NOU 2005:6 Teamwork and trust - the State and local democracy – The first report of the Local Democracy Commission
NOU 2005:9 Use of resources and legal safeguards in the county boards for social matters
New Regulations relating to medical devices
Withdrawal of authorization for independent laboratory and radiology services. Draft regulations relating to quality requirements
Development plan for mental health 1999-2008. Draft guideline for mental health care work with adults in the municipalities
Organization of blood bank services in Norway. Pilot project, Eastern Norway Regional Health Authority
Report "Feeling the pinch?" ("Et magrere liv for løven?").
The Offices of the County Governor
Audit of the defence boards
Structure of the civil defence
Additional requirements for notification of methicillin-resistant Staphylococcus aureus (MRSA) pursuant to the Regulation relating to the Norwegian Surveillance System for Communicable Diseases

Implementation of the Directive 2001/19/EF
– additional requirements for supervised services in order to be allowed to practice as a general medical practitioner within the national insurance system.

Facts and figures

Contents

This chapter presents an overview of the most important tasks of the Offices of the County Governor, the Norwegian Board of Health in the Counties, and the Norwegian Board of Health (centrally) as supervision authorities and appeals bodies. More detailed statistics are to be found on the web site of the Norwegian Board of Health: www.helsetilsynet.no.

COMPLAINTS RELATING TO THE SOCIAL SERVICES ACT

Dealing with complaints relating to the Social Services Act is a substantial task for the Offices of the County Governor. The Offices of the County Governor dealt with 6 021 complaints in 2005 (7 333 in 2004) (see Table 1). By complaints we mean cases in which individuals have complained about a decision made by a municipality about benefits or services according to the Social Services Act, and where the municipality has not accepted the complaint. The County Governor is the appeals body and can reverse decisions made by the municipalities. About one third of the cases were about economic support, the other cases were mainly about social services. Examples of complaints about economic support are complaints about the amount of benefit, and more specific complaints relating to benefits for food, rent, electricity, deposit, clothes, dental treatment, medicine, furniture and travel. Examples of complaints about social services are complaints about economic assistance for carers, practical assistance and training, including client-managed personal assistance, relief for carers and support persons. Complaints can be about the type of service, the extent of services offered and payment.

The County Governors supported the decision of the municipality in 71 per cent of cases (74 per cent in 2004). The proportion of decisions affirmed by the County Governors was higher for cases about economic support than for cases about social services. In 14 per cent of cases, the County Governors reversed the decision of the municipality. The decisions were revoked in 13 per cent of cases and returned to the municipality to be dealt with again. In two per cent of cases the decision was rejected, so that the complaint was not assessed. There are no statistics about what happens to cases that are returned, but many decisions are reversed by the municipalities on the basis of the comments of the County Governors.

The Offices of the County Governor are required to deal with cases within three months. Over 90 per cent of cases were dealt with within three months, and over 70 per cent within two months.

At the start of 2005 there were 704 pending cases, and at the end of 2005 there were 841. 6 154 cases were received – 240 fewer than in the previous year. 1 312 fewer cases were dealt with in 2005 than in 2004. The main reason for this was that several large Offices of the County Governor made a special effort to reduce the backlog in 2004. The main impression is that the County Governors have good control over cases of complaint relating to the Social Services Act.

Table 1. Complaints regarding the Social Services Act. Number of new cases and compledted cases, 2005

County	New cases	Completed cases – economic support	Of which decision affirmed (%)	Completed cases – social services	Of which decision affirmed (%)	Total completed cases
Østfold	528	397	65%	105	31%	514
Oslo og Akershus	1 420	1 011	75%	183	50%	1 278
Hedmark	243	180	83%	55	31%	257
Oppland	187	128	78%	41	51%	183
Buskerud	379	288	72%	90	53%	393
Vestfold	327	238	83%	57	70%	318
Telemark	240	185	77%	36	75%	245
Aust-Agder	111	89	87%	22	55%	119
Vest-Agder	174	136	76%	32	63%	168
Rogaland	526	440	81%	75	72%	525
Hordaland	560	451	76%	117	61%	588
Sogn og Fjordane	127	75	72%	38	71%	117
Møre og Romsdal	274	185	75%	81	59%	280
Sør-Trøndelag	270	167	85%	49	43%	223
Nord-Trøndelag	109	103	76%	25	40%	137
Nordland	323	217	72%	67	48%	307
Troms	246	158	82%	52	62%	220
Finnmark	110	129	64%	19	47%	149
Total	**6 154**	**4 577**	**76%**	**1 144**	**54%**	**6 021**

Table 2. Complaints regarding peoples' rights for health services. No. of cases completed by the Norwegian Board of Health in the Counties – assessed according to specific provisions in the the legislation, 2004 and 2005

Provision	Provision regarding:	No. of cases 2005	Of which decision in favour of the complainant	No. of cases 2004
Patients' Rights Act				
Section 2–1 first paragraph	the right to required health care from the municipal health services	62	10	34
Section 2–1 second paragraph	the right to required health care from the specialized health services	134	46	72
Section 2–2	the right to an evaluation within 30 workdays	25	19	5
Section 2–3	the right to a re-evaluation	3	2	4
Section 2–4	the right to choose hospitals	15	15	9
Section 2–5	the right to an individual plan	12	5	11
Section 2–6	the right to transport to health services	314	56	42
Chapter 3	the right to participation and information	22	7	11
Chapter 4	consent to health care	1	0	1
Section 5–1	the right of access to medical records	31	25	20
	Unspecified	2	0	47
The Health Personnel Act				
Sections 42, 43, 44	the right to correction of medical records the right to deletion of information in medical records the right to deletion of information in medical records recorded on the wrong person	26	13	23
Municipal Health Services Act				
Section 2–1	the right to required health care	182	52	143
Section 2–2	children's right to a health check	1	1	
Dental Health Services Act				
Section 2–1	the right to required dental care	1	1	1
Total number of assessments of specific provisions		**831**	**252**	**423**

COMPLAINTS REGARDING PEOPLES' RIGHTS FOR HEALTH SERVICES

The Norwegian Board of Health in the County is the appeals body when patients mean that they have not received the services that they have the right to receive according to the Patients' Rights Act and certain other regulations. Those who have responsibility for the services (the municipality or the health trust) shall have reassessed the case before a complaint is sent to the Norwegian Board of Health in the County. The Norwegian Board of Health in the County can assess all aspects of the case. The decision of the Norwegian Board of Health in the County is final.

The number of completed cases was 754 in 2005 (361 in 2004, 199 in 2003). A large part of the increase is due to new regulations from 1 September 2004 in the Patients' Rights Act about the right to transport to health services.

Some of the 754 cases were assessed according to several sections in the Act. Table 2 presents the distribution of the 831 assessments.

In 252 of the 754 cases, the decision was totally or partly affirmed.

Table 3. Supervision of social services. Number of system audits carried out by the Offices of the County Governor 2004 and 2005

	Number of system audits	
County	2005	2004
Østfold	9	7
Oslo og Akershus	16	6
Hedmark	10	4
Oppland	7	4
Buskerud	11	8
Vestfold	8	3
Telemark	8	3
Aust-Agder	7	8
Vest-Agder	8	5
Rogaland	8	3
Hordaland	10	5
Sogn og Fjordane	9	9
Møre og Romsdal	6	6
Sør-Trøndelag	14	8
Nord-Trøndelag	7	10
Nordland	9	10
Troms	8	6
Finnmark	5	4
Total	**160**	**109**

SUPERVISION OF SOCIAL SERVICES

System audits

The Offices of the County Governor carried out 160 system audits in 2005, see Table 3.

No breaches of laws or regulations were detected in 34 of the 160 system audits that were carried out in 2005.

80 of the 160 system audits were carried out jointly by the Offices of the County Governor and the Norwegian Board of Health in the Counties in relation to both health and social legislation.

The Offices of the County Governor carried out countrywide supervision on two themes according to guidelines produced by the Norwegian Board of Health in 2005:

- use of coercion and restraint for people with mental disabilities
  (See the article pp 4–5) – 53 system audits
- municipal health and social services for adults over 18 years of age who live outside institutions, who have complex and long-term needs for services (joint supervision with the Norwegian Board of Health in the Counties)
  (See the article pp 6–7) – 60 system audits.

Reports of countrywide supervision are published in the Norwegian Board of Health's report series.

Altogether, 47 system audits were carried out that were not part of countrywide supervision. The institutions and themes for supervision for these were chosen on the basis of information the Offices of the County Governor had on risk and vulnerability. The themes for these 47 system audits included:

- services for alcohol and drug abusers (20 system audits)
- administrative procedures for allocation of municipal services (6 system audits)
- other themes, such as services for elderly house-bound people and people with mental illness, legal safeguards etc. (21 system audits).

Per 31 December 2005, there were still open nonconformities (breaches of laws or regulations that had not been corrected) in five places where system audits had been carried out in 2004 or earlier. The nonconformities related to services for alcohol and drug abusers, relief for carers, and care services.

Supervision of institutions for alcohol and drug abusers

The Offices of the County Governor carried out supervision of 42 institutions for alcohol and drug abusers, according to the Regulations to the Social Services Act etc, Chapter 3.

Use of coercion and restraint for people with mental disabilities, according to the Social Services Act Chapter 4A

Legal safeguards for the use of restraint and compulsion for individuals with mental disabilities are regulated by the Social Services Act Chapter 4A.

The municipalities report decisions regarding measures to prevent injury in emergency situations (single episodes) to the Offices of the County Governor, according to the Social Services Act section 4A-5, third paragraph, a. The number of decisions was 24 337 in 2005 (21 110 in 2004), concerning 1 065 persons (1 032 persons in 2004) (see Table 4).

The Offices of the County Governor have to authorize planned measures to prevent injury in repeated emergency situations and measures to meet the client's basic needs for food, drink, dressing, rest, sleep, hygiene and personal safety, including teaching and training, according to the Social Services Act section 4A-5, third paragraph, b and c. The Offices of the County Governor authorized 839 decisions in 2005 (655 in 2004). The decisions related to (figures for 2004 in brackets):

- 301 (272) planned measures to prevent injury in repeated emergency situations
- 342 (242) measures of restraint to meet the clients' basic needs
- 57 (47) measures of use of mechanical means of restraint (16 decisions according to b, 41 to c)
- 131 (87) measures of comprehensive warning systems (51 decisions according to b, 80 according to c)
- 8 (7) measures of teaching and training.

The decisions applied to 457 persons (378 persons in 2004).

The Offices of the County Governor gave dispensation from the requirement to undergo training in 477 cases (312 cases in 2004), which in the Social Services Act section 4A-9 applies to personnel who shall implement measures according to the Social Services Act section 4A–5, third paragraph b and c.

The Offices of the County Governor settled three complaints regarding measures relating to the Social Services Act section 4A–5, third paragraph, a, and prepared the cases for two complaints regarding measures relating to the Social Services Act section 4A–5, third paragraph, b and c, to be dealt with by the County Committee for Social Affairs.

The Offices of the County Governor carried out 194 local supervisions of measures according to the Social Services Act section 4A–5 third paragraph, b and c, relating to the duty of supervision according to section 2–6 first paragraph, second point. Twelve local supervision visits were also carried out in addition.

The large increase from 2004 to 2005 in the number of people with decisions, and the number of people given dispensation from the requirement to undergo training, is probably partly due to the backlog of cases dealt with by the municipalities in connection with the new Chapter 4A of the Social Services Act, that came into force on 1 January 2004.

Issuing instructions

In 2005, the Offices of the County Governor did not issue instructions according to the Social Services Act.

SUPERVISION OF HEALTH SERVICES

Supervision of institutions

The Norwegian Board of Health in the Counties carried out 222 system audits in 2005 (see Table 5). Of these, 148 were system audits of municipal health services, 69 of specialized health services and 5 of other health services.

In addition, the Norwegian Board of Health in Rogaland carried out three system audits and 20 other types of supervision of health-related conditions in the petroleum industry.

Of the 148 (156 in 2004) system audits of municipal health services, 76 of these were supervision of both health and social services, carried out jointly by the Offices of the County Governor and the Norwegian Board of Health in the Counties.

In 119 of the 148 system audits of municipal health services, and in 51 of the 69 system audits of specialized health services, breaches of the legislation were detected.

In 2005, the Norwegian Board of Health in the Counties carried out countrywide supervision of two areas, according to guidelines developed by the Norwegian Board of Health:

- communication between health care personnel and between health care personnel and patients in health trusts that provide surgical treatment for patients with acute diseases and cancer in the gastrointestinal tract (see article pp 8–9) – 23 system audits.
- municipal health and social services for non-institutionalized adults over 18 years of age with complex and long-term needs for services (supervision carried out jointly with the Offices of the County Governor) (see article pp 6–7) – 60 system audits.

Reports summarizing the findings from each of the areas of countrywide supervision are published in the report series: Report from the Norwegian Board of Health. The reports are in Norwegian, with an English summary, and can be found at www.helsetilsynet.no.

Altogether 88 system audits of the municipalities were carried out, that were not part of countrywide supervision. The themes for these were:

- nursing and care services (49 system audits)
- emergency services (18 system audits)
- health and social emergency planning (6 system audits)
- other (15 system audits).

Altogether 46 system audits of specialized health services were carried out, that were not part of countrywide supervision. The themes for these were:

Table 4. Supervision of Social Services. Number of decisions and number of people for whom the decisions apply relating to the Social Services Act Chapter 4A, 2005

	Section 4A–5, a		Section 4A–5, b and c			Section 4A–9	
County	Number of people	Number of decisions	Number of people	Number of decisions approved	Number of decisions not approved	Despensation from the requirement to undergo training	Local supervision
Østfold	61	728	14	20	6	14	3
Oslo og Akershus	187	4 072	49	59	5	37	24
Hedmark	37	280	11	37	0	24	11
Oppland	36	430	45	61	0	43	29
Buskerud	46	383	10	19	1	17	11
Vestfold	30	451	12	18	1	10	9
Telemark	37	712	8	30	2	9	7
Aust-Agder	19	574	6	7	2	4	1
Vest-Agder	65	490	26	32	2	6	10
Rogaland	110	2 176	33	53	3	45	13
Hordaland	250	6 933	60	127	3	62	23
Sogn og Fjordane	37	808	15	20	0	11	11
Møre og Romsdal	44	944	44	118	2	49	7
Sør-Trøndelag	56	3 180	34	41	1	11	7
Nord-Trøndelag	11	199	21	48	0	75	13
Nordland	89	123	34	103	0	32	14
Troms	34	1 554	21	33	2	23	10
Finnmark	16	300	6	15	1	9	6
Total	**1 065**	**24 337**	**449**	**841**	**31**	**481**	**209**

- patients' rights (15 system audits)
- psychiatric services (9 system audits)
- maternity units (8 system audits)
- other, including private clinics, health services for alcohol and drug abusers, quality improvement work (14 system audits).

Nonconformities that are more than one year old

Per 31 December 2005, there were still open nonconformities (breaches of laws or regulations that had not been corrected) in 30 places where system audits had been carried out in 2004 or earlier. There were open nonconformities in 40 places per 31 December 2004, and in 71 places per 31 December 2003.

Of the 30 system audits with nonconformities per 31 December 2005, one had been carried out in 1999, one in 2002, four in 2003 and twenty-four in 2004. Three had been carried out in health trusts, and 27 had investigated various municipal services.

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

Issuing instructions

In 2005, the Norwegian Board of Health gave a warning about issuing instructions, or issued instructions about correcting conditions, in accordance with the Health Services Supervision Act section 5, the Specialized Health Services Act section 7-1, or the Municipal Health Services Act section 6-3, in the following cases:

- Research project, Aker University Hospital.
  Instructions issued to discontinue the project.
  Letter of 23 September 2005 to Aker University Hospital
- Excess patients in relation to capacity, including patients admitted under compulsion, Sandviken Psychiatric Hospital.
  Instructions issued to Helse Vest RHF (Western Norway Regional Health Authority). Letter of 9 March 2005
- Lack of a plan for health and social emergency planning.
  Warning about issuing instructions given to 103 municipalities and six health trusts.
  Instructions issued later to 26 municipalities.
  Per 31.12.2005, there were still 41 municipalities and one health trust for which the situation had not been rectified.

Table 5. Supervision of health services. Number of system audits carried out by the Norwegian Board of Health in the Counties, 2005

	Number of system audits			
County	**Municipal health services**	**Specialized health services**	**Other**	**Total**
Østfold	7	3		10
Oslo og Akershus	13	10		23
Hedmark	8	3		11
Oppland	4	2	1	7
Buskerud	9	3		12
Vestfold	6	5		11
Telemark	5	4	1	10
Aust-Agder	13	0	2	15
Vest-Agder	5	3		8
Rogaland	6	5		11
Hordaland	14	9		23
Sogn og Fjordane	10	3		13
Møre og Romsdal	7	5		12
Sør-Trøndelag	9	6		15
Nord-Trøndelag	5	2	1	8
Nordland	11	3		14
Troms	12	2		14
Finnmark	4	1		5
Total	**148**	**69**	**5**	**222**

SUPERVISION CASES (INDIVIDUAL CASES) IN THE HEALTH SERVICES

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

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

The number of new cases per 100 000 inhabitants varies from 20 in the county of Møre og Romsdal to 92 in the county of Finnmark.

The aim is that more than half of the cases shall be dealt with within five months. This aim was achieved in fifteen counties (Oslo and Akershus were counted separately) (ten counties in 2004). See Table 6.

Distribution

Information is given below about the source of supervision cases, what they relate to, and the assessments and results of the cases. Some cases are complex, so that several health services or health care personnel are assessed in the same case. Some cases are assessed according to several provisions in the legislation, so that the sum of the number of cases in the different categories is greater than the number of cases.

Distribution of supervision cases according to source

Patients, their relatives and their representatives were the source of 1 321 of the cases in 2005. Other common sources were the Patient Ombudsman (142 cases), employers (129 cases) and reports of incidents of severe injury to patients (114 cases). Altogether there were 2 103 sources for the 1 965 completed cases.

Table 6. Supervision of health services. Number of completed cases and percentage of cases that took more than 5 months to deal with, 2004 and 2005

County	Number of completed cases 2005	Percentage of cases that took more than 5 months 2005	Number of completed cases 2004
Østfold	122*	34%	89
Oslo og Akershus	294*	47%	457
Hedmark	90*	57%	77
Oppland	56	30%	65
Buskerud	149	46%	110
Vestfold	86	27%	67
Telemark	76	43%	70
Aust-Agder	51	31%	34
Vest-Agder	68	62%	50
Rogaland	137	46%	100
Hordaland	164	30%	115
Sogn og Fjordane	36	3%	44
Møre og Romsdal	65	82%	63
Sør-Trøndelag	148	41%	94
Nord-Trøndelag	51	49%	56
Nordland	110	54%	82
Troms	74	35%	65
Finnmark	71	45%	37
Backlog project	117*		
Total	**1 965**	**45%**	**1 675**

* Because of the long time taken to deal with supervision cases in Østfold, Oslo og Akershus, and Hedmark, the Norwegian Board of Health dealt with some of the cases from these three offices. The number of cases completed in 2005 was 117 (37 from Østfold, 39 from Oslo og Akershus and 41 from Hedmark).

Distribution of supervision cases according to type of service

Of the 1 965 supervision cases completed in 2005, 1 992 assessments were made of health services. See Table 7.

Table 7. Supervision cases (individual cases). Distribution of assessments according to type of service, 2004 and 2005

Service	Number of assessments 2005	Percentage of assessments 2005 (%)	Number of assessments 2004
Public specialized health services	772	39%	720
Regular medical practitioner	692	35%	680
of which: emergency services	198	10%	199
Nursing homes	137	7%	138
Private specialized health services	132	7%	155
of which: private hospitals	23	1%	36
Home-based health services	83	4%	90
Dental services	40	2%	49
Other health services	122	6%	124
Not specified	14	1%	24
Total	**1 992**	**100%**	**1 980**

In 66 per cent of assessments in 2005, no nonconformities were found (breaches of duty of health care personnel, or criticism of the system to the institution by the Norwegian Board of Health in the County, or case referred to the Norwegian Board of Health).

Distribution of supervision cases according to type of health care personnel and institution

In 2005, 1 211 assessments of supervision cases involving health care personnel were made. In addition, 761 assessments of institutions as organizations (municipality, health trust etc.) were made.

Table 8. Supervision cases (individual cases). Distribution of cases according to category of health personnel, 2003–2005

Healt care personnel	2005	2004	2003
Physicians	925	952	838
Nurses	104	118	97
Dentists	42	50	35
Psychologists	38	33	39
Auxiliary nurses	29	22	18
Physiotherapists	15	25	15
Chiropractors	9	3	1
Midwives	7	11	4
Emergency medical technicians	6	10	4
Other health care personnel	17		
Persons without authorization or licence	19		
Total	**1 211**		

The categories of health care personnel that were assessed most often in relation to supervision cases are shown in Table 8. Seventeen assessments for 6 categories of health care personnel are not specified in the table. There were 12 categories of health care personnel for which no assessments were made. Nineteen assessments were made for persons who had neither authorization nor a licence to practice.

Distribution of supervision cases according to specialty

In 2005, 830 cases were completed, involving 935 assessments, for institutions or health care personnel in specialized health services. Table 9 presents the distribution of these assessments according to specialty.

In 2005, no nonconformities were found in 62 per cent of assessments.

Table 9. Supervision cases (individual cases). Distribution of cases according to speciality, 2003–2005

Speciality	2005	2004	2003
Psychiatry	257	238	177
Surgery	169	133	109
Internal medicine	114	93	86
Obstetrics and gynaecology	70	79	62
Orthopaedic surgery	45	22	25
Anaesthetics	27	39	22
Neurology	17	26	17
Paediatrics	15	17	17
Physical medicine and rehabilitation	12	15	10
Ophthalmology	10	19	8
Child and adolescent psychiatry	10	17	20
Oncology	8	14	15
Other medical specialities	67	67	–
Not specified	114	124	–
Sum	**935**	**903**	**–**

Distribution of supervision cases according to legislative basis

The number of assessments according to legislative basis in 2005 was 3 043.

Table 10 shows, as expected, that the majority of supervision cases (approximately 66 per cent) are about sound professional practice. A large number of cases relate to information and documentation (approximately 9 per cent). Cases related to alcohol and drug abuse, and other reasons related to fitness to practice (approximately 3 per cent of cases), are often serious, and in many cases result in administrative reactions from the supervision authorities.

Table 10. Supervision cases (individual cases). Distribution of cases according to legislative basis, 2003–2005 (for the majority of individual cases)

Legislative basis	2005	2004	2003
Provisions in the Health Personnel Act			
Section 4. Sound professional standards: behaviour	216	200	183
Section 4. Sound professional standards: examination, diagnosis, treatment	1 350	1 313	1 208
Section 4. Sound professional standards: medication	202	169	159
Section 4. Sound professional standards: other	250	244	176
Section 7. Emergency treatment	54	43	58
Section 10. Information	75	99	74
Section 16. Organization of the service	144	140	119
Chapters 5 and 6. Duty of confidentiality, right of disclosure, duty of disclosure	87	95	83
Sections 39–44. Patient records	201	269	205
Section 57. Fitness to practice: alcohol and drug abuse	39	45	35
Section 57. Fitness to practice: other reasons	52	74	51
Provisions in the Specialized Health Services Act			
Section 2–2. Duty of sound professional standards	373	298	173
Total	**3 043**	**2 989**	**2 588**

Distribution of supervision cases according to outcome of cases

Table 11 shows the distribution of supervision cases dealt with by the Norwegian Board of Health in the Counties in 2003, 2004 and 2005 according to outcome of the case.

Table 11. Supervision cases (individual cases). Distribution of cases according to outcome, 2003–2005

	Number of cases		
Outcome	**2005**	**2004**	**2003**
Referred to the Norwegian Board of Health	294	293	195
Notification of breach of duty by health care personnel	353	284	213
Advice or guidance given to health care personnel	469	511	443
Criticism of the system, to the director / municipal executive	42	38	33
Criticism of the system, to the professional leader	9	14	17
No remarks	825	832	763
Total	**1 992**	**1 972**	**1664**

Supervision cases dealt with by the Norwegian Board of Health

Cases dealt with by the Norwegian Board of Health (the most serious cases, which are referred by the Norwegian Board of Health in the Counties to the Norwegian Board of Health (centrally) are discussed in a separate article on page 35. Statistics on administrative reactions to health care personnel and criticism of the system are presented in the article.

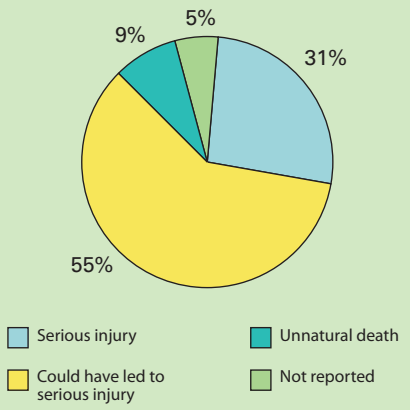
MEDEVENT

MedEvent (Meldesentralen – the Reporting System for Adverse Events in Specialized Health Services) is a database of reports of events that are registered according the Specialized Health Services Act section 3-3. Health institutions have a duty to send a written report to the Norwegian Board of Health 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 the result of provision of health care, or as a result of one patient injuring another.

The Annual Report 2004 for MedEvent provides a summary of the experience gained from reports of events that happened in 2004. The number of reports has increased by 51 per cent from 2001 to 2004. The Norwegian Board of Health means that this increase can reflect a positive development in people's attitude to reporting adverse events to the authorities. The increase does not necessarily reflect an increase in the number of adverse events that occur in specialized health services.

Per 1 December 2005, 2 056 reports of events that had happened in 2004 had been registered. Nine per cent of these were reports of unnatural deaths (Figure 1).

Figure 1.
Reports relating to the Specialized Health Services Act section 3–3 in 2005 (n=2056)



On quarter (24 per cent) of reports of events that had happened in 2004 were related to incorrect use of medicinal products. Eighty-five reports related to cases of suicide, and 49 related to cases of attempted suicide.

It is registered in 43 per cent of reports that the patient was informed about the event. It is registered in only ten per cent of reports that the patient was informed about Norsk Pasientskadeerstatning – NPE (Compensation for Injuries to Patients: an independent national body set up to process compensation claims from patients who believe they have suffered an injury as a result of treatment provided by the Norwegian public health service). It is of concern that many patients are not informed about the event or about NPE.

USE OF OUR WEBSITE: WWW.HELSETILSYNET.NO

In 2005, there were 650 000 visits to our website, and three million visits to specific pages. The most popular pages were (number of visits in brackets):

- publications (887 000)
- supervision reports (approximately 2 000 reports, 583 000 visits)
- the websites of the Norwegian Board of Health in the Counties (369 000, including their annual reports)
- legislation (257 000).

ACCESS TO DOCUMENTS

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

PRESS RELEASES

8/2005. Karl Evang Award presented to Borghild Haaland

7/2005. Invitation to the Karl Evang Seminar

6/2005. Do you have any nominations for candidates for the Karl Evang Award?

5/2005. The Norwegian Board of Health gives criticism to Nordlandssykehuset HF, Lofoten

4/2005. Deficiencies in health services to newly-arrived asylum seekers, refugees and people reunited with their families

3/2005. Deficiencies in allocating social services to alcohol and drug abusers

2/2005. Invitation from the Norwegian Board of Health to a press conference. Presentation of the Annual Supervision Report 2004

1/2005. Sixty health care personnel lost their authorization last year.

DIRECTIVES FROM THE NORWEGIAN BOARD OF HEALTH

The Norwegian Board of Health did not publish any directives in 2005.

The Norwegian Board of Health assists with the backlog of cases

Because of limited resources, the Norwegian Board of Health in Oslo og Akershus did not manage to meet the requirement regarding length of time to deal with cases, as laid down in the Proposition to the Storting No. 1 2004. The Norwegian Board of Health therefore helped to deal with 150 supervision cases, during the period 1 September 2004 to 1 September 2005. In addition help was provided with 46 of the oldest supervision cases from Hedmark, and 40 supervision cases from Østfold.

Of the 237 cases that were sent to the Norwegian Board of Health, five cases were returned to the Norwegian Board of Health in the Counties, two cases were written off without being dealt with, and six cases were assessed as not being supervision cases, but were completed by sending a letter to the relevant organization. Thirty-four cases (15 per cent) were sent to the Norwegian Board of Health for assessment of administrative reactions. Of these, 25 cases were completed during the project period (1 September 2004 to 1 September 2005).

FINANCIAL STATEMENT

Table 12 shows the financial statement for the Norwegian Board of Health for 2005, budget chapter 721.

The expenses of the Norwegian Board of Health in the Counties and expenses related to supervision carried out by the Offices of the County Governor are covered under the budgets of the Offices of the County Governor, chapter

Table 12. The Norwegian Board of Health Financial statement (NOK 1 000) – 2005

Budget Chapter 721	Budget	Accounts	Difference
Expenditure: fixed wages	37 519	36 852	667
Expenditure: variable wages	6 856	7 726	- 870
Operating costs, buildings etc. (rent, electricity, cleaning, security)	12 103	12 079	24
Other expenditure	12 820	12 377	443
Total expenditure	69 298	69 034	264
Income	5 108	5 497	- 389
Net expenditure / saving	64 190	63 537	653

Areas for countrywide supervision in 2006

Each spring the Norwegian Board of Health decides which areas shall be themes for supervision for the following year. These include areas for countrywide supervision, carried out as system audits, and areas for other types of supervision activities, such as area surveillance.

A nonconformity is a failure to fulfil requirements laid down in, or in accordance with, laws or regulations. **Observations** are made when no nonconformities are detected, but when the supervision authority finds reason to point out areas where there is room for improvement.

Resources are channelled to areas:

- that have great importance for the legal safeguards of individuals
- in which there is a high probability for deficiencies
- where the consequences of deficiencies for clients and patient are serious
- where clients and patients cannot be expected to look after their own interests.

Supervision shall contribute to ensuring that the population's need for services is met, that services are provided in accordance with statutory requirements and that deficiencies in services are prevented. When the Norwegian Board of Health directs attention towards selected services and areas, this is based on knowledge about areas where clients may experience serious deficiencies in service supply. In the process of identifying relevant areas, we confer with interest groups and professional groups.

For 2006, we decided to carry out countrywide supervision of the following areas:

- services for children with special needs, including both municipal health and social services and specialized health services
- multidisciplinary, specialized services for alcohol and drug abusers
- legal safeguards for use of coercion and restraint for people with mental disabilities.

The supervision reports are available on the websites of the Offices of the County Governor and the Norwegian Board of Health in the Counties. The Norwegian Board of Health publishes a summary report in its report series (Report from the Norwegian Board of Health) for each of the areas for countrywide supervision.

Countrywide supervision of services for children with special needs

Experience from previous supervision of rehabilitation services, and of services for children with special needs, shows that there are differences in organization, provision and content of the services, and that there are deficiencies in how services are adapted to clients' specific needs and how clients are followed up. Examples of this are lack of team work and coordination of services within the municipality and with specialized health services. This can mean that people who need long-term, coordinated services are not identified, or are not adequately assessed or followed up. Children with special needs are particularly vulnerable, and deficiencies in services for them can have serious consequences for their development.

Supervision will include municipal health and social services and specialized health services for children with congenital developmental disorders or damage to the nervous system, and for children who have acquired such disorders early in life. Team work involving municipal services and specialized health services will be a central theme for supervision. Supervision will focus on areas where the risk of deficiencies is particularly great, and where the consequences of deficiencies are serious.

Countrywide supervision of multidisciplinary, specialized services for alcohol and drug abusers

The Norwegian Board of Health's review of data on the health status of alcohol and drug abusers, and health services provision for this group, provides clear indications that many of these people do not receive the services they require and have the right to receive. The lack of services for drug abusers with serious addiction is of particular concern, because of their health problems, the serious mental and physical disorders that many of them suffer from, and the high level of mortality in this group.

After the reform of services for alcohol and drug abusers in 2004, responsibility for multidisciplinary treatment for his group lies with the regional health authorities, and the rights of alcohol and drug abusers have been improved. Experience gained from supervision of services, review of available knowledge, and from complaints, indicates that there is still a risk that alcohol and drug abusers wait too long for multidisciplinary specialized treatment, that services are not adequately coordinated, and that these clients do not receive the treatment they have the right to receive.

Countrywide supervision of use of coercion and restraint for people with mental disabilities

Supervision of social services in 2003 and 2004 showed that coercion and restraint for people with mental disabilities is used in a way that is not in accordance with statutory requirements. In almost half of the municipalities in which supervision was carried out in this area, nonconformities (breaches of laws or regulations) were detected and/or observations were made (observations are made when no nonconformities are detected, but when there is reason to point out areas where there is room for improvement). Further, experience from supervision shows that the municipalities still need to improve management services and ensure continual improvement. The municipalities often lack routines for ensuring that clients' rights are met when allocating and providing services, and when adapting services to meet clients' changing needs. There is a great deal of activity with regard to training, but it is also reported that systematic measures to ensure that staff have adequate knowledge and skills in the relevant areas are lacking.

In the view of the Norwegian Board of Health, it is unacceptable that so many municipalities do not meet the statutory requirements in relation to use of coercion and restraint for people with mental disabilities. The result can be that clients receive services that are not in accordance with sound practice or that are not ethically sound, and that clients' legal safeguards are not ensured.

This is the background for the choice of countrywide supervision of use of coercion and restraint for people with mental disabilities in 2005 and 2006.

In the countrywide supervision that was carried out in 2005, attention was focused on the muncipalities that had made decisions about, and/or reported use of, coercion or restraint for mentally disabled people. In the countrywide supervision that will be carried out in 2006, attention will be focussed on municipalities that have not made decisions about use of coercion or restraint for this group.

Publications from the Norwegian Board of Health

Reports from the Norwegian Board of Health

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

1/2005
Summary of Supervision of the Composition and Activities of the Norwegian Abortion Boards

2/2005
Norwegian Alcohol and Drug Abusers – Health Problems and Health Services in Relation to General Supervision. An Evaluation of Central References

3/2005
Summary of Countrywide Supervision in 2004 of Municipal Health Services for Newly-arrived Asylum Seekers, Refugees and People Reunited with their Family

4/2005
Summary of Countrywide Supervision of Municipal Social Services for Alcohol and Drug Abusers in 2004

5/2005
Annual Report 2003 for MedEvent (Meldesentralen – the Reporting System for Adverse Events in Specialized Health Services)

6/2005
Practice Concerning the Use of Restraint for People with Mental Disabilities, and Practical Services Offered by the Municipalities – Experience Gained from Supervision 2003-2004

7/2005
Nursing and Care Services Under Strain
Comparison and analysis of findings and experience from supervision of services in 2003 and 2004

8/2005
Does Provision of Dental Services Vary in Different Counties?
Provision of dental services to the priority groups, dental manpower situation, and reports on dental services from the Norwegian Board of Health in the counties.

Supervision info

In Supervision info (Tilsynsinfo) the Norwegian Board of Health provides information about important topics from supervision cases (individual cases) and other health legislation material related to supervision. The series was established in 2005. One can subscribe to the full text electronic version of this publication that is to be found on our website www.helsetilsynet.no.

1/2005
Topic: Treatment with addictive medication

2/2005
Topic: Incorrect treatment etc.

3/2005
Topic: The duty of confidentiality

4/2005
Topic: Administrative reactions given to health care personnel by the Norwegian Board of Health in individual supervision cases.

Correspondence

In many matters, the Norwegian Board of Health corresponds with other health and social organizations and services. A selection of some of this correspondence is published on our website www.helsetilsynet.no. Some of the topics are listed below:

Survey of the use of sedation and pain relief for terminally ill patients – Report of the survey sent to the Ministry
Letter of 18.01.2005 to the Ministry of Health and Care Services

Prescription of Subutex (buprenorphine) to opioid addicts in a short-term withdrawal programme
Letter of 21.02.2005 to the Norwegian Directorate for Health and Social Affairs

Status report on services for people with mental illness
Letter of 17.03.2005 to Minister of Health and Care Ansgar Gabrielsen

Employers' routines for checking the qualifications of health care personnel

Letter of 18.03.2005 to municipalities, health trusts and temporary staff recruitment agencies for health care personnel

Supervision of health services – meeting with the Minister of Health 1 July 2005
Letter of 27.06.2005 to Minister of Health and Care Ansgar Gabrielsen

Infection control programmes in nursing homes and tuberculosis control programmes in the municipalities. Summary of reports
Letter of 14.07.2005 to the Ministry of Health and Care Services

Future organization of MAR services (medication-assisted rehabilitation services for drug abusers)
Letter of 19.08.2005 to the Ministry of Health and Care Services

In addition to the letters listed above, letters concerning issuing instructions to institutions, and letters concerning administrative reactions given to health care personnel, have been published.

www.helsetilsynet.no
The website of the Norwegian Board of Health is primarily for people who have responsibility for health and social services, and for journalists.
The website was visited about 650 000 times in 2005.

On the website you will find:

- **Requirements laid down by the authorities for health and social services:** acts, regulations, directives and other documents that give the authorities' interpretation of acts and regulations
- **The results of the work of the supervision authorities** supervision reports, the report series: Report from the Norwegian Board of Health, the newsletter, Supervision info with completed supervision cases, other publications, hearing statements letters, articles
- **Information to the public about how to make a complaint**
- **Information about how the supervision authorities work:** methods, sources of information, plans for supervision, tasks, authority, organization

New menus in 2005:

- Supervision info
- Articles and features
- Cases of issuing instructions to health services
- Letters of general interest

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