

Turning around patient complaints in a regional hospital

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Abstract

This paper describes the introduction by a regional general hospital of a different system for handling complaints from patients. It outlines the underlying philosophy of the new system and the experiences of the hospital as the new system matured. The paper provides data for the first six quarters of operation of the system.

Background

The use of patients' complaints as part of the quality assurance and quality improvement programs of hospitals is not well developed in Australia, if the number of references available in the literature is any guide. Ten years ago Rice (1986) expressed the view that 'Hospitals in Australia have a dismal record for responding to complaints about their own standard of care...'

Has anything changed in the intervening years? In 1991 the Commonwealth Government established the Review of Professional Indemnity Arrangements for Health Care Professionals. The review commissioned a study which included investigating the issue of complaints by patients about hospital services. The interim report of that committee noted that comprehensive data on adverse events for hospital patients were not available in Australia (1994, p 12). The report points to the Harvard Medical Practice Study of 1984 to 1990, in which an adverse event rate for inpatients of 3.7 per cent was recorded. The report concluded that there was no reason to assume that the adverse events rates in Australia would be different. A further report released by the Federal Minister of Health in 1995 has now confirmed that Australia does have a significant incidence of adverse events in its hospitals (Wilson et al. 1995).

The initial intent of those involved in the project described in this paper was to establish a system identifying adverse events using a structured complaints system. It was thought that this could become an important part of the hospital's quality improvement program. In this paper we set out an attempt by one hospital to use patient complaint information as a medium for identifying service deficiencies and for improving quality. Our conclusions are that while the process established has been useful, it has probably not been effective in comprehensively identifying adverse events.

Quality assurance in health settings has often taken the form of the hunt for the 'bad apple', rather than a cooperative learning exercise (Berwick 1989). The exercise described in this paper is a genuine attempt to achieve communal learning and, to a large extent, that has been achieved. However, it would be naive to think that many staff do not still see the complaints evaluation process as a local witch hunt for a suitable scapegoat. The authors believe that the process outlined in this paper has been useful in dealing with complaints. However, the incidence of complaints reported here is low when compared with the incidence of adverse events reported in other settings. This suggests separate systems need to be in place for handling both issues.

Evolution of complaints management

The hospital described in this paper, in common with most other Australian public hospitals, initially had a very rudimentary complaints monitoring system. In 1991 it was proposed that a public relations officer be appointed and that this person be responsible for, amongst other things, receiving and monitoring complaints. In this initial phase, the emphasis was on recording the number of complaints received, and also ensuring that 'serious' complaints were quickly brought to the attention of the senior management. Although the public relations officer appointed did take the role seriously, there were other work pressures and the handling of complaints did not alter significantly as a result of the appointment. Certainly, there is no evidence in the hospital's records of that time to support the view that complaints were handled more expeditiously, or that problems were resolved to the satisfaction of the complainants more often as a result of the new appointment.

A characteristic of the complaint response process at that time was the narrow focus on the technical aspects of care that was used by clinical staff when responding to a complaint. Both medical and nursing staff had a tendency to consider complaints solely from the point of view of the technical correctness of the treatment offered and the outcome achieved. For example, if a patient

complained that a doctor had been rude to them in the emergency department, typically the investigation would focus on the treatment given and its technical appropriateness. The response might also point out the heavy workload of the department at the time of the incident. The 'right' of the patient to be aggrieved over a real or imagined slight was seldom even acknowledged, let alone considered from the patient's point of view.

This approach meant that there was little chance of mediating a mutually satisfactory outcome to the complaint. It also meant that a significant number of complainants took their grievance further, resulting in a longer and more difficult management process. To be fair, the great majority of staff were hard working and were trying their best for the patient. A lack of effective communication seemed to be the most common underlying problem, rather than incompetence or an uncaring attitude. Nonetheless, it was clear that the process being used at that time was not resolving complaints effectively.

In 1994 the hospital separated the role of complaints officer from the role of public relations officer by creating a new position. It appointed a person with a particular interest in identifying and mediating workplace problems and extended the complaints handling role. The new role included the following components of the complaints process:

- receiving complaints
- undertaking the initial investigation of the problems, including data collection
- mediating between involved staff and complainant
- involving implicated staff in the both the investigation and mediation processes
- monitoring and reporting on the number of complaints received, in process, and resolved.

Current phase

It was the intent of the hospital management, in introducing changes to the complaint management process, to use the complaints process as part of the total quality management program of the hospital. This meant that reporting on complaints had to go back to staff in a way that would allow staff to use the information to improve patient care and services. The initial reporting system classified complaints by:

- location of the patient at the time of the incident
- staff group held accountable by the complainant, and
- the nature of the incident (fall, incorrect treatment, and so on).

It became clear very quickly that this style of classification system irritated staff and was not an effective tool for quality improvement. As a result, a new system for sorting complaints was designed which allowed a 'service deficiency' classification, rather than one implying blame, which is how the staff viewed the existing system.

The new classification took as a starting point a fictitious patient. This hypothetical person made a number of statements about their expectations regarding the services offered by the hospital. The resulting document was labelled 'Statement of Patient Expectations' and was presented to the hospital executive committee, and then the hospital board for endorsement. The statement was in three parts, representing what management considered to be three important aspects of care within the hospital. The full statement is attached as an appendix. Some of the components reflect the particular environment of the hospital, but most of the components are generic to the extent that they would apply to all patients in all Australian hospitals.

Having developed a classification system for incoming complaints, the reporting system used by the complaints officer had now to be changed. A simple database was developed using a relatively simple off-the-shelf software product. The complaints officer took all incoming complaints and assessed them against each of the components of the Statement of Patient Expectations. Where it appeared that a patient felt one of those expectations had not been met, the complaints officer registered a 'fail' for that component. The monitoring also allowed recording of the physical location to which the complaint related, and the staff group (but not the individual) involved if staff were identified. Reports from this database were provided to the hospital's quality committee and the hospital executive on a monthly basis.

The Statement of Patient Expectations was widely circulated throughout the hospital and was also made available to patients when requested. This meant that staff had available to them in the patient care setting a document which gave some guidance on what was expected of them in terms of the total package of patient care. When a complaint was made, the document gave the involved staff an opportunity to consider the view of the patient, as expressed in the complaint, and judge their own performance against what the hospital said that it expected of staff. In general, staff found this a useful change from their previous experiences of dealing with a complaint where they had no benchmark or guidance on what was expected of them.

The second step taken to tie the complaints system into the quality improvement cycle of the hospital was to link the Statement of Patient Expectations to the

routine patient satisfaction surveys undertaken by the hospital. The hospital has a three-year study under way using a questionnaire developed by the University of Queensland. The questionnaire is structured to measure, amongst other things, the extent to which the hospital is meeting the standards set out in the Statement of Patient Expectations. The surveys are undertaken on a quarterly basis by hospital staff and the results analysed by the university's staff. In this way, the hospital is able to monitor the extent to which it is meeting its desired standards, using complaints as a retrospective measure and the satisfaction survey as a prospective measure. Both are built around a common standards document.

Initial experience

The monthly figures are collated and reported to the hospital management. At the time of introducing the system, there was concern that, by providing a vehicle for complaints, the hospital would see a significant rise in the numbers of complaints. There was also concern that there might be a large number of trivial complaints made that would involve staff in unproductive investigations.

The first six quarters of figures are summarised in figure 1. The figures show that there has not been a large increase in formal complaints. More importantly, the number of complaints that are being resolved to the satisfaction of both parties (staff member and patient) is high. Less than 2 per cent of complaints remain unresolved by the end of the reporting period (see table 1).

The hospital admits approximately 13 000 patients per annum and there are a further 70 000 patient contacts through the outpatient and emergency departments each year. On the basis of the experience to date, approximately 0.5 per cent of patient contacts result in a complaint being lodged, and the overwhelming majority of these are resolved to the satisfaction of the patient and the staff member.

Figure 1: Summary of complaints received and outcomes achieved by the complaints officer, by quarter

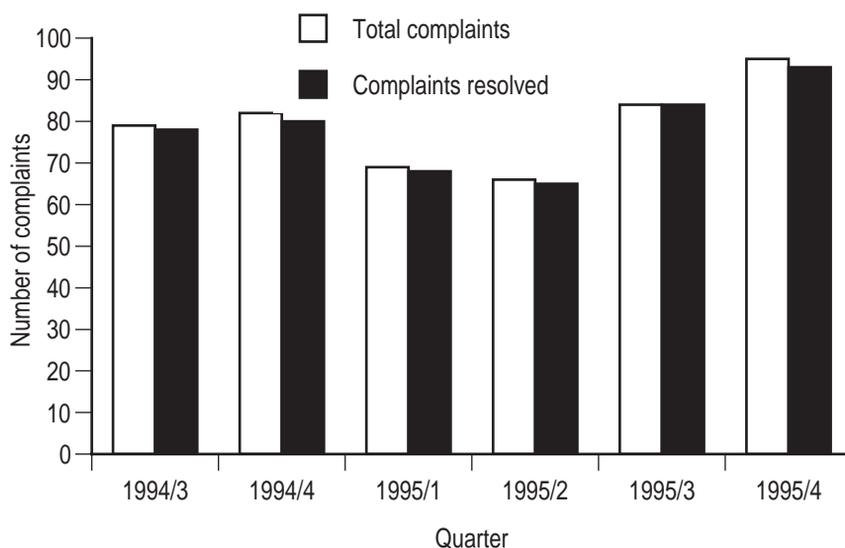


Table 1: Unresolved complaints, by quarter

Quarter	1994/3	1994/4	1995/1	1995/2	1995/3	1995/4
Unresolved complaints	1	2	1	1	0	2

Acceptance by staff

The majority of hospital staff, particularly the nursing and medical staff, were initially reluctant to embrace the changes proposed. Many were resistant to the idea of a person 'interfering' in their daily work, particularly as the person appointed was not a member of the nursing or medical profession and therefore seen by many as not being 'one of them'. The newly appointed complaints officer undertook a considerable amount of hard work to break down the professional stream barriers and to educate staff on the potential benefits of a complaints officer working hand in hand with patients, staff and hospital management.

To help break down this initial resistance, a questionnaire was developed and distributed to a broad range of staff within the hospital. Whilst a closing deadline was given for the return of responses, staff were assured that late returns would be accepted and considered if the returns were submitted within two weeks of

the closing time. This was done to ensure all staff, or as many as possible, were given the opportunity to respond to the questionnaire. Another area of concern for staff was their perception that any complaint was a 'personal attack' aimed at their personal integrity, their professionalism or, worst of all, their technical competence. It seemed that staff generally were of the opinion that complaints were a nuisance which needed to be sorted out by someone else. Many staff were reluctant to become involved in addressing the complaints. Although no formal assessment of the staff attitude was undertaken, it seemed that there was a combination of fear that professional competence was being challenged and of a lack of acceptance of the 'consumer rights' implicit in the changes occurring across health services. (Over time, there has been a very significant change in the attitudes of a large number of staff and a far greater acceptance of the concept of confronting the dissatisfied client/patient.)

A series of in-house workshops, in-service training sessions and ongoing discussions with staff at all levels, in all professions, provided the complaints officer with the necessary forums to assure staff that patients and their families had the right to seek assistance from a member of the hospital staff. Staff were reassured that the new complaints officer would work from the initial assumption that a complaint represented a fault in the system rather than a mistake by an individual staff member. As a result, investigations would focus on the hospital's systems rather than on any individual staff member who might have been identified in a complaint. Staff were assured that the patient complaints system was tied into the quality of care and would be a valuable tool for staff to use to identify failings within their service delivery. The flow-on effect was the opportunity to identify areas that were not working well and to improve service delivery in those areas.

Staff have come to accept the initiative of the complaints officer position and are now advising the complaints officer of situations which may have the potential to create problems for patients and staff if not addressed appropriately. Hospital staff are also referring patients to the complaints officer in order for patients to discuss problems or lodge a formal complaint. It seems that as staff become comfortable with the standards set out in the Statement of Patient Expectations, they can recognise those problems which are not of their making and which they cannot solve. Having decided it is not '...their fault...', they are happy to pass the problem on and get on with their own work.

The complaints officer has endeavoured to keep the position focused on patient care needs, and adopt a non-judgemental and non-threatening approach with staff. As a result, staff are becoming confident when referring patients with complaints that they, the staff, will be consulted and have input into the complaint mediation and resolution process. Staff generally now appear to have

accepted the appointment of the patient complaints officer well. Indeed, the early perception of 'staff have no rights' is diminished to such an extent that staff themselves approach the complaints officer to discuss their own work-related problems. Typical topics include problems with difficult patients (Item 3.5 in the Statement of Patient Expectations), problems with other staff, and coping with the demands of working within the hospital environment.

The patient complaints officer position has evolved from dealing with patient complaints to mediating and resolving a broad range of patient service-related problems. This includes staff complaints and problems relating to patient service. Reflecting this evolution, the position is now titled 'patient advocate/staff conciliator'. This reflects the change of staff perceptions from an early reluctance to accept a different approach to the improvement of service delivery. Although there has been no formal measurement, it appears that the non-threatening and conciliatory style adopted by the appointee has been an important factor in clinical staff accepting this new position. The conceptual framework has moved from reacting in an adversarial manner to patient complaints and is now better described as anticipating and responding to patient care difficulties. This is consistent with the general framework of continuous quality improvement in the hospital setting.

Although complaints still occur, and although there are situations which cannot be resolved with mutual agreement, the new system has reduced the time required for management of complaints. This has, in a very general sense, improved administrative efficiency by allowing hospital senior management to allocate time resources more appropriately. The old 'patient complaint' is now regarded by an increasing number of staff as a 'patient service problem', to be addressed proactively and with good will.

Effect on quality

There is considerable anecdotal evidence that the changed approach to managing complaints did contribute positively to quality of patient care. Examples of changed practice include staff coming forward with service problems rather than waiting till a complaint was lodged; speedier response to complaints which has allowed some situations to be resolved while the patient remains in hospital, in turn giving less dissatisfaction at the point of discharge; and changes to some hospital processes following weaknesses identified through complaints. Unfortunately, the objective patient service measures used by the hospital are not yet sensitive enough to quantify this in any way.

Compliance with standards

In 1995 the Council of Standards Australia published complaints handling standards (AS 4269 – 1995). These standards were not available to the hospital management during the years 1991 to 1994 when the system described in this paper was evolving and so it is interesting to compare the extent to which developed practice is consistent with recommended practice. The published standards include a list of the essential elements of a complaints handling system. Of the 13 essential elements listed in the standards document, most are present in the hospital system described in this paper. The standards document includes as an essential element the capacity to determine and implement remedies. This is not a feature of the hospital system we have described. The Australian standards are presented in the context of a commercial organisation and suggested remedies include refunds, replacement and compensation. These are options not usually considered within the discretion of the management of a public hospital.

The published standards also require that the complaints process be accessible to all. While it was certainly the intention of the hospital management to make the complaints system universally accessible, it is difficult to estimate the extent to which patients feel empowered to use the system. Fear of reprisal, or other issues, may be working and in fact limiting the real accessibility of the process. The number of complaints reported is well below the number of adverse incidents described in other centres (Wilson et al. 1995). This may point to a reluctance by patients to challenge the care they receive. It may, however, represent a lack of understanding by hospital clients of their own health care, allowing potentially important lapses by staff to pass unnoticed by the health consumers.

Conclusions

The focus of the role of the complaints officer is to mediate and resolve conflict between patient and staff of the institution where patient services are the cause of the dissatisfaction. There is a subtle but important distinction between this mediation role and the role of judging the quality of the services performed by the staff. This complaint handling system, based on early experience in this hospital, shows that it can be a very successful way of identifying and addressing causes of patient dissatisfaction.

The complaints officer is not a clinical watchdog, and does not seek out adverse patient care events. The figures published by Wilson and others (1995) suggest that approximately 16 per cent of all admissions to acute hospitals are associated with

an adverse event. The figures reported here show a complaint rate of less than 1 per cent for all patient contacts. Clearly, the complaints officer is not reacting to all adverse events if the incidence of adverse events in this hospital is similar to other Australian hospitals (and we have no reason to believe it would differ). Indeed, early figures suggest that adverse events and causes for patient complaints are quite different. If this is the case, other quality assurance measures must be used to monitor and improve the quality of clinical care and reduce clinical errors.

The process described in this paper is an effective way to deal with patient complaints about the service they have received from the hospital. It is a useful part of the continuous quality improvement program of the hospital and provides useful feedback to management on the extent to which the hospital is meeting the expectations of the people it serves. Monitoring of clinical effectiveness requires different systems from that described here.

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Appendix

Statement of Patient Expectations

As a patient of the Hospital, I believe I must participate with the staff of the Hospital to achieve a satisfactory outcome of the treatment of the illness which has caused me to become a patient. As a patient of the Hospital, I recognise my active role in the treatment program is essential for the long-term effectiveness of that treatment and for my ultimate return to better well being.

As a patient of the Hospital I have expectations of the staff and organisation of the Hospital. My expectations are that I will be assisted in achieving an improved state of well being. As a patient I believe the Hospital has a duty to me as an individual and a duty to provide effective medical care.

My specific expectations of the Hospital are:

1. SELF

- 1.1 I expect at all times to be treated as a human being in need of help.
- 1.2 I expect to be informed sufficiently to be able to participate in a meaningful way in my own treatment.
- 1.3 I expect to be informed of relative risk, advantage and disadvantage of various diagnostic and treatment options to a level consistent with my ability to understand.
- 1.4 I expect to be allowed to make my own decisions about my own treatment and to have those decisions respected.
- 1.5 I expect the Hospital will respect my desire for privacy and yet not deprive me of my need for human contact and comfort.

2. TREATMENT

- 2.1 I expect the staff of the Hospital to be competent and to maintain their skills at a high level of proficiency.
- 2.2 I expect my care to be effective and carefully delivered.
- 2.3 I expect a range of services and professional representation within the Hospital staff consistent with the role and stated ideals of the Hospital.

2.4 I expect my care to be delivered in timely fashion acknowledging that priority will always be given to those in greater need.

2.5 I expect my care to be free of all unnecessary risk.

3. ENVIRONMENT

3.1 I expect the environment of the Hospital to be safe. I acknowledge the inherent risks of Hospitalisation but I expect all reasonable precautions will be taken to protect me from the risk of infection and other physical dangers which may exist.

3.2 I expect to have my cultural traditions acknowledged and where possible complied with. I acknowledge the space, time and budgetary constraints under which the Hospital has to operate, but believe this does not absolve the Hospital of any requirement to acknowledge my cultural traditions.

3.3 I expect to be protected from other patients and visitors to the Hospital.

3.4 I expect the environment of the Hospital to be one which encourages healing in the physical, mental and spiritual senses of the word.

3.5 I acknowledge I must participate in the life of the Hospital. Therefore it will be expected of me that I co-operate with all reasonable rules and requests by staff.