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Investigating complaints to improve practice and develop policy

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Abstract

Purpose – This paper aims to make use of patient complaints as a valuable source of information to enable improvements to the quality of health service delivery.

Design/methodology/approach – Thematic analysis was used to analyse records of de-identified patient complaints made about medical or nursing staff or medical or nursing services between January 2006 and May 2008 in the Mount Isa Health Service District.

Findings – Three main themes were identified. These themes were labelled: "communication", "wait times" and "clinical". The latter related to specific concerns about the care provided to the patient or their relative. There were 101 complaints analysed. The majority (60 per cent) of complaints related to communication. Wait times for appointments (13 per cent), and clinical (28 per cent) were included in the remainder.

Research limitations/implications – The findings of this research are not generalisable beyond the Health Service District within which the data were collected. However, the principle of systematically using complaints information to improve practice and develop policy can be applied within all health services.

Practical implications – Recommendations to develop policies and improve practice that will address the matters identified in the complaints are made. Changes to complaints data records to assist future research are suggested. The need to facilitate indigenous patients' contribution to suggestions for service delivery improvement is highlighted.

Originality/value – The paper contributes to research that makes use of patient complaints to produce higher standards of patient service delivery.

Keywords Health services, Clinical governance, Quality improvement, Complaints, Patients, Australia

Paper type Research paper

Introduction

Patient satisfaction surveys are a useful tool to assist health care decision makers to monitor the quality of care provided in their organisations; however, respondents to such surveys are inclined to express high levels of satisfaction (Javetz, 1996). This type of feedback may be less than helpful as it may provide the organisation with a false belief that all is well. Furthermore, such feedback may provide minimal assistance in identifying ongoing and/or serious problems that diminish the quality of service provided by the health care organisation.

Complaints about the provision of health care have increased as consumers' expectations of care and awareness of their rights have grown (Anderson *et al.*, 2001; Chavan *et al.*, 2007) and are frequently considered to be unwelcome. Health professionals and/or health care organisations may react to complaints with fear and defensiveness (Anderson *et al.*, 2001). However, instead of being considered a source of negative information, patient complaints can be used as a valuable resource to identify the needs for service and care improvement (Siyambalapitiya *et al.*, 2007; Anderson

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et al., 2001). The Australian Council of Healthcare Standards (ACHS) specifies that patient complaints should be utilised to manage and improve the systems of care in hospitals (The Australian Council on Health Care Standards, 2008). Unfortunately, patient complaints are usually used to address the issues of individual consumers and there is a lack of research that makes use of patient complaints to produce higher standards of patient service delivery (Hsieh *et al.*, 2005).

The Mount Isa Health Service District (District) is situated in North West Queensland and covers an area of about 300,000 square kilometres. As of the 2006 Australian Bureau of Statistics (ABS) Census, the population of the area was 30,942, with the major portion (68.13 per cent) of the population situated in Mount Isa. The proportion of Indigenous Australians within this population is 22.7 percent compared to the Australian proportion of 2.3 per cent (Australian Bureau of Statistics, 2006). Mount Isa Hospital is the referral centre for the remote hospitals and health centres in the District and provides emergency, medical, general surgical, intensive, obstetric and paediatric care. The only form of land travel between Mount Isa Hospital and the remote health centres is over unsealed or development roads. Limited air travel is available and for residents of Mornington Island it is the only means of transport to the Mount Isa Hospital. Patients requiring care at a tertiary referral hospital are required to travel to Townsville Hospital that is 800 km from Mount Isa.

The Patient Liaison Officer (PLO) is based at the Mount Isa Hospital and receives records and processes all complaints and compliments made to the District. Forms on which complaints or compliments may be lodged are located in prominent areas of the wards and departments of the Mount Isa Hospital and in the remote hospitals and health centres. Complaints or compliments may also be lodged by telephone, by electronic means or in person to the PLO. The PLO is also notified of and processes complaints have been made directly to the local member of the Queensland state parliament or to the Queensland Minister for Health. On most occasions resolution of the complainants concerns is made by provision of further information required by the complainant and/or an apology from either the individual that the complaint was made about or on behalf of the service that was complained about.

Method

A de-identified database of complaints lodged with the Patient Liaison Officer of the Mount Isa Health Service District was examined to identify the data for inclusion in the research.

The types of complaints in the database varied widely but because the focus of this research is to improve organisational or workplace practices or policies in relation to medical and nursing care, only the complaints that were about medical or nursing staff or medical or nursing services were selected for inclusion in the analysis. All formal complaints made about medical or nursing staff or medical or nursing services were included in the study regardless of whether they were lodged in writing, by telephone, by electronic means or in person to the PLO. Thematic analysis (Denzin and Lincoln, 2000) was used to identify any regularities or patterns in the nature of the complaints made in relation to medical or nursing personnel or about medical or nursing care or service. Ethical approval for the research was sought from and granted by the Townsville Heath Service District's Human Research Ethical Committee.

Results

During the period of the study the district provided 485,608 occasions of service (Queensland Health, 2008). Occasions of service are defined as any contact with hospital services and includes contact via the Emergency Department as well as inpatient or ambulatory care services (Anderson *et al.*, 2001). There were 101 complaints about medical or nursing staff or medical or nursing services during this time that constitutes a ratio of 0.21 complaints per thousand occasions of service. The age and gender, relationship to patient and indigenous status of the complainants were not recorded in the complaints data and thus cannot be used in the analysis of the data.

The complaints were readily identified as falling into three main themes. These were: complaints about communication, complaints about wait times and complaints labelled as "clinical" as they related to concerns about the care provided to the patient or their relative.

The first sub-theme identified in the communication theme was labelled "individual communication" as these complaints related to the manner and approach that individual nursing or medical staff had toward the patient or their relative. The "wait times communication" sub-theme included complaints that resulted from a breakdown in communication with either the patient or the hospital to which they were being transferred in regard to planned treatment. The third sub-theme of the communication complaints labelled "clinical" was identified as complaints about clinical practice or processes that were or could have been resolved by better communication from the health professionals involved.

The theme of "wait-times" related only to wait times for outpatients services. Two sub-themes were identified within the "clinical" theme. The first of these was labelled "procedural" as the complaints related to perceived problems in the diagnosis and or therapeutic treatment of patients. The other sub-theme of clinical complaints was identified and labelled "Health Service Care". The complaints in this category were complaints that related to the process of health service delivery. The subject of the complaints varied widely and ranged from perceived inadequacies in care because of insufficient staffing to specific perceived inadequacies in care or non-specific complaints about care adequacy. The themes and sub-themes identified and the numbers of complaints within those groups are provided in Table I.

Discussion

The results of the data analysis suggest that patients and their relatives expect timely care to be delivered with competence and respect and few health professionals would

Theme	Sub-theme	No. complaints
Communication	Individual	40
	Wait times	8
	Clinical	12
Wait times		13
Clinical	Procedural	10
	Health service care	18
	Communication	12
	Total	101

Table I. Numbers of complaints by theme and sub-theme

argue against such an expectation. However, the provision of such care requires diligence to develop and uphold effective organisational practices and policies that support care delivery.

The combined complaints relating to communication represent approximately 60 per cent of the total complaints made. The higher proportion of complaints about communication compared to other complaint types is consistent with previously reported research but is higher than the 45 per cent reported by Anderson *et al.* (2001) and 48 per cent reported by Siyambalapitiya *et al.* (2007). This may be due to the proportion being artificially inflated because other complaint types were not included in this analysis. Nevertheless, it points to the need to ensure that medical and nursing staff have the skills and attitudes required to communicate well with patients and relatives. Doyal (2001) has argued that patients are frequently considered to be poor recipients of information but that there is also ample evidence of the lack of communication training for health professionals and their lack of communication skills. Moreover, Trumble *et al.* (2006) identify the strong link between medical practitioners' communication skills and patient satisfaction.

The Code of Conduct was introduced to Queensland Health in 2006 and guides the behaviour of all Queensland Health staff, particularly in relation to their communication with patients, relatives and other staff. Staff are introduced to the requirements of the Code of Conduct at induction to each Queensland Health organisation.

All staff identified in the complaints made were counselled regarding the Queensland Health Code of Conduct when a complaint was made about the manner and approach that the nursing or medical staff had toward the patient or their relative. Encouragingly, the number of complaints in regard to the manner or approach of medical or nursing staff over the period investigated in the study demonstrated a decrease in the average number of complaints of this nature from 1.58 per month in 2006 to 1.0 per month in 2008. This supports the link between education, improved communication and patient satisfaction (Trumble *et al.*, 2006). However, further reduction in the complaints about medical or nursing staff's communication is an achievable goal.

To improve and maintain a high standard of medical and nursing communication skills we recommend that measures are taken to ensure that all staff attend the district orientation programme within the first month of their term of employment. This orientation includes Code of Conduct education along with cultural awareness education. In addition to Code of Conduct education we recommend that regular mandatory workshops on how to communicate with patients/family so as to give appropriate explanation of events, procedures, processes and planned care be provided for health professionals. These workshops should also include education about how to receive and accept feedback when being counselled about the need for improvement in service delivery.

Cancellation of planned procedures is inconvenient for all patients. The distances that patients must travel to receive care at the Mount Isa Hospital, means that good communication about planned procedures is an absolute necessity. We recommend that the responsibility of communicating with remote patients about planned and/or rescheduled procedures be allocated to one staff member who would ensure that the patient has been contacted should their appointment time need to be changed. In the

circumstance that this person is unable to contact the patient by phone then contact with the patient should be made via the nurse or an indigenous health worker at the local hospital or health centre.

During the period of the study there were 28 complaints about perceived problems in the diagnosis and or therapeutic treatment of patients and specific or non-specific complaints about care adequacy. Research by Otani *et al.* (2005) indicated that when interacting with physicians, obtaining the correct diagnosis and treatment was a better predictor of patient satisfaction than the physician's interpersonal skills. To address the issues relating to diagnosis and treatment we recommend that complaints relating to problems in diagnosis or the therapeutic treatment of patients are monitored regularly. This will enable instances where individual staff may need further education or training to be identified and addressed in a timely manner.

It is reasonable to assume that the number of formal complaints received during the study period does not fully reflect the number of occasions that patients or relatives may have had reason to complain. This may be because many consumers are deterred from complaining about their health care experiences because they fear that their care will suffer as a result (Javetz, 1996). As noted earlier, complaints are often thought of by health professionals as unwelcome. On the other hand, a learning organisation may consider complaints to be a resource to be used to improve the quality of service that the organisation provides (Siyambalapitiya *et al.*, 2007). To ensure the maximum use of complaints as a learning resource, the haphazard nature of their receipt should be addressed. This can be done by providing complaint/compliment forms to individual patients and relatives on admission rather that placing them in a central position in a ward or department. Furthermore, complaint/compliment forms should indicate that the organisation welcomes their feedback as a means to guide service quality improvement. Thus, rather than fearing retribution for complaints made, patients and relatives would be encouraged to use the opportunity to partner the organisation in their efforts to provide high quality services.

If complaints are to be used as a means to improve service quality then it is recommended that hospitals or health service districts collect complaints data in a standardised manner and regularly analyse the data to enable service delivery to be improved (Anderson *et al.*, 2001). In addition, we agree with Anderson *et al.*'s (2001) argument that such analyses should be shared with the health care community through publications to facilitate knowledge development.

As noted earlier, the vast majority of complaints are resolved through the mediation of the PLO who provides an explanation of the matter to the complainant and/or an apology from an individual or on behalf of the service. While such actions may placate individual complainants they do not ensure that any organisational practices or policies that may underlie the basis of the complaint are addressed. We therefore recommend that complaints are regularly reviewed at executive management level to ensure that problems in practice or policy identified through the complaints have been addressed.

Accurate information about the actual proportion of the use of health care services by indigenous patients in the district is not available and the complaint records do not identify the indigenous status of complainants. This means that it is impossible to determine the proportion of complaints lodged by indigenous patients or relatives. However, it is likely that few complaints were lodged by indigenous patients as

English is a second or third language for many indigenous patients in this District and the level of literacy among indigenous Australians in remote areas is typically low (McMullen, 2007). We recommend that identification of indigenous status be included in the complaints records and also that when necessary Aboriginal Liaison Officers assist indigenous patients to complete the complaint/compliment forms provided to patients. These measures will enable the specific issues that affect the health outcomes for this particular group to be identified and addressed. Such actions may be valuable in helping to "close the gap" between the life expectancy of indigenous and non-indigenous Australians (Andreasyan *et al.*, 2007) in this Health Service District.

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