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Learning from complaints about hospital care

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Background

Complaints are often seen as a negative experience in healthcare, with patients or family members writing about poor experiences of care, or things that went wrong. These things that go wrong may be small issues or major problems. Patient complaints are usually written with the aim of helping to improve healthcare for future patients. Patients may have a perspective that differs from healthcare providers. For example, providers might not know about how patients dignity was respected, whether they experienced delays, or how they were interacted with. Patients, however, know all of these things. It is known that patient insights into their care can improve healthcare. However, these insights may not be considered to the same extent as staff measures of quality and safety of care. Most assessments of quality of care in Irish healthcare services are focused on healthcare workers' opinions, statistics about observable events (e.g., how many patients got an infection in hospital), or investigating large errors.

Until recently, complaints have not been used by hospitals or the healthcare service in Ireland to make broad improvements to healthcare delivery. While these complaints receive individual responses, there is no focus on analysing these complaints together and using this data to learn about key issues in specific services and the healthcare system. This means that patients' desire, and ability, to contribute to identifying problems and potential solutions are limited.

Researchers at the London School of Economics have developed the Healthcare Complaints Analysis Tool (HCAT)[1] that guides the systematic analysis of the cause and severity of complaints. The Health Research Board (HRB) and Health Service Executive (HSE) funded research project utilised the HCAT to analyse complaints received about Irish healthcare organisations. The research involved the collaboration of researchers, HSE managerial staff, healthcare workers, and quality and patient safety professionals in hospitals.

[1] The 'Healthcare complaints analysis tool', by Gillespie & Reader, paper and user guide is freely available at https://qualitysafety.bmj.com/content/25/12/937

Aims of the project

The overall goal of the 'Learning from complaints about hospital care' research project was to assess the added value to quality and safety in healthcare of drawing on user perspectives of poor service and demonstrate how they can be used to improve patient care.

The project aimed to:

- take a reliable and systematic approach to analysing and learning from healthcare complaints in Ireland;
- identify the types and severity of healthcare complaints made about care in acute hospitals in Ireland;
- identify hot spots and blind spots in quality and safety in Irish hospitals; and
- develop guidance on how the data from healthcare complaints can be used to improve patient safety.

Methods: What was done

The project was carried out in two stages.

Stage 1. Complaints analysis

A total of 641 complaints were sampled from 16 Irish hospitals from Quarter 4 of 2019. These complaints were anonymised to ensure no identifying information could be seen by the researchers. The HCAT was used by the researchers to categorise the complaints. The HCAT can be used to identify three distinct domains (clinical, management and relationship) within healthcare complaints, comprising seven categories (safety, quality, environment, institutional processes, listening, communication, and respect and patient rights). The HCAT also categorises the stage of care, harm, and severity reported in the complaint.

Stage 2. Identification of potential solutions

Once the complaints categorisation was completed, those complaints identified as frequent and high-severity were brought to two focus groups. These were carried out with stakeholders (researchers, healthcare workers, HSE managers, patients) in order to identify solutions to address and prevent the issues identified in these complaints reoccurring. After each of the workshops, the participants were then asked to rate each potential solution using the APEASE criteria. That is, the Affordability, Practicability, Effectiveness, Acceptability, Side effects (i.e. potential for the intervention to have negative unexpected consequences), and Equity (i.e. could be carried out in any hospital in the Republic of Ireland) of the intervention.

Stage 1 findings: Complaints analysis

A total of 641 complaints were analysed. This sample represented 72% of all complaints (total n=896) received by Irish hospitals during the fourth quarter of 2019. Many complaints contained more than one issue or problem within them. As a result, a total of 1,308 unique issues in the complaints were analysed.

Harm

Harm ranged from 0 (No harm reported) to 5 (catastrophic harm/permanent injury or death). Almost half of complaints in this sample reported no harm n=308, 48%. Examples of harm reported in the complaints can be found in Table 1. It is important to note that all examples in this report are from the perspective of patients/families, and are taken at face value. These are not necessarily the same as the findings from official investigations.

Table 1. Breakdown of complaints by harm

Harm	*N* complaints (%)	Example
0. No harm, harm not mentioned	308 (48)	'Luckily I caught it before it did any harm.'
1. Minimal harm	112 (17)	'I was very upset by that.'
2. Minor harm	114 (18)	'He is too anxious to go back as a result of how he was treated.'
3. Moderate harm	58 (9)	'I had to get another round of antibiotics which should have been unnecessary.'
4. Major harm	28 (4)	'I have continuing severe pain in my arm since the incident which prevents me from going back to work.'
5. Catastrophic harm	12 (2)	'My mother would still be alive if this had not happened.'

Categories

There are seven HCAT categories, with their frequency and examples listed in Table 2 below.

Table 2. Breakdown of complaints issues by HCAT category and examples

Category	*N* issues (%)	Example
Institutional Processes	390 (30)	'I was left on a waiting list for surgery for years'
Quality	189 (14)	'I was discharged from ED without even seeing a doctor'
Respect and patient rights	182 (14)	'They discriminated against me because of my background'
Communication	180 (14)	'I was never sent my test results'
Safety	160 (12)	'They completely misdiagnosed my appendicitis'
Environment	115 (9)	'There was what looked like blood on the bathroom floor'
Listening	92 (7)	'We as the parents were ignored when we told them about our child's allergies'

Severity

A summary of the severity of the complaints is provided in Table 3 below.

Table 3. Breakdown of complaints issues by severity

Severity level	*N* issues (%)
1. Low	292 (22)
2. Medium	726 (56)
3. High	287 (22)

Stage of care

Stages of care are the points in the patient care pathway where issues from complaints occurred, which are presented below.

Table 4. Breakdown of complaints issues by stage of care

Stage of care	*N* issues (%)	Example
1. Admission	322 (25)	'She was turned away instead of admitted even though she was at risk of self-harming'
2. Examination and diagnosis	233 (18)	'I was horrified to see what looked like dried blood on the vaginal probe during examination'
3. Care on the Ward	370 (28)	'While our new-born son was on the ward they took too long to notice his difficulty breathing and transfer him to the NICU'
4. Operation and procedures	78 (6)	'I told them that I didn't think the sedation was working and they ignored me'
5. Discharge	68 (5)	'I wasn't even told when I was discharged that my cancer was terminal, I found out afterwards'
6. Other	171 (13)	'I keep getting letters relating to another patients medical status'

Hot spots and blind spots

The HCAT analysis also allowed researchers to identify hot spots and blind spots in care (see Box 1). Hot spots for harm were found during the examination and diagnosis, care on the ward, and operation/procedures stages of care. Blind spots were identified at the transition points of care (admission and discharge), and when patients experienced issues at more than one stage of care (blind spot for systemic issues). This means that these points of care need to be focused on for improvement.

Box 1. Hot spots and blind spots definitions

Hot spots
Areas in care where harm (or a near miss for harm) occurs frequently.
Blind spots
Areas in care where problems occur that are not easily observed by staff members, or are incorrectly observed (e.g., while a patient is waiting for a follow-up appointment or referral).

Conclusions from complaints analysis

All of these findings gave us a greater insight into problems in Irish hospital care and the issues that cause dissatisfaction for patients and their relatives. The analysis also helped to identify which areas should be focused on for the second part of the research project — the stakeholder workshops. The main areas which were prioritised following this analysis were the hot spots and blind spots.

Stage 2 findings: Identification of potential solutions

Two workshops were held, one focused on quality of care and the other on safety of care. The stakeholders included: patients (n=3), doctors (n=1), nurses (n=3), health service researchers (n=2) and managers within the health service (n=3). The categories were chosen because they were two of the most frequent categories in the analysis. High-severity issues that occurred during stage 3 (care on the ward) were focused on, as these were hot spots that emerged from the complaints analysis.

Workshop 1: Focused on high-severity quality issue occurring during care on the ward

The first workshop focused on a patient who was left fasting for a prolonged period on the ward. The workshop resulted in the generation of 32 potential solutions to this problem. These potential solutions were then rated by the workshop participants using the APEASE criteria[2]. Top-rated interventions can be found in the table below.

Table 5. Top-rated interventions from quality workshop

Rating	Interventions
1	Healthcare staff should know, and follow, the most recent guidelines on fasting.
2	Healthcare staff must keep clear and explicit notes for each patient.
3	Conduct standardised handovers in which any delays in treatment for specific patients are discussed and any issues addressed.
4	Improve communication between theatre and ward team on delays and which patients will be seen on a particular day.
5	Ensure that patients are informed about delays and changes in their care by healthcare staff.

[2] APEASE framework: A means of evaluating interventions on their Acceptability, Practicability, Effectiveness, Affordability, Side-effects, and Equity. See https://www.unlockingbehaviourchange.com/pdfs/5c766be7b6281890464249.pdf for more information.

Workshop 2: Focused on high-severity safety issue occurring during care on the ward

This workshop focused on a patient who fell out of their bed while receiving care on the ward. Again, 32 potential interventions were discussed in the workshop. The top 5 recommended interventions are presented below.

Table 6. Top-rated interventions from safety workshop

Rating	Interventions
1	Ensure patient has everything they need near them.
2	During the ward round, specifically discuss the fall risk of a patient and strategies to mitigate this as necessary.
3	Ensure there is an appropriate falls prevention and management policy.
4	Conduct a risk analysis of areas where falls are likely and address any issues identified (spread solutions elsewhere as necessary).
5	Family members should make healthcare staff aware if a patient is frail.

Feedback on the process to identify potential solutions

Participants in the workshop also provided the research team with feedback on how they found the process of identifying and rating potential interventions. Overall, they had a positive opinion on the process, highlighting aspects such as 'Multidisciplinary and non-medical participants', 'blue-sky brainstorming' and 'listening to patients and families' as strengths. Some suggestions to improve the process included 'inviting more people to participate', 'having a survey box in hospitals to get the public involved' and 'including patients who have had the experiences'. Participants also rated the process on a scale from 0-100, where 100 is strongly agree. The average responses to each of the statements are presented in the table below.

Table 7. Average responses to each of the statements

Statement	Average response
I think the process we used to identify the interventions was effective in generating ideas	82
I think the process we used to identify the interventions was effective in identifying feasible solutions to issues in hospitals	77
I think the process we used to identify the interventions should be adopted by hospitals	79

Recommendations

1. Institutional processes issues were the most prevalent in the complaints, and the system/ hospitals should focus on improving the issues raised in these complaints.

2. High-harm and high-severity complaints need to be examined in order to improve patient safety.

3. Hot spots and blind spots that emerge from complaints analysis can help researchers and the health service to prioritise what issues to address.

4. Stakeholder workshops and groups should be used to identify useful, and feasible, solutions to improve safety and quality from issues identified in patient complaints.

Conclusions

This project has highlighted the potential for complaints to be used as a form of learning to improve hospital care. The HCAT can be used for the analysis of complaints about Irish hospitals, shifting the focus from resolving individual complaints to using patient insights to improve healthcare at a local, regional, and national level. Such analysis can help researchers, healthcare workers, and managers to make positive changes in the system, and improve the quality and safety of care for future patients. Involving stakeholders in developing ways to improve hospital care can generate new ideas that are based on the findings of complaints.

Learning from complaints about hospital care