

Best Practices and Recommendations for Patient Care Complaints Management within the

Vancouver Island Health Authority

Warren O. Lokke

University of Victoria

Capstone Supervisor:

Dr. Lyn Davis

Second Reader:

Dr. Barton Cunningham

Client:

Crystal White

Date of Submission:

March, 13, 2013

Executive Summary

Contemporary healthcare knowledge holds that the handling of complaints is an integral component in providing patient centred care. Responding to patient care complaints through incorporating learnt lessons and modifying protocol contributes to a culture of continuous quality improvement. The Patient Care Quality Office (PCQO) of the Vancouver Island Health Authority (VIHA) is responsible for coordinating reviews into complaints lodged by patients or their representatives. To better serve its community, the VIHA PCQO wishes to create a comprehensive patient care complaints management handbook accessible to all VIHA employees. This report encompasses one component of the preliminary background research for the future comprehensive complaints management handbook. The purpose of this report is to provide the VIHA PCQO with an increased understanding of the best practices associated with patient care complaints management. Best practices are the evidenced based proven methods used in completing a given task. For the VIHA PCQO, an awareness of patient care complaints management best practices will assist towards increasing the organization's capacity.

For this research, a participatory methodology was adopted to integrate the researcher and the PCQO personnel as co-contributors. The primary methods employed in this research were document analysis and focus groups. This inquiry identified best practices documentation authored by international leaders in patient care complaints management. In total, five best practices documents were ultimately selected for further data analysis in the report. The individual best practices within these five documents were subsequently extracted. From this, the researcher discovered that these individual best practices could be clustered into general themes. A focus group with VIHA PCQO employees was conducted to discuss their professional experiences as complaints managers within the community in addition to the

documented best practices. During the focus group, the PCQO participants verified to the researcher that the documented best practices were applicable to the VIHA context. The focus group discussion allowed the PCQO participants to highlight both strengths and areas in need of improvement with respect to patient care complaints management in VIHA. From the results of this focus group discussion, recommendations pertaining to best practices in patient care complaints management for the VIHA PCQO were formulated. These recommendations are: Mandatory PCQO presence at all new VIHA employee orientations; Create a dedicated PCQO Educator Position; Collect relevant Patient Care Complaints data; and Increase General Public Awareness of the PCQO.

Table of Contents

Introduction.....	1
Background	2
Literature Review	5
Organizational Conflict Theory	5
Constructive Conflict Theory.....	7
Service Recovery: Rationale for Managing Patient Care Complaints	8
Methodology	10
Document Analysis – Best Practices Sources	11
Stage 1 Extracting data from original source documents	15
Coding of the source document data	15
Grouping Themes	16
Focus Group	16
Findings.....	17
Best Practices	17
Focus Group	20
Discussion.....	25
Options/Recommendations	27
Appendix 1.....	32
Appendix 1-A.....	32
Appendix 1-B	33
Appendix 1-C	34
Appendix 1-D.....	35
Appendix 1-E	36
Appendix 2 (Mind-Maps).....	37
Appendix 2-A.....	37

Appendix 2-B 38

Appendix 2-C 39

Appendix 2-D..... 40

Appendix 2-E 41

Appendix 2-F..... 42

Appendix 2-G: General Best Practices..... 43

Appendix 2-H: Patient Centered and Empathetic 44

Appendix 2-I: Simplified Accessibility..... 45

Appendix 2-J: Administrative Fairness..... 46

Appendix 2-K: Privacy and Open Disclosure (Transparency)..... 47

Appendix 2-L: Timely Response 48

Appendix 2-M: Accurately Collecting and Reporting Information 49

Appendix 2-N: Appropriate Action & Continuous Quality Improvement 50

Appendix 2-O: Organizational Commitment..... 51

Appendix 3 (Focus Group Briefing Materials) 52

Appendix 3-A: Complaints Toolkit – handling complaints within the NHS (March 2008)..... 52

Appendix 3-B: Patient Concerns/Complaints Resolution (April 2007)..... 53

Appendix 3-C: Better Practice Guidelines on Complaint Management for Health Care Services
..... 55

Appendix 3-D: Guide to Complaint Handling in Health Care Services (2005 - Australia)..... 56

Appendix 3-E: Best Practices for Advanced Skills in Healthcare Service Recovery (SHCA
Annual Conference Presentation April 2011) - Dr. James Pichert 57

Appendix 4 (VIHA’s Vision, Purpose and Values) 58

References 59

Introduction

In simple terms, a complaint is a “voiced” dissatisfaction with a good or service provided. Complaints are a typical component in virtually every service delivery industry including healthcare (Ward Platt, 2008). However, due to the intimate nature of healthcare services, these complaints often entail a heightened level of personalization. A healthcare complaint may literally be about a life and death issue. For healthcare institutions, the objective is to manage complaints in an effective manner that assists in the de-escalation of conflict (Osborne, 2004). It is important for healthcare institutions to have the dedicated capacities available for complaints management. Through handling patient complaints in a systematic manner, healthcare institutions can demonstrate to their patients a commitment to providing quality service (Bendall-Lyon & Powers, 2001). Healthcare institutions that treat complaints seriously will develop transparent procedures for dealing with complaints (Ward Platt, 2008).

In recognizing that patient complaints are endemic to healthcare, it is important for health institutions to properly manage them. This mentality is aligned with the concept of Alternative Dispute Resolution (ADR). ADR is the continuum of negotiation, mediation, and arbitration outside of the court (legal) system (Rowe, 1990). The management (or handling) of patient care complaints is itself a form of ADR (Marshall & Robson, 2003). When patients or their representatives lodge complaints about their care, the issue(s) are almost always resolved without resorting to litigation. Working through issues (including many complaints) via ADR avenues often allows for more expedient and cost effective settlements (Marshall & Robson, 2003). This is because both legal fees are relatively expensive and the court system itself is perpetually backlogged with impending cases.

Employing ADR methods in complaints management allows for a wider opportunity of outcomes available to disputing parties (Marshall & Robson, 2003). Typically, ADR methods do not promote the dichotomous win-lose outcomes generally found within traditional litigation. From ADR approaches, it is possible to produce agreements that actually strengthen bonds between parties by emphasizing common interests and shared goals (Marshall & Robson, 2003). This is particularly important as many patients have lengthy relationships with their health service providers. These long-term relationships are often a result of circumstance rather than choice. Due to the particular specialization of health services, the ability for patients to seek competing service providers within close geographic proximity is limited. In recognition of this, a considerable onus is on the health institution for making a concerted effort to reasonably accommodate its patients' particular needs.

Background

The Vancouver Island Health Authority (VIHA) is a public healthcare services provider within the Canadian Province of British Columbia. VIHA operations include, but are not limited to; providing hospitals, specialized healthcare clinics, and residential care facilities (About VIHA, 2013). In addition, VIHA enforces public health policies within its respective communities. The geographical jurisdiction of VIHA consists of Vancouver Island; the Gulf Islands and the neighboring mainland areas north of Powell River and south of Rivers Inlet. The total population that VIHA serves is 765 000 (About VIHA, 2013).

Appropriate handling of patient care complaints within the respective Vancouver Island Healthcare Institutions has been a priority since 1993. During that year, a client concerns management department for the Greater Victoria Hospital Society (GVHS) was established. In

April 1997, the GVHS along with surrounding primary, secondary and tertiary health services formed the Capital Health Region. As a result, the now former GVHS client concerns management subsequently expanded into a Vancouver Island regional department known as the Client Relations Office (CRO). Tasked with the responsibility of customer satisfaction, the CRO provided a consistent process for handling concerns, complaints, and freedom of information and privacy issues.

The CRO was an early adopter of patient centered care within British Columbia. Rather than one-size-fits all approaches, patient centered care is the tailoring of the healthcare services experiences to the individual patron. In the following years, the principles of patient centered care would usher in a fundamental shift in British Columbia's healthcare industry. In 2008, this culminated with Bill 41, known as the *Patient Care Quality Review Board Act* (PCQRB Act) (Patient Quality Review Board, 2011). The PCQRB Act requires all British Columbia health authorities to establish centralized departments for patient care complaints known as Patient Care Quality Offices (PCQOs) (B.C. provides new avenues to complain about health care, 2008). The PCQRB Act defines legislated timelines for Health Authorities when handling complaints. These timelines apply to all stages of the review process from acknowledgment of the complaint, to stating the maximum length for conducting an investigation and ultimately delivering a response back to the patient.

The Vancouver Island Health Authority chose to integrate its existing CRO personnel into the new provincial mandate of the PCQRB Act. This resulted in the creation of the Vancouver Island Health Authority Patient Care Quality Office (VIHA PCQO). Since its inception, the VIHA PCQO has experienced considerable growth in the volume of patient care

complaints it receives. Much of this is attributed to the increasing awareness of the PCQO amongst the general public.

Operating as a legislatively mandated body has not been without its challenges for the VIHA PCQO. This especially applies to the management of patient complaints. Although the PCQRB Act defines operational procedures, practical directives for complaints management are non-existent. As a result, it is technically possible to follow the legislative requirements of the PCQRB Act without handling patient care complaints in a manner that promotes patient satisfaction and continuous quality improvement. Understanding evidence based best practices in patient care complaints management can support the VIHA PCQO with addressing these particular gaps. As defined by Aveyard & Sharp (2009), "...evidence based practice is practice that is supported by clear reasoning, taking into account that patient or client's preferences and using your own judgment."(p. 7) Evidence based practices highlight proven methods from actual instances where desired results have occurred. Thompson et al. (2005) created this five stage process for how an evidence based practice is developed:

1. Identify a clinical question
2. Search for the most appropriate evidence.
3. Critically appraise this evidence.
4. Incorporate the evidence into a strategy for action.
5. Evaluate the effects of any decisions and action taken.

In the spirit of being proactive, the VIHA PCQO opted to undertake this research inquiry into best practices of patient care complaints management. The VIHA PCQO approached Warren Lokke, a former Masters CO-OP student about the possibility of coordinating the research. Warren Lokke agreed to participate in this research as the deliverable report was

deemed to meet the requirements for a 598 Masters Degree Capstone Project. For the purposes of this report, the VIHA PCQO serves as the client for Warren Lokke's Master of Arts in Dispute Resolution 598 Capstone project. This report focuses specifically on 'best practices'. Best practices are those most current evidence based practices (Aveyard & Sharp, 2009). Using best practices in patient care complaints management increases the likelihood of successful outcomes. As patient care complaints are serious entities, it is important for healthcare personnel handling patient care complaints to be versed in best practices.

Literature Review

This section of the report outlines the linkages between Alternative Dispute Resolution theory and the realm of Patient Care Complaints Management. The complimentary theoretical concepts of 'organizational conflict', 'constructive conflict' and 'service recovery' are explained. 'Organizational conflict' and 'constructive conflict' frame the theoretical justification for a collaborative and integrative orientation to health care complaints. 'Service recovery' provides the rationale for systematically managing patient complaints in an effective manner.

Organizational Conflict Theory

Organizational conflict theory provides an applicable dispute resolution lens for understanding healthcare complaints management. Roloff (1987) declares, "organizational conflict occurs when members engage in activities that are incompatible with those of colleagues within their network, members of other collectivities, or unaffiliated individuals who utilize the services or products of the organization" (p. 496). The objective for organizations is not to remove conflict, but to manage it effectively (Rahim, 2002). Further, conflict is not an inherently negative entity within organizations. Conflict has the potential to be both constructive and destructive. The implied challenge for organizations is how to harness the constructive

aspects of conflict. Building on this research, Gelfand et al (2007) articulate four types of organizational conflict cultures; *collaborative conflict cultures*, *avoidant conflict cultures*, *passive-aggressive conflict cultures*, and *dominating conflict cultures* (p. 6). These four types of conflict cultures are products from the approaches in which organizations handle conflict (p. 8). From this, conflict is perceived as inevitable and endemic within organizations.

In collaborative conflict cultures, disputes are dealt through active problem solving that is shared amongst participants (Gelfand et al, 2007, p.14). The overall wellbeing of the group is considered highly important and there is an emphasis on maintaining positive relationships. Diversity of opinions amongst the conflict participants is encouraged, and it is believed that through open discussion, the best available solutions to a problem will be found (Gelfand et al, 2007, p.14).

Avoidant conflict cultures are present where participants refuse to acknowledge disputes but make attempts to maintain a civil working environment (Gelfand et al, 2007, p.14). Rather than deal outright with conflicts, avoidant cultures prefer to sugar-coat such situations or simply change controversial discussions to avoid the possibility of offending anyone (p. 12). Open discussion and active problem solving are seen as potentially destructive to the organization. In other words, conflict is dangerous and one should never speak of or engage with it.

Passive aggressive conflict cultures are typified by an obstructionist yet subverted competitive approach to dealing with problem solving. Actions amongst participants have the objective of not providing assistance to others. Common ways of handling conflict passively are through withdrawing from constructive interaction and employing the silent treatment (p. 12).

Dominating conflict cultures are characterized by an openly competitive confrontational approach to problem solving. Within dominating cultures, conflicts are dealt in a direct manner by participants. Heated arguments and blatant threats of intimidation are common place within dominating conflict cultures. Conflicts are seen as events that produce winning and losing parties. The goal for a participant is to not be on the losing side (p. 11).

Constructive Conflict Theory

For healthcare institutions, a collaborative culture is preferred in the handling of patient care complaints. Additional justification for a collaborative approach to healthcare complaints management is found in Mary Parker Follett's theory of 'Constructive conflict' (Pitman, 1973). According to Follett, conflicts are unavoidable and deeply ingrained into society. For Follett, conflicts themselves are not inherently negative entities. Rather, many conflicts possess the ability to yield opportunities for improvement. From this lens, it makes sense to embrace disputes as they provide insights into the strengths and weaknesses of an organization. Follett outlines three main approaches humans attempt to resolve conflict: domination, compromise and integration (Pitman, 1973).

Domination is the exertion of one party's power over another (Pitman, 1973). The party with the most available resources will likely win a given dispute. Follett concedes that domination is the most common conflict resolution approach. However, domination also more likely leads to destructive outcomes, such as the extreme cases of wars.

Compromise is when each party forgoes something in negotiation for the purpose of reaching an agreement (Pitman, 1973). Follett uses employer/trade union talks as an example of compromise. Follett contends that no one actually prefers compromise because of concessions. As a result of compromise, parties are left with less than satisfactory outcomes.

Integration fosters the exchanging of ideas between the various parties of a respective conflict (Pitman, 1973). Follett asserts that the ideal resolution of a complaint should be an integrative process between parties. This potentially allows for learning and understanding to occur between those in conflict. As opposed to competition, integration creates a shared interest between the parties within a dispute. Integration additionally promotes civility and de-escalation of disputes.

Service Recovery: Rationale for Managing Patient Care Complaints

The rationale for handling healthcare complaints management may be found within the concept of service recovery. Bendall-Lyon and Powers (2001) define service recovery as "...the service provider taking responsive action to "recover" lost or dissatisfied customers, to alter their negative perceptions, convert them into satisfied customers, and to ultimately maintain a business relationship with them (Bendall-Lyon & Powers, 2001, p. 279)." In the case of healthcare, service recovery affords institutions and their respective personnel the opportunity to restore trust within the patient. Bendall-Lyon and Powers developed a six step roadmap for incorporating service recovery principles into patient complaints management. These six steps are:

- (1) encourage complaints as a quality improvement tool;
- (2) establish a team of representatives to handle complaints;
- (3) resolve customer problems quickly and effectively;
- (4) develop a complaint database;
- (5) commit to identifying failure points in the service system; and
- (6) track trends and use information to improve service processes. (Bendall-Lyon and Powers, 2001, p. 279)"

Service recovery practicing healthcare institutions do not ignore complaints. Instead, complaints are welcome and viewed as honest disclosures of feedback from a patient's healthcare service experience. Encouraging patients to voice care complaints is necessary for continuous quality improvement (Javetz & Stern, 1996). Complaints provide opportunities for learning on both individual and systems levels. Through complaints, actual effects of given practices or procedures on the consumer (patient) are illustrated. When further investigating complaints, healthcare institutions gain an increased understanding of the operations at hand (Parry & Hewage, 2009). A service recovery practicing healthcare institution will acknowledge the complainant's experience and subsequently make the necessary adjustments to rectify the situation. When complaints are lodged by patients or their advocates, they reveal an interruption in the complainant's relationship with the healthcare service provider. If appropriate measures are not used to deal with this interruption, then increasingly serious challenges may arise. For instance, a relatively small dispute left unattended could grow into an institutional crisis.

The quality of the care a healthcare institution produces has an effect on its service recovery abilities. There is an increasing amount of evidence linking patient satisfaction and a healthcare institution's dedication to employee performance excellence. The more committed healthcare workers are to providing quality service, the more likely patients will view their experiences as positive. Through analyzing an American sample of 113 Veterans Health Administration ambulatory care centers, Scotti et al. (2007) argue that high performance work systems (HPWS) promote favorable patient perceptions of healthcare services. As defined by Bonias et al. (2010), a HPWS is "...a group of separate, but interconnected human resource practices that together recruit, select, develop, motivate and retain employees. HPWS practices are presumed to affect performance by enhancing employees' knowledge, skills, abilities and

commitment. It is suggested that HPWS provide employees with the information and discretion necessary to capitalise on their skills and commitment in completing their jobs...” In other words, in order to provide quality care, healthcare workers need to believe in their organization. This translates to the healthcare institution promoting a culture of high morale amongst its personnel. If healthcare employees themselves are not satisfied, the quality of their work may decline. A healthcare institution’s emphasis on quality has significant ramifications on service recovery initiatives. Highly skilled healthcare workers driven to succeed are able to respond to complaints in a much more systematic manner, which in turn promotes service recovery.

Methodology

The methodology section situates the research through identifying and explaining the research paradigm, methodology, and methods utilized in the project.

The research paradigm of this project is firmly grounded within constructivism. Constructivism assumes that meanings are socially created through humans interacting with their respective environments (Cresswell, 2009). Humans interpret their environments through their own ingrained cultural influences. The goal for the researcher operating within a constructivist paradigm is to investigate the specific socio-cultural contexts of the participants. This means the primary researcher (Warren Lokke) actively engaging with the study’s participants (PCQO Personnel) in order to elicit relevant data (Cresswell, 2009).

This inquiry was conducted using the qualitative methodology of participatory research. In participatory research, both the subjects and the researcher contribute to the investigation and findings of a research initiative (Given, 2008). Participatory research holds that “participants are co-researchers” who provide valuable contributions to the study (Given, 2008, p. 599). Cornwall & Jewkes (1995), argue that “... The key difference between participatory

methodologies and conventional methodologies lies in the location of power in the research process. (p.1)” As opposed to many traditional research methodologies, participatory research does not place the primary researcher as the lone authority. Participatory research is particularly applicable for healthcare inquiries as it considers local expertise of the subjects valuable. Participatory methodology involves individuals providing meaningful contributions rather than simply attending a research initiative (Cornwall & Jewkes, 1995). This methodology was chosen in order to integrate the expert viewpoints of the VIHA PCQO department personnel. As complaints managers within VIHA, PCQO employees have a wealth of local knowledge, which is particularly important in formulating community relevant best practices in patient complaints management. To allow a space for PCQO personnel to discuss their professional complaint handling experiences, a focus group was conducted.

There were two primary types of methods used within this research project. The method of document analysis was used in examining the best practice sources. The method of focus group was used for research involving the VIHA PCQO personnel.

Document Analysis – Best Practices Sources

Document analysis was the method used for extracting data from the best practices literature. Before the collection of the data, the researcher established several parameters regarding the nature of the data (documentation) to be used in the report. Firstly, there was a conscious effort to target documentation from the countries of Canada, United Kingdom, Australia, New Zealand and the United States. These countries were selected because they are predominately English speaking with similar demographics and advanced levels of economic development. This was done to maintain a high level of cultural similarity between the respective data sources and VIHA, the client of this report. The second criterion of the data was

that it be limited to patient care complaints management best practices documentation published either by or intended for healthcare institutions and organizations. This is because the client of this report, Vancouver Island Health Authority (VIHA), is itself a healthcare institution.

A comprehensive internet search using Google, Bing and the University of Victoria library catalogue was undertaken during this study. This method of search was employed in order to isolate best practices documentation from healthcare institutions and healthcare organizations available in the public realm. As a result, the data collected from these documents could be used for this project without acquiring approval from external ethics or privacy boards. The keywords of “best practices”, “better practices”, “healthcare”, “patient complaints”, “complaints management”, “grievances” and “complaints handling” were searched in multiple combinations. This method for searching was applied in recognition for the diversity of terms used within the study of healthcare complaints management.

Upon compiling sources that adhered to the criteria desired, the researcher selected five documents (out of a total of 11 located) of best practices in patient complaints management for further analysis. These five original source documents were chosen because of the prominence of their authors and their clear articulation of best practices. The authors of these documents are all highly regarded healthcare organizations and institutions within their own countries and across the world. For the researcher, best practices in complaints management stated by these prominent healthcare institutions and organizations are likely to be legitimate and therefore useful in analysis. The five documents chosen were *Complaints Toolkit: Handling Complaints within the NHS (United Kingdom)*; *Better Practice Guidelines on Complaints Management for Health Care Services (Australia)*; *Guide to Complaint Handling in Healthcare Services (Australia)*; *Patient Concerns/Complaints Resolution (Canada)*; and *Best Practices for*

Advanced Skills in Healthcare Service Recovery (United States). The following paragraphs explain why these particular document sources were used in the report.

The *Complaints Toolkit: Handling Complaints within the NHS (United Kingdom)* is a sanctioned standardized training guide intended for complaints managers within the UK (Healthcare Commission, 2008). The Healthcare Commission, the document's author, "...is an independent body for reviewing the quality of healthcare and public health in England and Wales" (Healthcare Commission, 2008, p. 2). Up until being replaced in 2009 by the Care Quality Commission, the Healthcare commission was additionally tasked with independently reviewing NHS complaints not resolved at the local level (Healthcare Commission, 2008). As the Healthcare commission was both a regulatory and advising body within the United Kingdom's public healthcare system, the researcher believed that the best practices articulated in this document are credible and should subsequently be included in further analysis.

Better Practice Guidelines on Complaints Management for Health Care Services (Australia) was produced by the Australian Council for Safety and Quality in Health Care. The Australian Council for Safety and Quality in Health Care was created by the Australian Health Minister in January 2000 to advance quality care on the national level (Australian Council for Safety and Quality in Health Care, 2004). This council reports annually to the Australian health ministry. The stated purpose of this document was to "...provide better practice guidelines on complaints management for healthcare services (Australian Council for Safety and Quality in Health Care, 2004, p. i)." As the author of this document occupies a significant position in Australia's healthcare policy advancement, the researcher decided to use its best practices content.

Guide to Complaint Handling in Healthcare Services (Australia) was authored by the Health Services Review Council (HSRC). Established by legislative mandate in 1987, the HSRC is a patient care complaints advisory body for the state of Victoria in Australia (HSRC, 2005). This particular document was “...designed to assist health service providers to develop and implement effective complaints handling practices (HSRC, 2005, p. iii).” It was this stated objective that provided the researcher with a convincing rationale to include its best practices in the inquiry. As the HSRC is an advisory body for an Australian State government, there is a high likelihood that this report contains relevant evidenced-based information.

Patient Concerns/Complaints Resolution (Canada) was chosen because of the stakeholders involved in the formulating of this document. The author, The Health Quality Council of Alberta, had the contents of this document reviewed by: “...Alberta Medical Association; Alberta Cancer Board; Alberta College of Pharmacists; Alberta Health & Wellness; Alberta Ombudsman; Alberta Mental Health Board; College & Association of Registered Nurses of Alberta; College of Physicians & Surgeons of Alberta; Federation of Regulated Health Professions; Patient Representatives Network and the Patient Concerns Officers from Alberta’s nine health regions (HQCA, 2007, p.1).” The fact that these respective Alberta healthcare bodies provided their input into this document is highly significant. As a result, the best practices content within this document is likely to have a high level of credibility and should therefore be used in this report.

Best Practices for Advanced Skills in Healthcare Service Recovery (United States) was selected because Dr. James. Pichert is a highly regarded authority in the research of patient care complaints management best practices. Dr. Pichert is the co-director of the Center for Patient and Professional Advocacy (CPPA) at Vanderbilt University. The content from this particular

document was presented during the 2007 Society for Healthcare Consumer Advocacy (SHCA) conference. Members of SHCA are individuals from professional and academic backgrounds with an interest in patient care complaints management. The relevant target demographic coupled with the author's prominence in the field justified to the researcher the utility of this document.

The structure and presentation of best practices within the original source documents used in the study varied considerably. To account for this, the researcher adopted a simple uniform scheme to display the themes (individual best practices) from each respective original source document. The scheme outlined the source and subsequently listed its best practices themes in point-form. (See Appendices 1-A through 1-E)

Stage 1 Extracting data from original source documents

The individual best practices from the source documents contained the bulk of data used by the researcher in this project. For further analysis, the researcher transposed the individual best practices into mind-map illustrations. The researcher used "mindgenius", a computer-based software program to visually display the best practices data. Mindgenius requires one to manually input information according to a top-down hierarchal structure. In the first step, a 'parent bubble' named after each individual original source document was created. The respective individual best practices found within the particular source then were attached as 'branches' to the parent bubble. In the interests of maintaining visual clarity, the extended detailed definitions of the individual best practices were omitted in the mind-map illustrations.

Coding of the source document data

Once the data from the themes sections were visually displayed on the mind maps, unique colored "buttons" were added to distinguish each individual source document. (Appendix 2-F) For the mind maps, these buttons were applied to each parent and their respective branches.

These buttons would serve as a catalogue reference back to their original source parent. This allows one to trace an individual best practice back to its original source document.

Grouping Themes

Upon reviewing the respective individual best practices themes, it became evident to the researcher that similar terms existed. This was the case for both within and between the source documents. For instance, the individual best practice of “Access” occurs as a branch within three separate source documents (parent bubbles). The researcher believes that similar individual best practices can be clustered within the mind-mapping visuals through further coding and grouping. To denote similar individual best practices, the researcher used different color-filled shapes within the mind maps. Each individual best practice theme retained its original source button and was placed in a color-filled shape as those similar to it.

Focus Group

Once the researcher had summarized and clustered the best practices data into distinct themes, it had to be presented to the PCQO department personnel. On April 24 2012, the researcher facilitated a focus group with members of the Patient Care Quality Office (PCQO). The focus group was conducted in the Watson Conference room from 12:00-1:00 at the Royal Jubilee Hospital Campus. Approximately one week before the focus group, PCQO personnel were given a briefing package providing background information on the research (See Appendices 3A-3E). **The briefing package contained a summary of the original best practices source documents as well as the mindgenius illustrations.** The purpose of this was to inform the PCQO participants of the best practices data collected by the researcher.

The focus group was designated as a non-hierarchical discussion opportunity where all participants were encouraged to discuss their experiences and roles as complaints managers within the Vancouver Island Health Authority. The personal experiences of the PCQO

personnel supplied a relevant community context for the research. The focus group allowed the VIHA PCQO employees to contribute their local insights into handling patient care complaints. This focus group discussion uncovered several challenges and opportunities facing VIHA with respects to managing patient care complaints.

Findings

Best Practices

The interpretation of the original source documents was relatively simple since the best practices in each original source were clearly articulated. As these sources were intended to be used as training materials, each document had its best practices listed and defined like a dictionary (See Appendix 3). This enabled a straightforward and transparent data extraction of the best practices.

Through the grouping of similar individual best practices, the researcher was able to formulate over-arching themes, or general best practices. As a result, individual best practices from different original sources could be clustered together into distinct well-defined groups of general best practices. In total, eight general best practices were identified. The general best practices are; “patient centered and empathetic”, “simplified accessibility”, “administrative fairness”, “privacy and open disclosure (transparency)”, “timely response”, “accurately collecting and reporting information”, “appropriate action and continuous quality improvement”, and “organizational commitment”. (See Appendices 2-G through 2-O) These general best practices are explicitly defined below.

The general best practice of “patient centered and empathetic” (See Appendix 2-G) refers to the orientation of a healthcare institution towards providing services with the patient’s needs as a priority. Patient Centered healthcare service delivery is simply not a one-size-fits-all affair.

Rather, patients are distinct individuals whom within reason are to be accommodated. A patient centered healthcare institution is likely to have the capacities available for appropriate handling of disputes. Patient centered health institutions will develop services and facilities for patients with unique cultural and physical requirements. For example, resources for blind and deaf patients would be readily available.

The general best practice of “simplified accessibility” (See Appendix 2-H) refers to the ability of patients or their representatives to access the care complaints process. Simply put, the easier it is to make a formal complaint, the better. In practicing this ideal of simplified accessibility, healthcare institutions would ideally advertise their complaints management policy and process. For instance, ensuring pamphlets and posters of the healthcare institutions complaints department are readily available in and around service delivery centers. The writing in these advertisements should be written in plain language. In addition, patients would be able to lodge complaints using multiple mediums such as email, letter, telephone and in-person at the central office.

The general best practice of “administrative fairness” (See Appendix 2-I) refers to the subsequent care given to patients whom have made a complaint either at the local level or with the institution’s complaints management department. When practicing administrative fairness, the objective is to not have one’s care adversely affected after lodging a complaint. This means that healthcare service providers should not take personal offense and react negatively to patient complaints. In most cases, a patient is making a complaint because he/she feels that their care situation needs to be altered. This attitude feeds back to the concept of recognizing the importance of complaints towards continuous quality improvement.

The general best practice of “privacy and open disclosure (transparency)” (See Appendix 2-J) refers to the confidentiality and openness of the review of a patient complaint. Although confidentiality and transparency may appear to be contradictory, in the context of patient care complaints management they are in fact complementary. When a patient makes a complaint, it is important that this information remain discreet and disclosed to only those it needs to be. Meanwhile, healthcare institutions should have a policy of open disclosure for the complainant about the complaints process. Health institution personnel involved in the review of the complaint should be readily available to clearly explain and provide updates to the complainant.

The general best practice of “timely response” (See Appendix 2-K) refers to the pace at which complaint reviewers provide a response to the complainant. It is an ideal best practice to provide a thorough response to the patient in as short time as possible. To achieve this, realistic deadlines for a response should be established and clearly articulated to the complainant. The overall purpose of a timely response is to not unnecessarily delay a complaint from being resolved.

The general best practice of “accurately collecting and reporting information” (See Appendix 2-L) refers to the internal process of complaints management. For effective complaints handling, it is important for health institutions to properly document complaints. This translates to having a centralized point for all investigators to submit documentation related to a given complaint. This allows those working on a complaints review easy access to all relevant information.

The general best practice of “appropriate action and continuous quality improvement” (See Appendix 2-M) refers to handling patient complaints in a manner that promotes learning from them. This translates to health institutions possessing the ability to reflexively analyze their

complaints management processes. When issues with patient complaints handling are identified, the health institution should make adjustments aimed at improving the system. As no complaints management system is inherently perfect, there are always avenues for improvement. Stagnation and complacency are seen as negatives for this general best practice. Appropriate action and continuous quality improvement necessitates that health institutions be adaptable and ready to accept the challenges and opportunities of new realities.

The general best practice of “organizational commitment” (See Appendix 2-N) refers to the value the institution places on complaints management. Organizational commitment does not stem from the complaints department itself, but the highest levels of administration in the health institution. If the executive offices of a health institution promote patient care complaints management, it is likely that the message will proliferate throughout the various departments. Favorable attitudes from the executive offices can significantly increase the institution-wide reverence of patient care complaints management. In addition, the executive office often has the ability to influence the allotment of funding for departmental resources. This potentially means that confidence from the executive offices may contribute to an increased capacity with respects to managing patient care complaints institution-wide.

Focus Group

During the focus group, participants were asked by the researcher to give their opinions regarding the best practices documentation supplied in the briefing materials (Appendices 3A-3E). There was a consensus amongst participants that the documentation on patient care complaints management best practices was complete with “nothing missing”. The participants also believed that the researcher’s grouping/clustering of best practices from individual sources to general principles made logical sense and allowed for a clear articulation of the material.

For the most part, it was agreed by the participants that VIHA adheres to the best practices formulated by the researcher. Although, it was noted that not all respective individual best practices listed fell within the primary jurisdiction of the VIHA PCQO. Rather, there are other departments who assumed the responsibility to enforce these best practices. For example, ‘appropriate action and continuous quality improvement’ is enforced by the Quality Insurance Committee.

The focus group also outlined the unique characteristics of the VIHA PCQO and how it operates within the greater organization. In particular, the mediating role that the PCQO plays between the administrative and clinical levels became evident through the discussion. The VIHA PCQO regularly maintains direct contact with both the point of service departments and management offices. There are few other departments within the VIHA organization that occupy such a niche. As a result, VIHA PCQO is in a crucial position to relay information between the frontline service delivery and Health Authority executives. The participants agreed that this makes the VIHA PCQO a crucial stakeholder for many institutional policy initiatives.

The discussion topic of complaint accountability identified a crucial element to VIHA’s orientation to managing patient care complaints. Specifically, the researcher asked the participants who “owns” (assumes handling responsibility) for a complaint within VIHA. The answer by the PCQO participants was that all VIHA employees are complaints handlers. This means that if a patient voices a complaint to a VIHA employee, the employee is then expected to respond in a manner that promotes de-escalation and resolution. In practice, this may involve employees resolving the complaint themselves or directing the complaints to appropriate authorities. It follows that VIHA employees should have a working understanding of the complaints management procedures.

The focus group discussion revealed some aspects of the PCQO operations that could be improved. The best practice of ‘Continuous Quality Improvement’ highlighted one significant area in need of further development and clarity: data collection. Specifically, there is a desire amongst the participants to establish a “metric” of PCQO performance. This metric or scheme would enable the PCQO to track and report important data on patient care complaints. The ability for the PCQO to measure the number and nature of complaints coming into their department would be a significant component of this metric. The PCQO hopes that the analysis of the data from the metric will identify trends in the Health Authority’s patient care complaints. It is important that although the PCQO does currently having a complaint tracking tool, the patient safety learning system (PSLS), the focus group participants believed additional abilities could be added to further advance its utility. In reference to this, one focus group participant mentioned how the USA-based patient complaints management organizations whom are members of the Society for Healthcare Consumer Advocacy (SHCA) use their grievance tracking system as a means to promote transparency. On a routine basis, the American PCQO equivalents post the volume and nature of actual patient care complaints for the department, staff and general public to view. Making PCQO complaints public would allow external monitoring of the volume and nature of VIHA’s patient care complaints. Additionally, this increased level of transparency may contribute to greater public confidence in the VIHA complaints management process.

The topic of data collection additionally exposed another challenge the PCQO currently faces. This challenge is summarized in the dual responsibilities of PCQO personnel to document complaints and interact with patients. For many complainants, their initial expectations are that the PCQO is an independent avenue for patient advocacy like many USA based patient care

complaints management organizations. American complaints managers, operating under the lens of patient advocacy are afforded a much greater degree of autonomy from healthcare providing institutions. One focus group participant pointed out that often when a complaint is lodged within an American hospital, independent complaints managers can go straight to the department in question to initiate an inquiry. However, as the PCQO is a VIHA department, it is not an independent body and subsequently unable provide an identical service. In recognizing its allegiance to VIHA, the focus group participants believed that there is room for increased PCQO independence to be built into its processes.

During the focus group, there was a consensus amongst participants that additional work is needed on several fronts with relation to PCQO awareness. This can be further broken into the sub-categories of staff awareness and community awareness. In reference to staff awareness, the participants believed that more education about the PCQO is required. The participants voiced that when working alongside VIHA departments; the PCQO often has to explain to the respective staff the process, roles, and obligations of undertaking a complaint investigation. The participants agreed that if all VIHA staff were better informed of the PCQO, the completing of complaints reviews would operate in a more efficient manner.

On the topic of community awareness, the PCQO personnel agreed that more needs to be done. Although the provincially mandated posters and brochures are widely available at VIHA's point of service outlets, a considerable lack of understanding about the PCQO within the greater public persists. As referenced earlier, much of this can be attributed to patient/complainants incorrectly assuming the PCQO to be a VIHA-independent investigative body. In many cases, a patient is first introduced to the PCQO when lodging a complaint. The PCQO wants to make considerable strides in this matter through additional promotion of its roles and responsibilities.

If the more of the public is aware of the VIHA PCQO's scope, then it encourages more appropriate and efficient use of its resources. This is particularly the case when patients contact the VIHA PCQO before making any effort to resolve an issue at the point of service. Many patients still do not realize that they should first address their concerns with their immediate healthcare service providers. Local resolution typically provides the quickest and most appropriate response to issues of patient care. If the attempts at local resolution have not satisfied the complainant, then he/she should notify the VIHA PCQO. It is essential that the PCQO educate the public about this operational mandate of local resolution as the preferred first stage in the complaints management process.

Awareness also refers to understanding the VIHA community and its particular needs. The focus group touched on some of the unique demographics of those members of the general public who use VIHA services. It was noted that a considerable proportion of VIHA health service recipients are elderly individuals. This produces its own set of associated challenges with respect to communication. As many elderly citizens have issues accessing information online, it is important to keep other traditional avenues including letter writing open. Another unique characteristic of the VIHA community is its language diversity. As Vancouver Island has become increasingly multicultural, the number of individuals speaking primarily foreign languages has grown. The PCQO personnel believe that additional support for non-native English speakers is needed. This specifically refers to providing more foreign language healthcare policy documentation and interpreters. With more communication resources available to non-native English speakers, it is likely that the quality of their experiences when accessing VIHA services will improve.

The significant potential for the PCQO as an educator was also discussed during the focus group. One PCQO participant suggested the idea of forming an authority-wide education initiative. This would involve PCQO personnel traveling to numerous VIHA sites in order to conduct informative presentations. The prospect of holding routine PCQO interactive webinar training sessions was also discussed. Ideally, all willing VIHA personnel would be able to remotely attend these sessions using a telephonic or video-conferencing medium. During these meetings, the PCQO would both lead discussions on complaints management topics and answer questions from attendees. The intent of these webinars is to increase the capacity amongst fellow VIHA personnel.

Discussion

From the focus group, the three areas in need of further attention are building employee complaints management capacities, appropriate data collection, and increasing PCQO general public awareness. This section discusses the implementation potential of specific findings identified during the focus group.

It is evident to the VIHA PCQO the institution will benefit through employees gaining additional complaints management skills. The task for VIHA is to prioritize those initiatives intended to increase staff complaints handling abilities. The recognition by the PCQO focus group participants that complaints are “owned” by all staff members is significant. Putting this idea into practice, it follows that VIHA staff are aware of the complaints management procedures. Staff cannot be reasonably expected to gain this understanding without some formal training. However, a heightened role for the PCQO as an educator in complaints management presents its own challenges and opportunities. For instance, does this educator role necessitate the creating of a dedicated fulltime position? Additionally, as VIHA’s geographical catchment

area is rather expansive, travel costs should also be an important factor to consider. The VIHA PCQO webinar suggested in the focus group might be one tool for staff complaints management education. Although travel costs are significantly decreased with a webinar, VIHA employees must still schedule time off to participate. This places an added importance on ensuring that the content of the education be relevant and beneficial to participants. Whichever staff training/awareness initiatives VIHA chooses to undertake, the rewards should heavily outweigh their operational costs.

During the focus group, participants suggested an approach to data collection that advances continuous quality improvement within the institution by use of a “metric”. Determining appropriate patient complaints data collection requires a review of the processes currently in place. At the moment, VIHA’s complaints data collection methods are not conducive to a proactive orientation to healthcare complaints management. Specifically, the complaints recording software used by VIHA needs additional abilities to easily produce meaningful reports. The PCQO should schedule a meeting with technology experts to discuss the features they require for relevant complaints data collection. This will better ensure that the PCQO is getting as much usefulness as it can with respect to its data collection software. Admittedly, any modifications to technologies will require additional expenditures. However, the potential prospect of easier analysis of complaints data is worth additional investigation on the part of VIHA. A more robust data collection medium will assist VIHA in the adherence to best practices principles. This is because an effective data collection streamlines the complaints management process. When patients request a review into their care, an increased integration of the recorded complaint information will take place.

The participants made it apparent during the focus group discussion that the public needs to acquire a greater understanding of the PCQO. This inevitably entails some type of public awareness campaign. Above all, there must be an emphasis to convey information to the public about the VIHA PCQO in clear and consistent manner. This translates to creating promotional materials using easily understood language. Commonly held misconceptions of the PCQO such as the idea that they are independent advocates should be addressed head-on. This will encourage both transparency and reasonable public expectations of the VIHA PCQO.

Options/Recommendations

The recommendations are the outcomes from the PCQO focus group and the analyzed documentation of best practices in patient care complaints management. The purpose of all recommendations collectively is to increase the overall effectiveness of VIHA's patient care complaints system. The international best practices documentation sourced for this research provided a credible evidence-based background into the realm of managing patient care complaints. The VIHA PCQO focus group contributed valuable experiences from complaints management experts working within the community. The intentions of these recommendations are to highlight areas for both service improvement and potential future growth with respect to VIHA's patient care complaints handling. This section additionally identifies how these recommendations are aligned with VIHA's current 'Vision', 'Purpose', and 'Values' (See Appendix 4). VIHA defines its current vision as; "Excellent care — for everyone, everywhere, every time". VIHA's purpose is; "To provide superior health care through innovation, teaching and research and a commitment to quality and safety — creating healthier, stronger communities and a better quality of life for those we touch." VIHA's four principle values are known as C.A.R.E.; "Courage: To do the right thing — to change, innovate and grow; Aspire: To the

highest degree of quality and safety; Respect: To value each individual and bring trust to every relationship; Empathy: To give the kind of care we would want for our loved ones.” The recommendations are listed and explained below.

- 1) Mandatory PCQO presence at all new VIHA employee orientations: From the onset of their careers, new staff should be aware of the VIHA PCQO’s roles and responsibilities. This necessitates having the PCQO readily accessible to new VIHA staff. During VIHA’s routine new employee orientations, there should be a guaranteed time allotment for a PCQO led presentation. Using actual success stories, this presentation would illustrate how employee adherence to PCQO complaints management procedures improves patient centered care. If new employees are indoctrinated early to the effective handling of patient complaints, they are more likely to develop a service-recovery mindset. For the PCQO, the ideals of effective complaints management would likely proliferate across the institution over time and contribute to VIHA’s vision of providing excellent care. Through implementation of this recommendation, the VIHA executive is putting its value of aspiring to the highest degree of quality and safety into practice. The costs associated of including the PCQO into new staff orientations are relatively small when one considers its potential benefits to the entire VIHA community. Ensuring VIHA’s employees are adequately prepared at the beginning of their careers to provide “Excellent care” is a worthwhile investment.
- 2) Create a dedicated PCQO Educator Position: The investigations/reviews of patient care complaints are not an easy process for many departments and their managers. This lack of understanding amongst many VIHA personnel into the PCQO complaints process was mentioned during the focus group. A PCQO educator would target the challenges faced

by departments conducting patient complaints investigations at the source. The act of teaching (educating) is one aspect of VIHA's current purpose of promoting a healthier and stronger community for its patrons. This recommendation provides an opportunity for the PCQO to actively contribute to an increased patient complaints management capacity within the organization as a whole. A PCQO employee available to assist departments during the review process would be a considerable asset. One component of the general best practice of organizational commitment (Appendix 2-O) is applying the complaints policy consistently across the institution. Through training and coaching departments, the PCQO educator will be promoting a consistent complaints handling process. The PCQO educator additionally qualifies as an excellent individual to oversee PCQO working group. Creating a space for VIHA employees to discuss and share their own patient care complaints experiences with others outside their departments is crucial to normalizing conflict and advancing the principles of patient centered care across VIHA. This working group would provide participants with an outlet to both debrief and relay constructive feedback to each other. Another possibility is combining this working group with the webinar training initiative proposed by PCQO participants during the focus group. This would allow VIHA personnel to contribute to the understanding of patient complaints management while receiving guidance from the PCQO educator. In addition, a webinar medium would allow more participants to attend while significantly cutting travel costs. Through providing its staff with additional support in handling complaints, VIHA increases the likelihood of successful complaints management outcomes. This alone is justification for the VIHA executive to implement this recommendation.

- 3) Collect relevant Patient Care Complaints data: In accordance with the general best practice of ‘Accurately Collecting and Reporting Information’ (Appendix-2M), the data retained on patient care complaints must be useful for VIHA. The discussion of the “metric” during the focus group provides a guide to meaningful PCQO data collection. A user-friendly and accessible database system is needed in order for the PCQO to record and monitor patient care complaints. Ideally, this database has the ability to easily produce detailed reports about the flow and nature of complaints. These reports can then be further analyzed by the PCQO and other departments for the purpose of promoting continuous quality improvement. This proactive orientation to complaints data collection feeds into VIHA’s value of courage – to change, innovate and grow. Understanding the types of complaints coming in will help identify complaints trends and formulate the appropriate actions to deal with them. For the VIHA executive, implementing this recommendation may translate to a significant initial amount financially. However, the costs associated with database overhaul should not be the sole determining factor for implementation. This is because collecting data more effectively serves as an investment in research. Research is itself a tenet of VIHA’s articulated purpose.
- 4) Increase General Public Awareness of the PCQO: As referred to in the focus group, an individual’s first interaction with the PCQO is typically as a complainant. Under this scenario, patients often have expectations of the PCQO that are not within its mandated purview such as being a VIHA-independent patient care advocate. To address this reality, the VIHA PCQO should create a general public awareness campaign where it clearly outlines its roles, responsibilities, and available services. Greater PCQO public awareness promotes additional patient empowerment. If patients know how and when to

properly use the PCQO, then it better serves its mandate of providing a process for requesting reviews into patient care. One possible initiative is having kiosks at public gatherings where PCQO staff could answer general questions about their functions. The objective here is to demonstrate to the general public that the VIHA PCQO is a resource available to the community. Having an increased public presence additionally promotes the best general best practice of transparency by the PCQO. A higher level of transparency should likely translate to increased public confidence as well.

Implementing this recommendation provides the VIHA executive with a positive public relations opportunity to showcase its patient care initiatives. VIHA's executives should seriously consider allocating funds for this recommendation because it encourages a healthy community through public awareness.

Appendix 1

Appendix 1-A

Document: *Complaints Toolkit – handling complaints within the NHS* (March 2008)

Themes:

- Access
- Discrimination
- Appropriate Action and Learning
- Applying complaints policy consistently across institution
- Response to the complainant be “Customer-Centered”
- Providing case studies to staff for training purposes

Appendix 1-B

Document: *Patient Concerns/Complaints Resolution* (April 2007) – Alberta, Canada

Themes:

- Accessible
- Responsive
- Patient Focused
- Integrated
- Appropriate & Effective
- Confidential & Anonymous
- Accountable & Transparent
- Fair
- Organizational commitment
- Information & Reporting
- Quality Improvement & Continuous Learning

Appendix 1-C

Document: *Better Practice Guidelines on Complaint Management for Health Care Services – Australia*

Themes:

1. Commitment to consumers and quality improvement
2. Accessible
3. Responsive
4. Effective Assessment
5. Appropriate resolution
6. Privacy and Open disclosure
7. Gathering and using information
8. Making improvements

Appendix 1-D

Document: *Guide to Complaint Handling in Health Care Services (2005 - Australia)*

Themes:

“Seven Guiding Principles”:

1. Quality Improvement
2. Open disclosure
3. Commitment
4. Accessibility
5. Responsiveness
6. Transparency and accountability
7. Privacy and confidentiality

Appendix 1-E

Document: *Best Practices for Advanced Skills in Healthcare Service Recovery* (SHCA Annual Conference Presentation April 2011) - Dr. James Pichert

Themes:

“HEARD Protocol”:

1. Hear the person’s concerns
2. Empathize with the person raising the issue.
3. Acknowledge, express Appreciation to the person for sharing, and Apologize when warranted.
4. Respond to the problem, setting time lines and expectations to follow-up.
5. Document or Delegate the documentation to the appropriate person.

Appendix 2 (Mind-Maps)

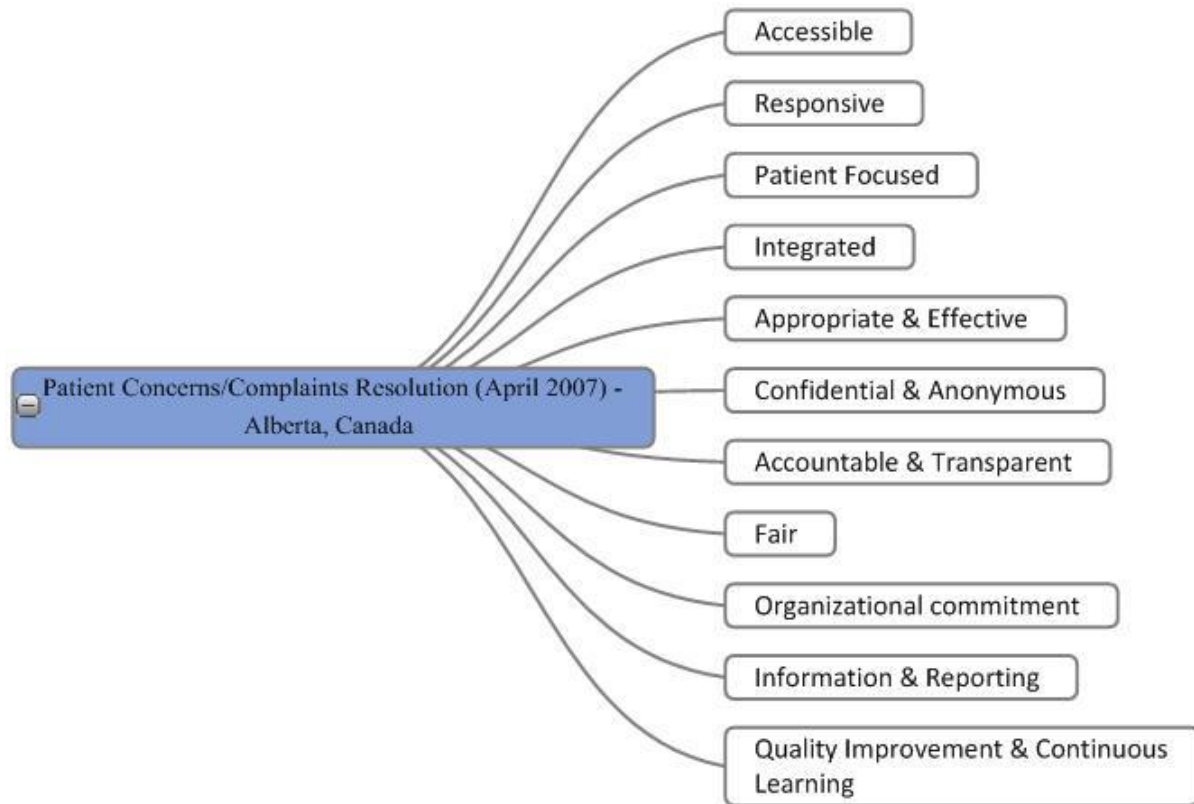
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Document: *Complaints Toolkit – handling complaints within the NHS (March 2008)*



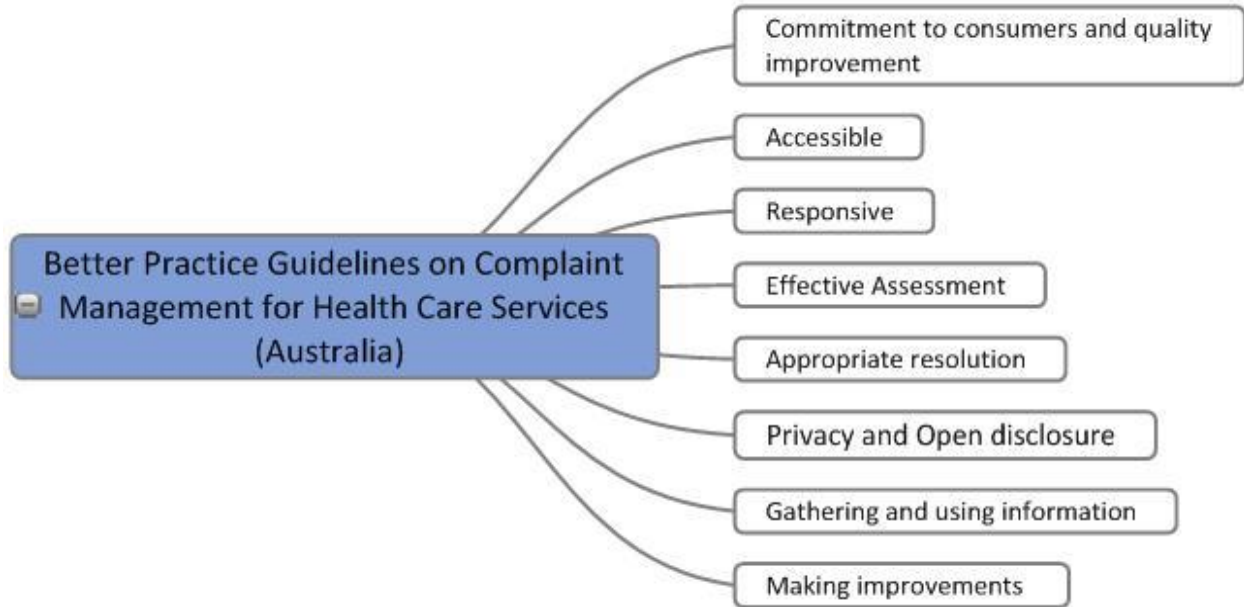
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Document: *Patient Concerns/Complaints Resolution (April 2007) – Alberta, Canada*



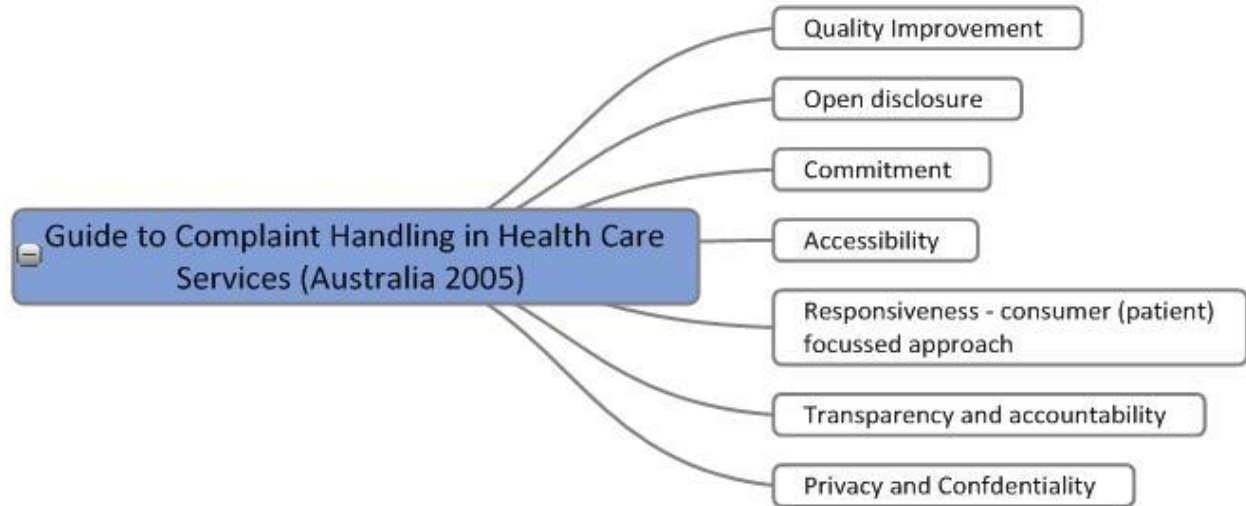
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Document: *Better Practice Guidelines on Complaint Management for Health Care Services – Australia*



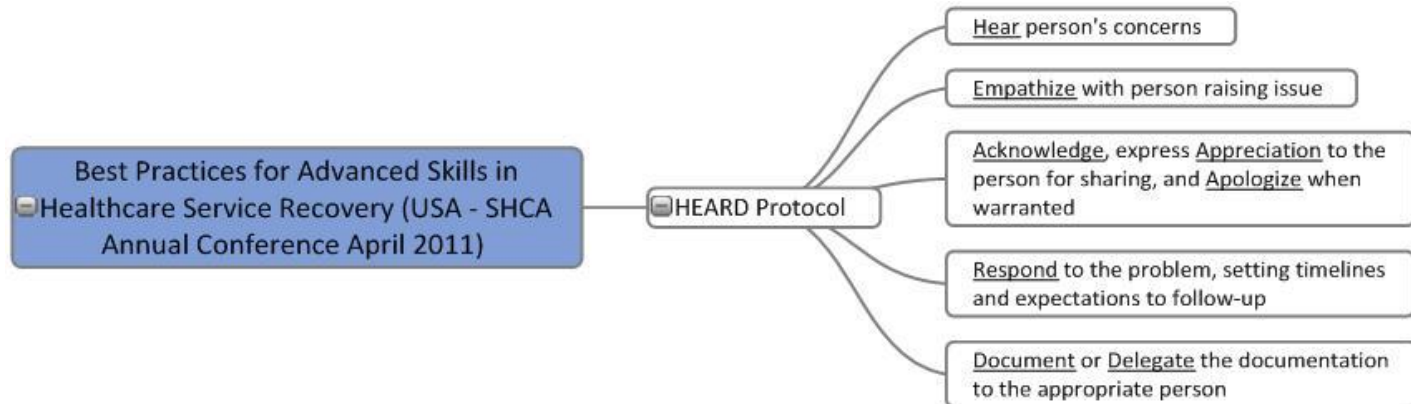
Appendix 2-D

Document: *Guide to Complaint Handling in Health Care Services (2005 - Australia)*

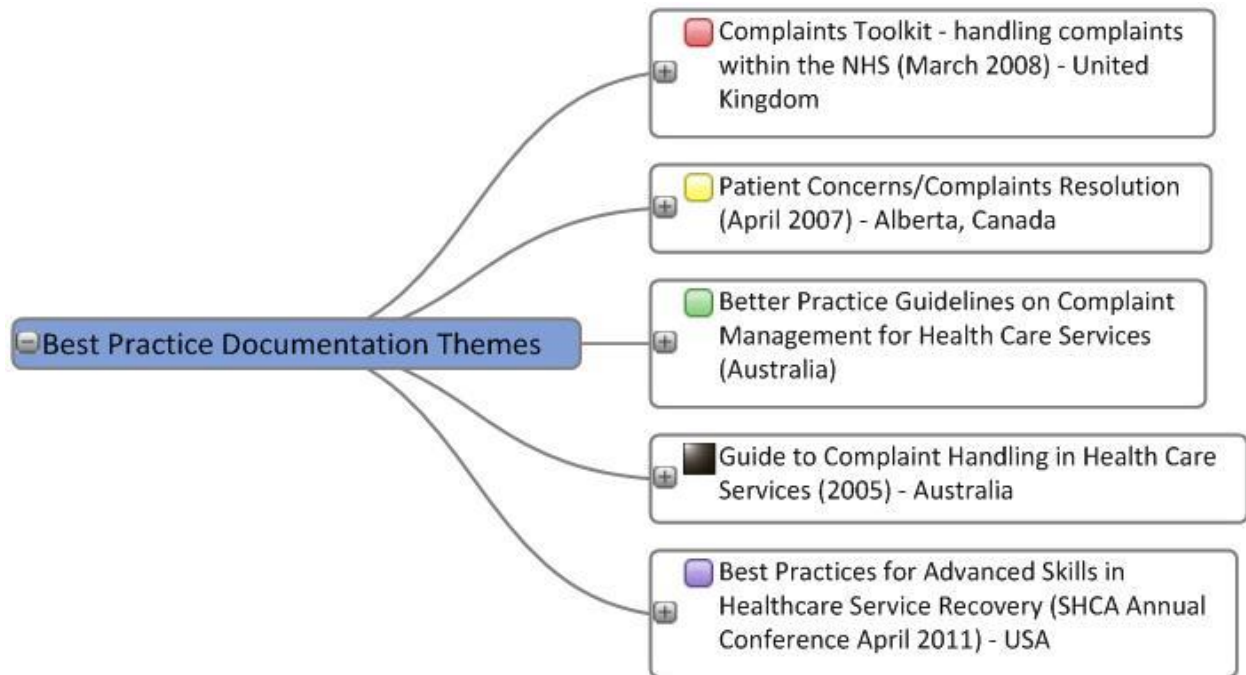


Appendix 2-E

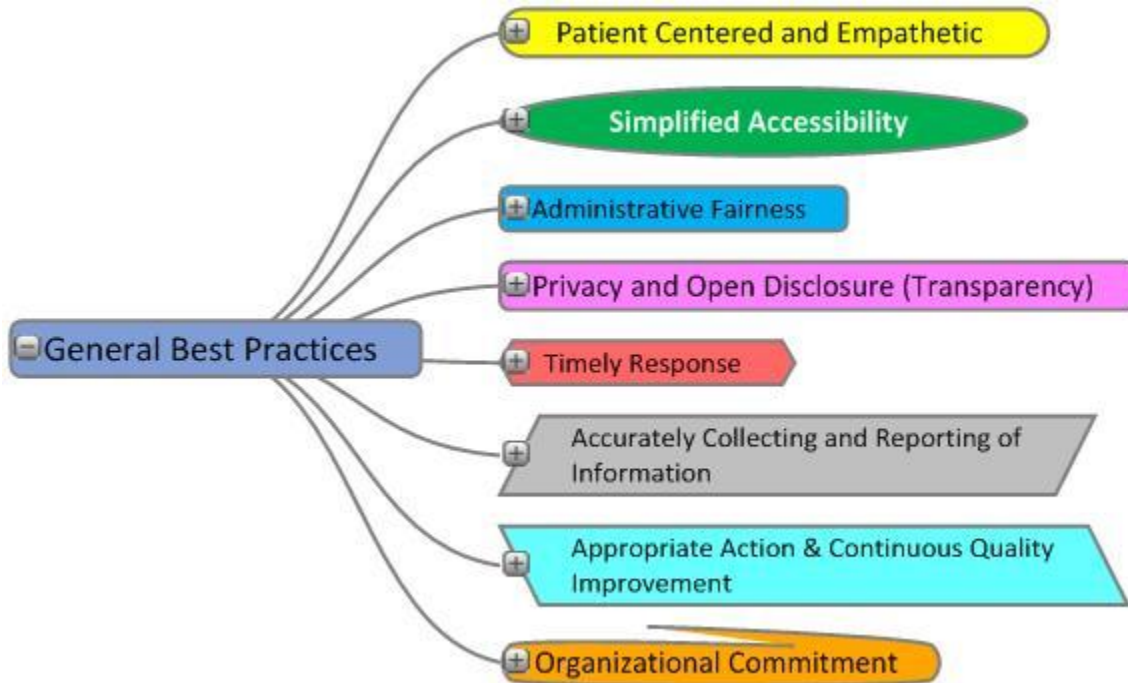
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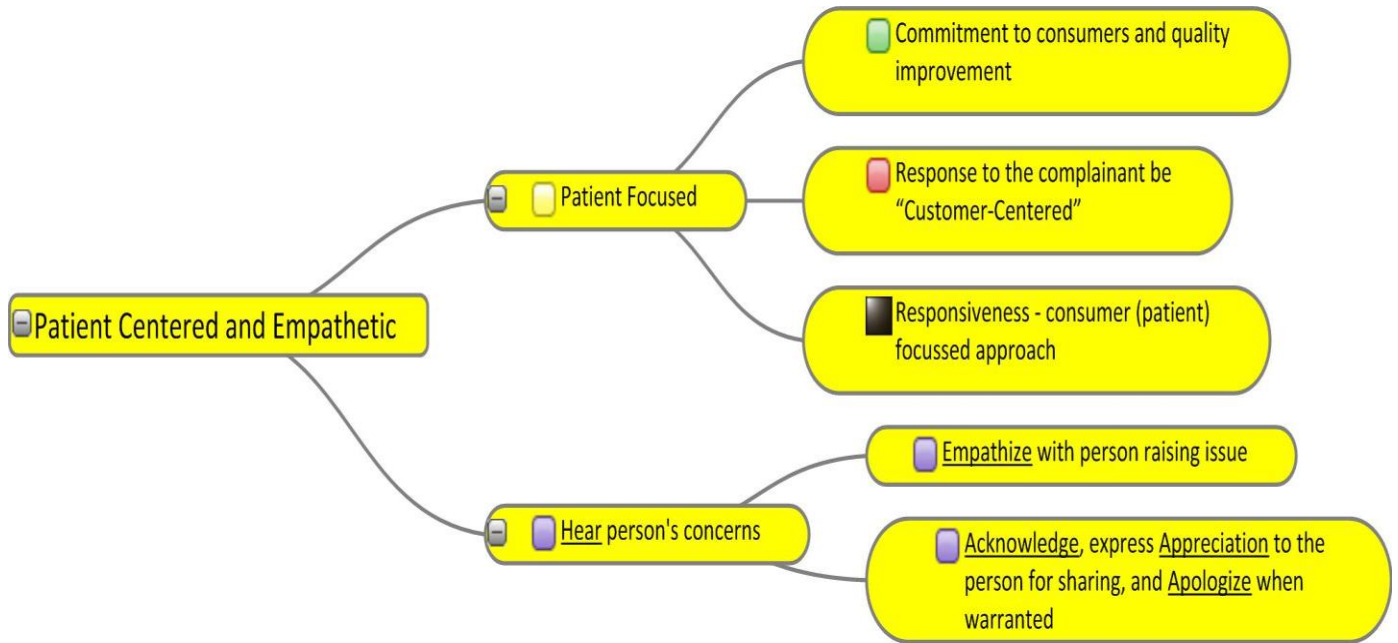
Appendix 2-F



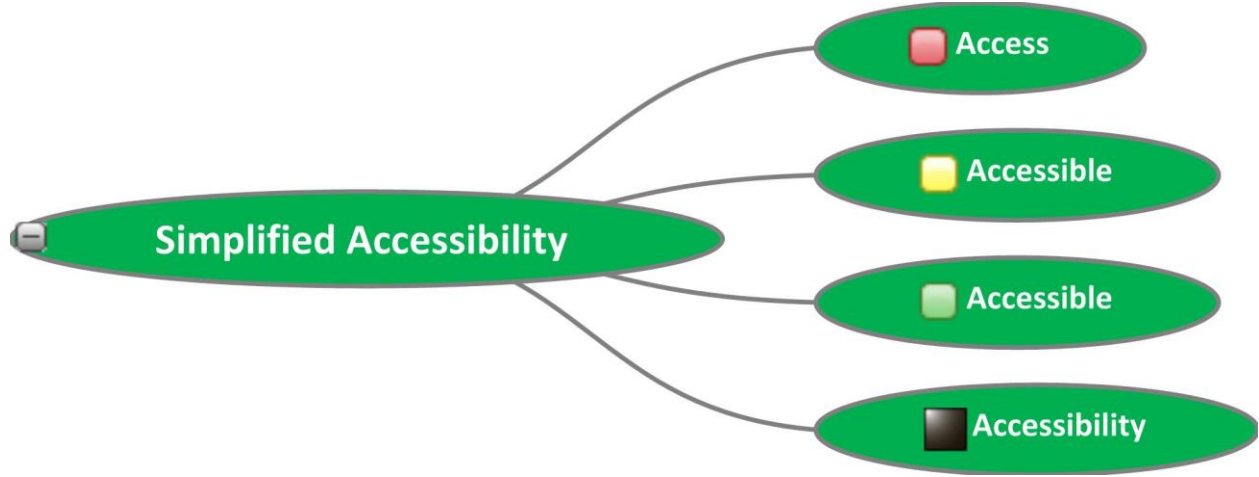
Appendix 2-G: General Best Practices



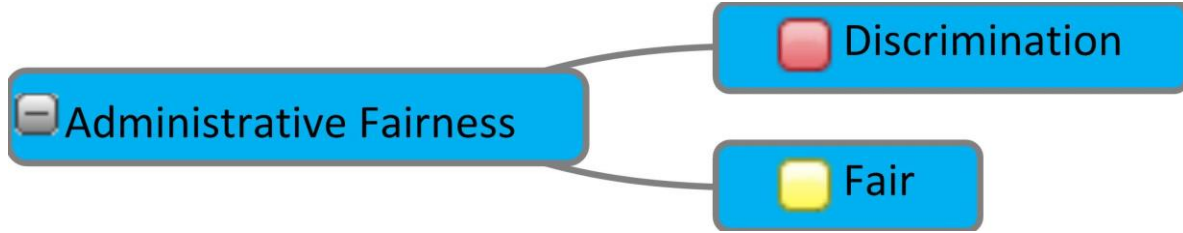
Appendix 2-H: Patient Centered and Empathetic



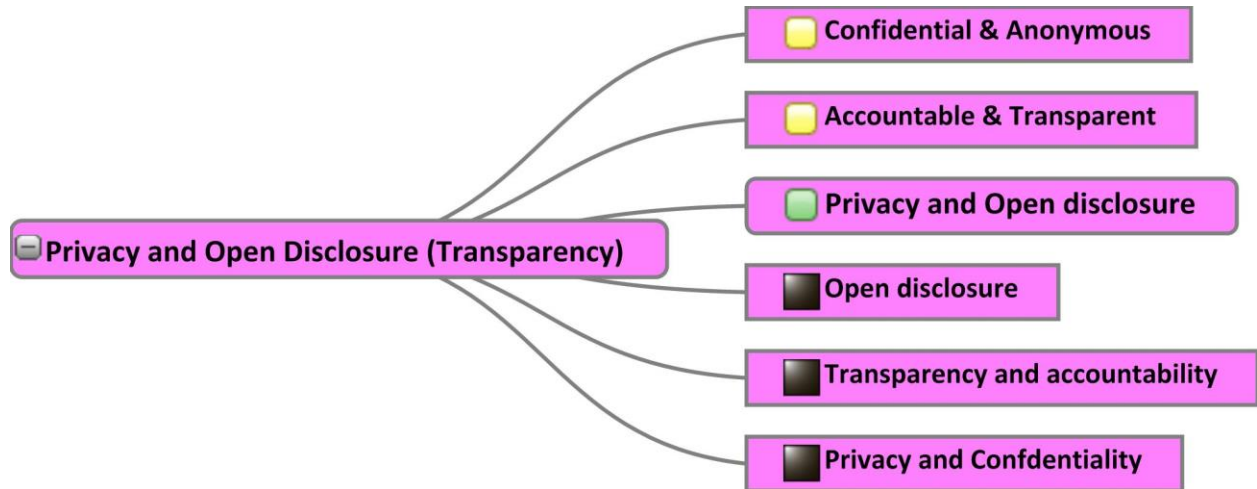
Appendix 2-I: Simplified Accessibility



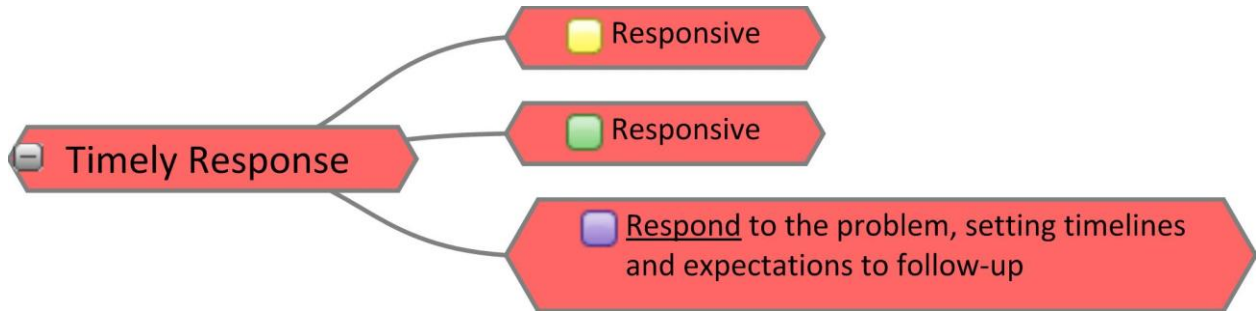
Appendix 2-J: Administrative Fairness



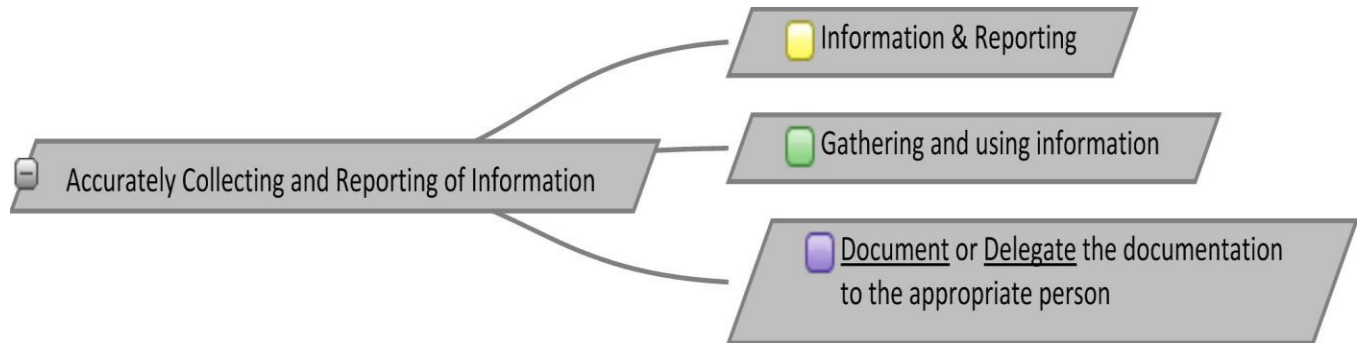
Appendix 2-K: Privacy and Open Disclosure (Transparency)



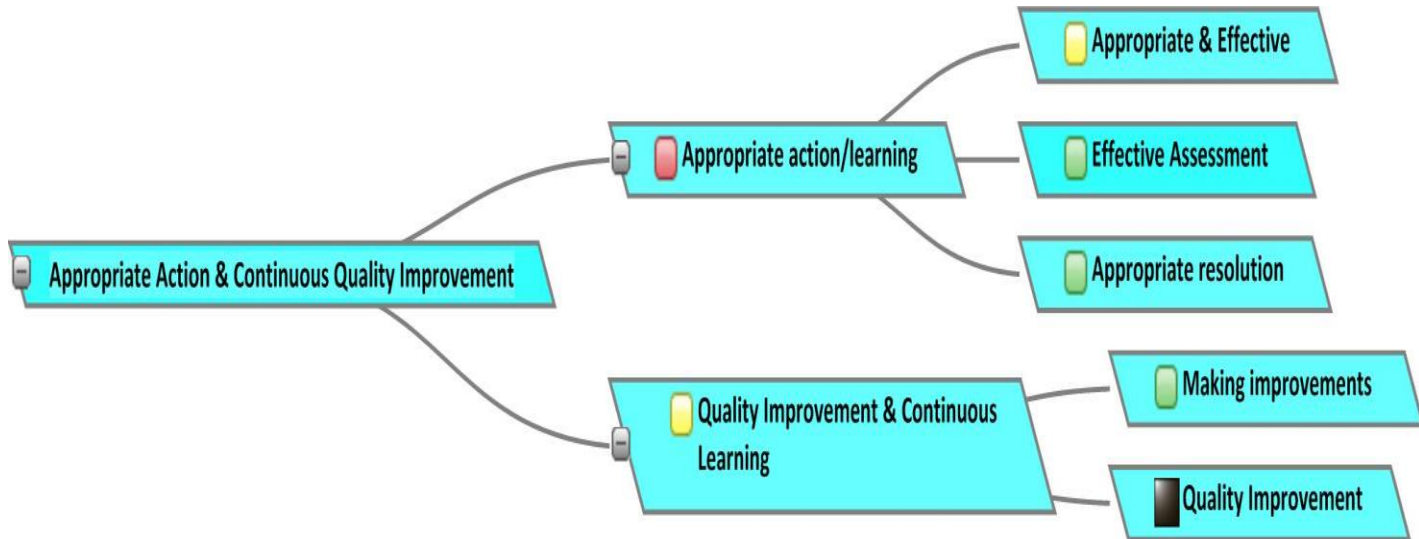
Appendix 2-L: Timely Response



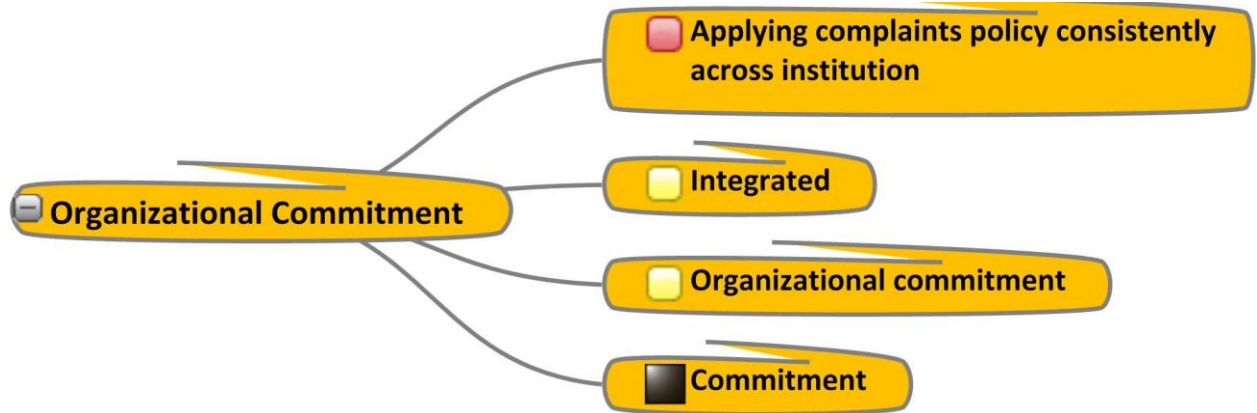
Appendix 2-M: Accurately Collecting and Reporting Information



Appendix 2-N: Appropriate Action & Continuous Quality Improvement



Appendix 2-O: Organizational Commitment



Appendix 3 (Focus Group Briefing Materials)

Appendix 3-A: Complaints Toolkit – handling complaints within the NHS (March 2008)

Country: United Kingdom (England and Wales)

Source: Health Care Commission. Abolished in 2009, the Health Care Commission was an independent public body sponsored by the department of health. During its existence, the Health Care Commission was tasked with reviewing healthcare quality within the NHS. The Health Care Commission was additionally the body in charge of reviewing NHS complaints not resolved at the local level.

Themes:

- Access
 - Awareness of complaints procedure for service providers
 - Service providers trained on complaints procedure
 - Accessibility of complaints system to health care recipients
 - Complaints system being suitable for needs of community it serves
 - Salient Characteristics: Age, Ethnicity, Culture
 - Accessible publication materials for recipients that are clearly written with accurate information
 - Promoting feedback from recipients on quality of care
- Discrimination
 - Ensuring complaining does not negatively an individual(s) current or future care
 - Having a system measuring changes in service delivery upon a patient complaining
 - Communicating to patients that complaining will not adversely affect their care
- Appropriate Action and Learning
 - Draw linkages between individual complaints and systems learning
 - Respond appropriately to complaints
 - Make changes to policies if necessary
- Applying complaints policy consistently across institution
- Response to the complainant be “Customer-Centered”
 - Arriving at a satisfactory outcome
- Providing case studies to staff for training purposes

Appendix 3-B: Patient Concerns/Complaints Resolution (April 2007)

Country: Canada (Alberta)

Source: Health Quality Council of Alberta (HQCA)

Themes:

1. Accessible: The concerns/complaints resolution process should be easily accessible to everyone (e.g., patients, staff, physicians and the public). Information on how to lodge a concern/complaint and the process used to investigate the concern/complaint should be readily available and easy to understand and use.
2. Responsive: Concerns/complaints should be acknowledged and managed efficiently without unnecessary delays.
3. Patient Focused: A patient-focused approach that welcomes feedback and demonstrates commitment to resolving concerns/complaints. This approach should respect the opinions of patients and their right to complain. It should also act on the information they provide as part of a continuous quality improvement cycle.
4. Integrated: There should be a seamless transition from one service provider or organization to another when a concern/complaint is handled or addressed by one or more party.
5. Appropriate & Effective: Concerns/complaints should be dealt with in a way that is administratively fair to all parties and provides appropriate outcomes.
6. Confidential & Anonymous: Information is managed in a manner that protects the personal privacy of the person(s) involved.
7. Accountable & Transparent: The concerns/complaints resolution should be open, clear and plainly evident to everyone including staff, patients, physicians and the public. This ensures that reporting on and accountability for actions and decisions related to concerns/complaints management are clearly established.
8. Fair: A concerns/complaints resolution process should be administratively fair to both the complainant and the organization or person who the complaint is made.
9. Organizational commitment: Leaders in the organization should promote and support a patient-centered concerns/complaints resolution process as part of continuous quality improvement at all levels of the organization.
10. Information & Reporting: Concerns and complaints provide important information about patient's experiences. This information should be analyzed to identify system, recurring and/or one time issues and trends.

11. Quality Improvement & Continuous Learning: Program, service and organizational improvement comes from managing concerns/complaints at an individual complaints level as well as analyzing aggregate concerns/complaints data. This information contributes to overall quality improvement and organizational learning.

Appendix 3-C: Better Practice Guidelines on Complaint Management for Health Care Services

Country: Australia

Source: Australian Council for Safety and Quality Health Care

Themes:

1. Commitment to consumers and quality improvement – promoting a consumer focused approach to complaints as part of a continuous quality improvement program.
2. Accessible – Service encourages consumers to provide feedback about the service, including concerns and complaints, and makes it easy to do so.
3. Responsive – The service acknowledges all complaints and concerns and responds promptly and sensitively.
4. Effective Assessment – The service assesses complaints to determine appropriate responses by considering risk factors, the wishes of the complainant and accountability.
5. Appropriate resolution – The service deals with complaints in a manner that is complete, fair to all parties and provides just outcomes.
6. Privacy and Open disclosure – The service manages information in a fair manner, enabling relevant facts and decisions to be openly communicated, while protecting confidentiality and personal privacy.
7. Gathering and using information – The service records all complaints to enable review of individual cases to identify trends and risks, and report on how complaints have led to improvements.
8. Making improvements – The service uses complaints to improve the service, and regularly evaluates the complaints management policy and practices.

Appendix 3-D: Guide to Complaint Handling in Health Care Services (2005 - Australia)

Country: Australia

Source: Health Services Review Council (Australia)

Themes:

Seven Guiding Principles:

1. Quality Improvement – Complaints management is an integral part of the quality improvement approach that has been adopted by the health service.
2. Open disclosure – The health service has a policy of open disclosure in relation to adverse events and complaints.
3. Commitment – the health service and its senior management are fully committed to an integrated complaints management system and will provide the necessary support for it to operate effectively.
4. Accessibility – The health service encourages consumers and staff to give feedback about the service and makes it easy for them to do so.
5. Responsiveness – The health service has a consumer focused approach, being receptive to complaints and treating complaints seriously.
6. Transparency and accountability – The complaints process is clearly articulated, open and accountable to both staff and consumers.
7. Privacy and confidentiality – The health services respects the privacy and confidentiality of consumers and the information received during the complaints process, while at the same time making its decisions open and accountable.

Appendix 3-E: Best Practices for Advanced Skills in Healthcare Service Recovery (SHCA Annual Conference Presentation April 2011) - Dr. James Pichert

Country: United States of America

Source: Society for Healthcare Consumer Advocacy (SHCA). SHCA is the largest professional membership organization of patient care complaints managers in the United States.

Themes:

HEARD Protocol:

1. Hear the person's concerns
2. Empathize with the person raising the issue.
3. Acknowledge, express Appreciation to the person for sharing, and Apologize when warranted.
4. Respond to the problem, setting time lines and expectations to follow-up.
5. Document or Delegate the documentation to the appropriate person.

Appendix 4 (VIHA's Vision, Purpose and Values)

Vision

Excellent care — for everyone, everywhere, every time

Purpose

To provide superior health care through innovation, teaching and research and a commitment to quality and safety — creating healthier, stronger communities and a better quality of life for those we touch.

Values

CARE will guide everything we do:

Courage: To do the right thing — to change, innovate and grow.

Aspire: To the highest degree of quality and safety.

Respect: To value each individual and bring trust to every relationship.

Empathy: To give the kind of care we would want for our loved ones.

(URL: http://viha.ca/about_viha/vision.htm)

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