

The evolution of complaint management in the Hong Kong Hospital Authority. Part 1: Complaints management—a tool for system change?

An issue of great concern to medical practitioners, both in the public and private sectors, is complaints on medical services. This two-part series aims to present a more positive side of dealing with complaints received in our health care system. In the first part in this issue, we raise the possibility of achieving positive organisational enhancements through a more complete and efficient monitoring of the feedback received. This parallels a similar developing awareness in other overseas health care systems, for example, in the United States and the United Kingdom. In the second part—which will be published in the next issue—we share details of some more pertinent cases we have handled, and the lessons learnt.

Background

The Hospital Authority (HA) of Hong Kong was established under the HA Ordinance,¹ and took over the management of all Hong Kong public hospitals in December 1991. As of 31 March 2002, the HA has provided more than 90% of all in-patient bed-days in Hong Kong, managed 41 hospitals, and employed about 50 000 staff; in the previous year, it was responsible for more than 1.2 million in-patient and day-patient admissions, 2.5 million accident and emergency (A&E) attendances, and 8.5 million out-patient clinic attendances.² Given the diversity, complexity, and rising volume of patient activities in public hospitals, complaints by patients and members of the public are expected.

Under Section 5(m) of the HA Ordinance,¹ the HA is obliged to “establish and maintain a system for providing a proper consideration of complaints from users of hospital services, or of members of the public, in relation to [public] hospital services”. Since its establishment in 1991, the HA has set up a two-tier system of handling complaints: the first-tier at the individual hospital level and the second at the level of the Public Complaints Committee (PCC).

All complaints, wherever received, are handled first by the hospital(s) concerned, and complainants are informed of the available appeal mechanism. Since 1991, the hospitals and the PCC have built up a valuable and substantial cache of thousands of complaint cases from all departments of the HA.

So far, however, the HA has focused its attention on the handling of individual complaint cases, some of which could be very complex and could involve more than one hospital or department, or different aspects of hospital care. Although the satisfactory resolution of individual cases is important, it is also essential to discern whether there are particular trends or systemic problems in health care provision. A comprehensive overview of the range of issues that have been raised in the complaints received, or of the characteristics of the patients, departments, and hospitals that have been involved in the complaints would thus be useful.

Focusing only on individual complaints also precludes the systematic study of circumstances that led to past complaints, in the hope that precautions may be taken to minimise the chances of similar complaints from arising again. In other words, we lose the opportunity to effect ‘system change’ by identifying “sentinel events” as the trigger or the alert to health care managers about possible serious system flaws that need to be dealt with.³ The concept of a “sentinel event” refers to recent risk management studies that have identified that many modern operational systems, including health care systems, can be complex, but that there may be particular crucial steps in the process that, if they go wrong, may have very serious effects. The identification of such “sentinel events” may be therefore particularly important to the integrity of the entire system.

To develop a time- and cost-effective review mechanism

Table 1. Frequency of complaints, by category of complaint*

| Category | 3-year cohort (2000-2002), n=241 | 2-year cohort (2001-2002), n=169 | 1-year cohort (2001), n=86 |
|---|-------------------------------------|-------------------------------------|-------------------------------|
| | No. (%) | No. (%) | No. (%) |
| Clinical services | 220 (91.3) | 151 (89.3) | 77 (89.5) |
| Staff attitude/communication | 77 (32.0) | 61 (36.1) | 26 (30.2) |
| Administration | 61 (25.3) | 55 (32.5) | 25 (29.1) |
| Environment (eg cleanliness) and others | 5 (2.1) | 5 (3.0) | 4 (4.7) |
| Total | 363 | 272 | 132 |

* Because a case may involve more than one category of complaint, the total percentage exceeds 100% and the total number exceeds that of each cohort

Table 2. Frequency of complaints, by hospital type

| Hospital type | No. (%) | Weighted frequency* |
|--|------------|---------------------|
| General acute hospitals with accident and emergency department | 143 (84.6) | 0.89 |
| Mixed acute/non-acute | 12 (7.0) | 0.91 |
| Non-acute/infirmarary | 4 (2.4) | 3.01 |
| Psychiatric | 5 (3.0) | 5.00 |
| Special-nature hospitals | 5 (3.0) | 0.73 |
| Total | 169 | N/A† |

* Weighted frequency of complaint per patient discharge

† N/A not applicable

that is also sensitive and valid, we initiated a systematic audit of 3 years (2000-2002) of individual cases in the HA PCC cache, aiming at gaining a better understanding of the demographic characteristics of patients. The experience gained from such an audit, and the demographic characteristics obtained, would help in the development of a useful prospective indexing system for all HA complaint cases in the future. Such an indexing system would greatly facilitate the future analysis of demographic data, the identification of useful trends, and the identification of particular risk factors or sentinel events.

Results of the systematic audit

A total of 241 case files from the years 2000-2002 were retrospectively reviewed. The consolidated results were as follows:

Characteristics of complaints

The frequencies of different categories of complaints are shown in Table 1. The audit also showed that 80 (33.2%) of the 241 cases involved medico-legal matters, 57 (23.7%) cases had PCC members interviewing the complainant or representative, 39 (16.2%) had PCC members interviewing the staff, and 79 (32.8%) needed at least one independent expert review of the case.

Among the complaints studied, 14 (5.8%) were substantiated and 43 (17.8%) were partially substantiated. The majority, 184 (76.3%) however were not substantiated after full deliberation by the PCC. Overall, 108 (44.8%) of the complaints were made by the patient, whereas the other complaints (133; 55.2%) were made by others on behalf of the patient.

Most of the complaints were centred in large acute general hospitals with A&E services (Table 2), which is not surprising, in view of the greater throughput and complexity of cases seen in these hospitals compared with other institutions. After correction for the varying activity levels in the five categories of hospitals (ie after weighting by discharges and deaths), psychiatric hospitals and non-acute or infirmarary hospitals attracted the most complaints per patient discharged (Table 2).

The breakdown of incidence of complaints by medical specialty is shown in Table 3. The six specialties most complained about were general medicine (27.8%), surgery

Table 3. Frequency of complaints, by medical specialty

| Specialty | No. (%) |
|-------------------------------|------------|
| General medicine | 67 (27.8) |
| Surgery | 37 (15.4) |
| Accident and emergency | 32 (13.3) |
| Orthopaedics and traumatology | 25 (10.3) |
| Obstetrics and gynaecology | 23 (9.5) |
| Psychiatry | 20 (8.3) |
| Oncology | 7 (2.9) |
| Neurosurgery | 5 (2.1) |
| Paediatrics | 5 (2.1) |
| Otorhinolaryngology | 4 (1.7) |
| Physiotherapy | 4 (1.7) |
| Rehabilitation | 3 (1.2) |
| Hospice | 2 (0.8) |
| Intensive care | 2 (0.8) |
| Ophthalmology | 2 (0.8) |
| Others | 3 (1.2) |
| Total | 241 |

(15.4%), A&E (13.3%), orthopaedics and traumatology (10.3%), obstetrics and gynaecology (9.5%), and psychiatry (8.3%).

Characteristics of patients

Nearly one half (49.0%) of patients who complained (or had a complaint lodged on their behalf) were female, and the overall mean age of the patients was 50.4 years (standard deviation, 21.8 years), with a median of 48.0 years; at the time of discharge home, 172 (71.4%) of patients were alive.

Factors associated with complaints in Public Complaints Committee cases

Although data were limited by the small number of cases in the review, we were keen to identify early trends. We used Fisher's exact test to compare categories of data, as well as univariate and multivariate analyses. When we compared the 57 cases in the 3-year cohort that were substantiated or partially substantiated with the 184 cases that were not, the category of complaint was not significantly associated with whether a complaint was substantiated (Table 4). There was, however, a statistically significant association between the source of complaint (ie patient or proxy) and the outcome of the complaint (ie whether substantiated or not) in the 3-year cohort of cases. The odds that complaints lodged by proxies were substantiated were about twice those of complaints lodged by patients ($P < 0.05$; not shown).

No statistically significant association was found between the sex of the patient and whether the complaint was substantiated or not ($P=0.35$), or between the condition of the patient (ie whether he or she was dead or alive at discharge) and whether the complaint was substantiated or not ($P=0.82$).

Older age of patients (≥ 64 years) was significantly associated with complaints related to falls (odds ratio [OR]=12; 95% confidence interval [CI], 1.3-109.5; $P<0.01$). This association remained even after paediatric patients aged 10 years or younger were excluded from the sample (OR=11.05; 95% CI, 1.07-554; $P<0.05$).

Results of the multivariate logistic regression analysis to examine possible predictor variables that were independently associated with the substantiation of a complaint are shown in Table 5. The odds that complaints not made by a still-living patient were substantiated were 2.14 times those of complaints made directly by a living patient. Furthermore, the odds that complaints related to infection control were substantiated were 3.98 times those of complaints that were not related to infection control.

Discussion

Despite the small sample size, the findings suggest that a hospital-based complaints management system is a useful quality-of-care management tool. The audit provided useful patient demographic data, as well as important insights into the reasons for complaint. Associations were found between selected populations of patients and the outcomes of complaints, suggesting that evidence-based targeting of particular risk factors may lead to better management.

This study also demonstrated the potential of prospective monitoring and auditing of complaints. Establishing a computerised indexing system, further validity testing, and documenting sentinel events would provide further enhancement. Attention should also be paid to the unwanted side-effects of excessive profiling of complainants, because it is a cardinal principle of the PCC that all complaints and complainants are dealt with fairly, transparently, and equally. For example, some data may ascribe propensity to complain

Table 4. Univariate analysis of the association between complaint category and whether a complaint was substantiated

| Category | Odds ratio (95% CI) [†] | P value |
|---|----------------------------------|---------|
| Clinical services | 1.95 (0.55-6.88) | 0.29 |
| Staff attitude/communication | 1.09 (0.58-2.04) | 0.80 |
| Administration | 1.21 (0.62-2.35) | 0.58 |
| Environment (eg cleanliness) and others | 3.31 (0.46-24.04) | 0.21 |

* CI confidence interval

† Fisher's exact test, $P>0.05$ for all

Table 5. Multivariate logistic regression analysis showing relations between selected variables and substantiation of a complaint

| Predictor variable* | Odds ratio (95% CI) [†] | P value |
|--------------------------------------|----------------------------------|---------|
| Dead versus alive (self) | 1.24 (0.57-2.70) | 0.63 |
| Alive (non-self) versus alive (self) | 2.14 (1.02-4.49) | 0.05 |
| PSP [‡] (infection control) | 3.98 (1.29-12.36) | 0.02 |
| PSP (human error) | 1.83 (0.96-3.47) | 0.07 |

* Alive and dead refer to the patient, who lodged the complaint (self) or who had a proxy make the complaint (non-self)

† CI confidence interval

‡ PSP patient safety practices; both PSP variables are discrete variables

to patients with certain characteristics. This should not result in such patients being unfairly targeted by health care staff.

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