Learning from past complaints to improve the care of patients

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This article gives an outline of the NHS complaints procedure, the role of the nurse in the management of complaints and the lessons learnt from complaints received by the Healthcare Commission. By raising awareness of the concerns frequently raised in complaints about nursing care, nurses will be better prepared to handle complaints and to use them and the complaints process to drive changes and improvements in patient care.

All NHS organisations should have a complaints policy (Department of Health, 2004). Whether a complaint is made verbally or in writing, nurses should be aware of their organisation’s policy and how to respond. Verbal complaints are frequently made while the patient is still in hospital and are often made to the nurse(s) responsible for her or his care.

All complaints should be responded to in the following way:

- Listen to the complainant’s concerns, be direct and realistic and ask them what outcome they want;
- Make notes and document all discussions and decisions fully in the clinical records;
- If necessary, inform your line manager and discuss how to resolve the complaint.

You should consider the following:

- Can action be taken immediately?
- Is further investigation or advice required?

You should advise the complainant what action will be taken. If the complainant remains dissatisfied with your response, and further discussions fail to resolve the complaint, advise them of the trust’s complaints procedure and how to seek help and advice in taking their complaint forward.

Your trust will usually have patient information leaflets that give details of how to make a complaint, who to contact and where the complainant can seek support and advice in making a complaint, for example Patient Advice and Liaison Services (PALS). Ensure your work area has a ready supply of these leaflets.

Complaints should be made in writing to the trust’s chief executive. Under the NHS complaints procedure (DH, 2004), a complaints manager must acknowledge receipt of a written complaint within two working days. The trust must respond in writing within 20 working days. If the investigation is likely to take more than 20 days to complete, the complainant must be informed in writing.

Staff directly or indirectly involved may be interviewed or asked to write a statement. The final response should be collated and signed by the trust’s chief executive.

Further written responses or a meeting with key trust staff may be offered if the initial response fails to resolve the complaint satisfactorily.

When responding to a written complaint you should be open and honest at all times. You should refer to the clinical records and state the facts, supported by the documentation available, and acknowledge any failings that may have occurred. When appropriate, offer an apology and state what actions will be taken to prevent a recurrence.

Within your team develop an action plan involving agreeing actions and setting timescales and review dates. You should ensure the whole team is aware of the action plan and each member’s responsibility and inform the complainant of the results of any actions taken. For example, if the action was to implement a ‘falls’ assessment on admission:

- How has this improved patient care? (What is done differently now?)
- Are all patients now assessed on admission? (What documentation is used?)
- Has this reduced the number of falls on the ward? (Was an audit undertaken and what were the results?)

While actions following a complaint will not always
change the experience of the complainant, they may go some way to reassure her or him that a similar situation will not occur for future clients.

**Role of the Healthcare Commission**

If a complainant remains dissatisfied with the trust’s formal written response or if the complaint has been with the healthcare provider for six months and has not been resolved, an independent review of the case can be requested. On 30 July 2004 the Healthcare Commission became responsible for this second stage of the NHS complaints procedure.

The Healthcare Commission receives 600–700 complaints each month. Nursing-related issues have been identified in 19% of all complaints received from acute and mental health trusts and in 14% of complaints received from foundation trusts.

**Identifying good practice**

Not all complaints received demonstrate poor standards in nursing care. It is often poor communication and the handling of complaints that leads to a complainant approaching the Healthcare Commission.

Reviewing clinical records and complaints files has also enabled the identification of good practice and high-quality care. While not widespread there have been some excellent examples of:

- Good communication and extensive efforts made to try and resolve complaints;
- The development of a falls strategy, falls assessment, care planning and associated documentation;
- A positive culture of reporting adverse events through incident reporting systems;
- The use of a discharge process pro forma to improve the patient’s journey;
- The use of Essence of Care as a tool to review practice and demonstrate improvements in care;
- The development of patient/carer information leaflets, particularly: MRSA information; care of the dying; critical care discharge to general wards; and a clinical observation chart incorporating a physiology scoring tool and referral guidelines for deteriorating patients and acute illness training.

Many complaints are received from complainants following the death of a relative. Families seeking understanding and closure as part of the grieving process often pursue a complaint in search of answers as to why their relative died. When care is found to be acceptable, this needs to be communicated sensitively and the case well-managed to ensure adequate bereavement support is offered.

**Emerging themes**

Where care has fallen below the expected standard, there are lessons to be learnt and a number of common themes. In order to illustrate this 25 case reports classified as ‘serious to high risk’ have been reviewed. In each of the 25 reports the three main nursing issues were identified and categorised according to the Essence of Care benchmark to which they relate. The results are shown in Table 1 and are expressed as a percentage of the total number of issues identified.

Among issues frequently identified in complaints to the Healthcare Commission are:

- Lack of investigation into reasons for incontinence;
- Not being kept informed or involved in changes to care or treatment;
- Poor assessment and care planning, particularly oral hygiene;
- Inappropriate diet or no assistance with feeding;
- Lack of wound care documentation;
- Curtains being opened during care or lack of privacy;
- Missing records or incorrect information documented.

In these incidences care was found to be below an acceptable standard and, as a result, recommendations were made to improve the standard in each area of concern. Specific recommendations are often made using Essence of Care as a framework to improve care.

Communication and record-keeping are two of the most common issues identified in complaints about nursing care. However, it is also worth noting that they are also the most commonly identified issues in most complaints, not just those involving nurses.

When a complaint is reviewed, the first stage is to review the clinical records. The care delivered is evaluated using the documentation provided.

The NMC (2002a; 2002b) states that ‘record keeping is an integral part of nursing care’ and should be afforded the same level of importance as other aspects of patient care. As a rule, if it is not documented, it was not done. If records are poor it is difficult to provide evidence to the contrary when a complaint is being reviewed.

Likewise, communication is also an integral part of

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<tr>
<th>ESSENCE OF CARE ISSUE</th>
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<tr>
<td>Communication</td>
<td>25</td>
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<tr>
<td>Continence, bladder and bowel care</td>
<td>5.5</td>
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<tr>
<td>Personal and oral hygiene</td>
<td>8</td>
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<tr>
<td>Food and nutrition</td>
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<td>Pressure ulcers</td>
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<tr>
<td>Privacy and dignity</td>
<td>5.5</td>
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<td>Record-keeping</td>
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**REFERENCES**


This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net
patient care. The need for improved communication skills among health professionals was recognised in The NHS Plan (DH, 2000). Conversations and verbal interactions are often poorly recorded. Documentation needs to reflect the level of communication afforded to patients, their relatives and their carers. It should outline specific information discussed and advice given, as well as the number of interactions made.

The following areas have also been identified as a concern or a reason for making a formal complaint:
- Meeting the specific needs of patients with mental health or learning disability needs while in a general care setting;
- General ward cleanliness;
- Drug prescribing and administration, particularly medicines not being given or being left at the bedside;
- Ward visiting arrangements, staff attitude and behaviour;
- End-of-life decisions, in particular the involvement of the patient and relatives in do not attempt resuscitation (DNAR) decisions;
- Lack of recognition by nursing staff of highly dependent patients requiring medical intervention.

Essence of Care
The first step in reducing the number of complaints related to nursing care is for all nurses to be aware of common issues raised in complaints. Being aware of what clients are concerned about places us in a position to potentially prevent these incidences from occurring.

The majority of issues in complaints can be broadly classified using the Essence of Care framework. A complaint should be seen and used as a tool in the Essence of Care benchmarking process. A record of the number and type of complaints should be kept, detailing the issues raised and any actions taken.

Analysing past complaints can enable nurses to identify systems and processes that require review. Nurses should ask themselves:
- What issues were raised in the complaint?
- Was the complaint justified? (If not, what factors led to the complaint. For example, was there evidence of poor communication or lack of understanding?)
- What were the contributing factors? (Were there system or process failures?)
- Could similar complaints be prevented in the future? (How do other areas or trusts prevent or minimise the risk of this issue occurring?).

Case study
A complaint is received from Jayne Adams (not her real name). She is concerned that her mother has been discharged from hospital with a pressure ulcer, which she states was not present when her mother was admitted. Ms Adams lives some distance away and was unable to visit her mother regularly.

How to respond
Obtain the clinical records and provide a report for response to the complaint. Review and comment on the information documented. Obtaining additional information from key staff such as the patient’s named nurse can support your response. Issues to address will include:
- Was a pressure ulcer risk assessment completed on admission and at least weekly thereafter?
- Following assessment was a care plan developed to minimise any risks identified?
- Was the care that was planned and delivered evidence-based and was it in line with current ‘best practice’ guidance?
- Was the level and quality of documentation in relation to assessment, care planning and evaluation of an acceptable standard, for example, in line with NMC (2002a; 2002b) standards?
- Do the records demonstrate involvement and good communication with the patient and their relatives in relation to the complainant’s concerns?
- If appropriate, was information regarding pressure ulcers and their treatment documented on discharge and communicated effectively to community services for continuing care?

Further action
If care is found to be less than ideal this must be acknowledged and appropriate action taken. However, following a review of the facts, the complainant’s view may not always be upheld or supported by the clinical records. For example, in this case the records may show that the patient had an existing pressure ulcer on admission and that on discharge the ulcer was actually much smaller and healing.

In response to the complaint, this information should be communicated sensitively with reference to the documentation available. The complainant may request a copy of the healthcare records to confirm the response they receive, therefore your report must be based on facts and not assumptions.

Guided reflection
Use the following points to write a reflection for your PREP portfolio:

- Outline your place of work and why you were interested in this article;
- Detail the last time you encountered a patient who had a complaint;
- Discuss how you or your managers dealt with that complaint;
- Explain how a piece of information in this article could have helped you in that instance;
- Detail how you intend to disseminate what you have learnt to your colleagues.
REFERENCES

Reference name. (1999) ‘Reference title’ of the source document follows the authors name.
Publishers name follows in ‘Ref. body’ text style.
Note all right hand side-text columns containing reference information always have the copy range left.

For journal articles
Reference name. (1999) individual references for each article in the Clinical section is twelve.