Safer Care Victoria

November 2022

# Thematic interrogation of patient complaints in the state of Victoria

## Executive Summary

OFFICIAL

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# Foreword

**Thematic interrogation of patient complaints in the state of Victoria is a research project led by Safer Care Victoria. The project aims to demonstrate whether the Healthcare Complaints Analysis Tool (HCAT) can provide a useful categorisation of patterns in patient complaints, which can then be used to identify quality and safety shortfalls and opportunities for improvement.**

Complaints provide useful and unique insights into the whole patient experience. There is recognised value in analysing complaints at the systems level to determine trends.

Analysing aggregate complaints data enables exploration of underlying patient safety and experience risks[1]. The *Targeting Zero* report exemplifies how trends in complaints can provide warning signs in the lead up to serious adverse events. An investigation into multiple paediatric deaths at a single health service found the warning signs included an increase in the number of complaints about the poor quality of obstetric care provided at the hospital. Effective, robust complaint handling processes supported by reliable data means that critical warning signs can be detected earlier, and potentially used to mitigate further patient harm[1].

The HCAT is an evidence-based, standardised tool for systematically coding, organising, and analysing complaints information to reliably assess health care problems, their severity, and the level of patient reported harm[2]. The HCAT can be used for service monitoring, organisational learning and research into complaints, and as an early indicator for patient safety risks. The aim of the HCAT is to identify trends and encourage learning, rather than to resolve individual complaints.

There is no common systematic interrogation of patient complaints across the state. The Victorian Health Incident Management System (VHIMS) is used by most health services to collect patient feedback. The HCAT is built into the VHIMS Central Solution (CS) feedback module, but not all health services use CS. This presents a missed opportunity to encompass the patient voice in the quality improvement process. This project seeks to address this gap. It aims to demonstrate how the HCAT can be applied to categorise patterns in patient complaints at a health service and a jurisdictional level, to identify safety shortfalls and opportunities for improvement.

SCV invited CEOs from public health services across Victoria to provide their health complaints data to be coded and analysed for this project. Nine health services submitted 8,602 pieces of correspondence for the 2017 period. Each service will receive a report focused on their own data. This report is an Executive Summary covering the full cohort.

# How to use this report

**This report is an overview of the insights found by applying the HCAT taxonomy to the health complaints data submitted to SCV for this project.**

First, we provide a snapshot of the overall findings, comparing the peer groups to each other and the full study cohort. Following this is an overview of the study demographics and key data points, followed by a closer look at the 3 domains of the HCAT. For each domain there is further detail about the trends and patterns identified by applying the HCAT, including the frequency and severity of the concerns raised.

| | |
|---|---|
| **CLINICAL PROBLEMS** Issues relating to quality and safety of clinical and nursing care provided by healthcare staff (i.e., doctors, nurses, radiologists, and allied health professionals) | **Quality:** *Clinical standards of healthcare staff behaviour* |
| | **Safety:** *Errors, incidents, and staff competencies* |
| **MANAGEMENT PROBLEMS** Issues relating to the environment and organisation within which healthcare is provided (for which administrative, technical, facilities and management staff are usually responsible) | **Environment:** *Problems in the facilities, services, clinical equipment, and staffing levels* |
| | **Institutional Processes:** *Problems in bureaucracy, waiting times, and accessing care* |
| **RELATIONSHIP PROBLEMS** Issues relating to the behaviour of any specific member of staff towards the patient or their family/friends | **Listening:** *Healthcare staff disregard or do not acknowledge information from patients* |
| | **Communication:** *Absent or incorrect communication from healthcare staff to patients* |
| | **Respect and patient rights:** *Disrespect or violations of patient rights by staff* |

**Safety**: *Errors, incidents, and staff competencies*

- Sub-categories: Error-diagnosis; Error-medication; Error-general; Failure to respond; Clinician skills; Teamwork.
- Keywords: "incorrect", "medication error", "did not notice", "mistake", "failed to act", "wrong", "poor coordination", "unaware", "missed the signs", "diagnosis".

| 1. Low severity | 2. Medium severity | 3. High severity |
|---|---|---|
| Slight delay in making diagnosis | Clinician failed to diagnose a fracture | Clinician misdiagnosed critical illness |
| Slight delay administering medication | Staff forgot to administer medication | Incorrect medication was administered |
| Minor error in recording patient progress | Delay noticing deteriorating condition | Onset of severe sepsis was not identified |
| Not responding to bell (isolated) | Not responding to bell (multiple) | Not responding to heart attack |
| A minor error filling-out the patient notes | Clinician overlooked information (e.g. previous experience of an illness) | Clinician overlooked critical information (e.g. serious drug allergy) |
| Minor misunderstanding among clinicians | Test results not shared with clinicians | Failure to coordinate time-critical decision |

**Communication**: *Absent or incorrect communication from healthcare staff to patients*

- Sub-categories: Delayed communication; Incorrect communication; Absent communication.
- Keywords: "no-one said", "I was not informed", "he/she said 'X'", "they told me", "no-one explained", "contradictory", "unanswered questions", "confused" "incorrect".

| 1. Low severity | 2. Medium severity | 3. High severity |
|---|---|---|
| Short delay in communicating test results | Long delay in communicating test results | Urgent test results delayed |
| Patient received incorrect directions | Patient received conflicting diagnoses | Patient given wrong test results |
| Staff did not communicate a ward change | Staff did not communicate care plan | Dementia patient discharged without the family being informed |

The taxonomy hierarchy has 3 domains, 7 problem categories, and 36 subcategories. This table shows the domains and categories, with further details for 2 categories (including subcategories, key words, and severity indicators).

**Figure 1. HCAT domains (problems) and categories, with safety and communication in detail[2]**

There are 4 steps to applying the HCAT[3]:

1. Use the coding taxonomy to identify the concerns in the complaint, and assess severity
2. Specify the stages of care at which the problems occurred
3. Indicate the level of harm arising from the reported problem
4. Provide descriptive information about the letter of complaint.

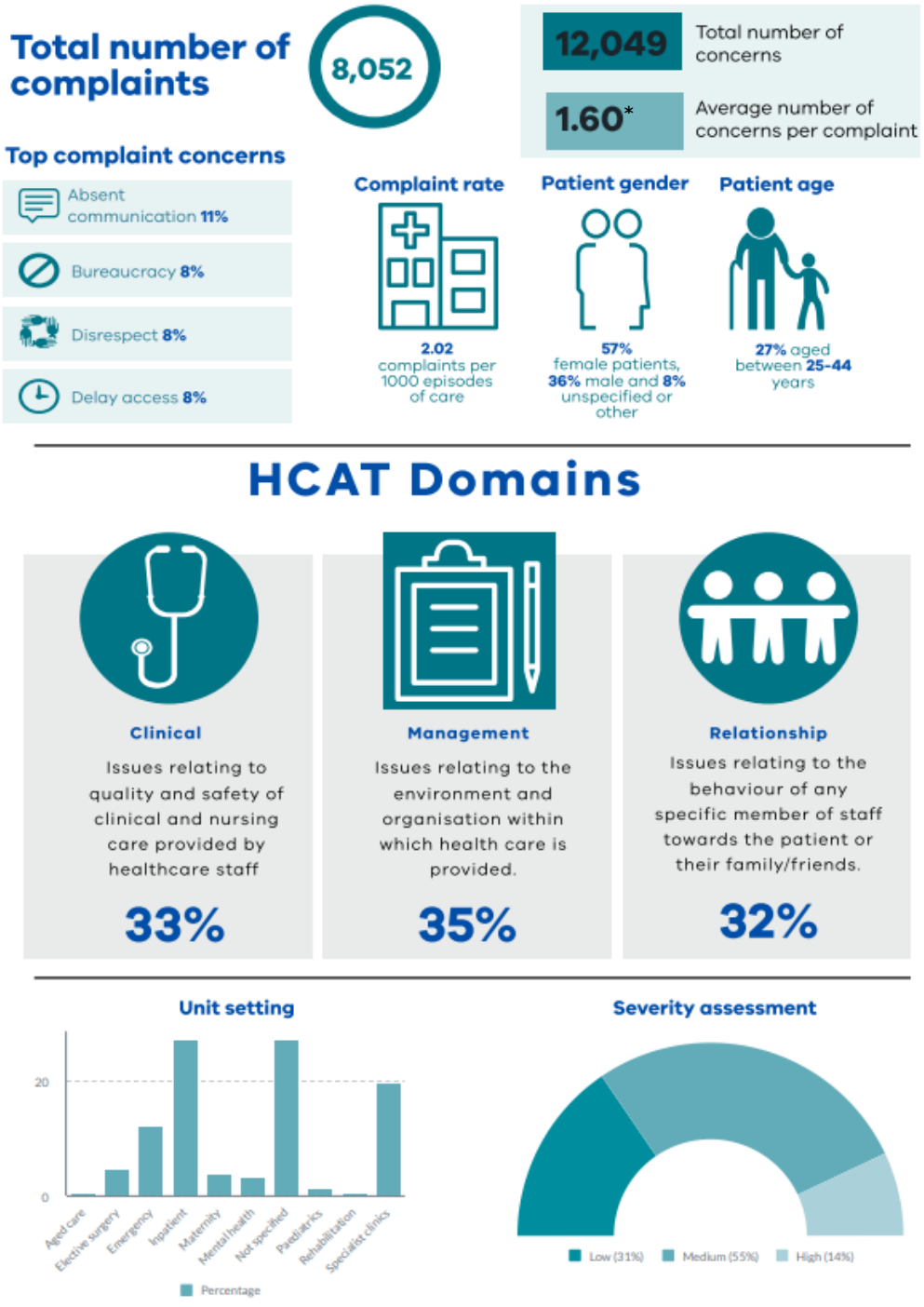
Further details about the HCAT and our study methodology can be found in the Appendices, along with the HCAT guide online. <https://qualitysafety.bmj.com/content/suppl/2016/01/05/bmjqs-2015-004596.DC1/bmjqs-2015-004596supp_new.pdf>

# Summary of findings

| | Data point | Regional peer group* | Major peer group* | Specialist peer group* | Tertiary peer group* | Total study cohort (9 services) |
|---|---|---|---|---|---|---|
| | Complaint rate** | 2.73 | 1.82 | 1.86 | 2.28 | 2.02 |
| | Average number of concerns per complaint | 1.33 | 1.79 | 1.58 | 1.57 | 1.60 |
| **Domain** | **Clinical** | **33%** | **35%** | **29%** | **34%** | **33%** |
| Category | Safety | 12% | 15% | 10% | 14% | 14% |
| | Quality | 22% | 20% | 8% | 20% | 20% |
| **Domain** | **Management** | **34%** | **32%** | **36%** | **36%** | **35%** |
| Category | Institutional processes | 19% | 23% | 33% | 20% | 22% |
| | Environment | 15% | 10% | 3% | 16% | 13% |
| **Domain** | **Relationship** | **33%** | **34%** | **35%** | **31%** | **32%** |
| Category | Listening | 6% | 7% | 6% | 5% | 5% |
| | Communication | 9% | 14% | 15% | 13% | 13% |
| | Respect and patient rights | 18% | 14% | 15% | 13% | 13% |
| Severity | Low | 46% | 29% | 23% | 37% | 31% |
| | Medium | 54% | 58% | 60% | 51% | 55% |
| | High | 14% | 14% | 17% | 12% | 14% |

*Peer group is defined by VAHI classifications
**Number of complaints compared to total activity, calculated as a sum of three separate factors – inpatient separations, outpatient occasions of service, and emergency presentations

# Overall data summary




*Only complaints with enough detail to identify and code concerns were included in the average

# Clinical complaints

Of the 12,049 total concerns identified in the complaints submitted to this project, 33 per cent (n=4,028) related to clinical care. The clinical domain covers issues relating to quality and safety of clinical and nursing care provided by healthcare staff. The categories underneath this are **quality** (clinical standards of healthcare staff behaviour) and **safety** (errors, incidences, staff competencies).

Of the clinical complaints, 9 per cent (371 of 4,028) were rated as high severity, and of these, 38 per cent (141 of 371) related to *examination and monitoring*. Themes from these concerns related to patients feeling they were discharged either too early or without sufficient tests and missed diagnoses due to inadequate examination and testing.

**Quality**

Of the total concerns, 20 per cent (n=2,399) related to quality. In this category, the most common subcategories were *making and following care plans*, *outcomes and side effects*, and *examination and monitoring*.

**Safety**

Of the total concerns, 14 per cent (n=1,629) related to safety. Within this category, the most common subcategories were *clinician skills*, *error diagnosis,* and *error medication*.

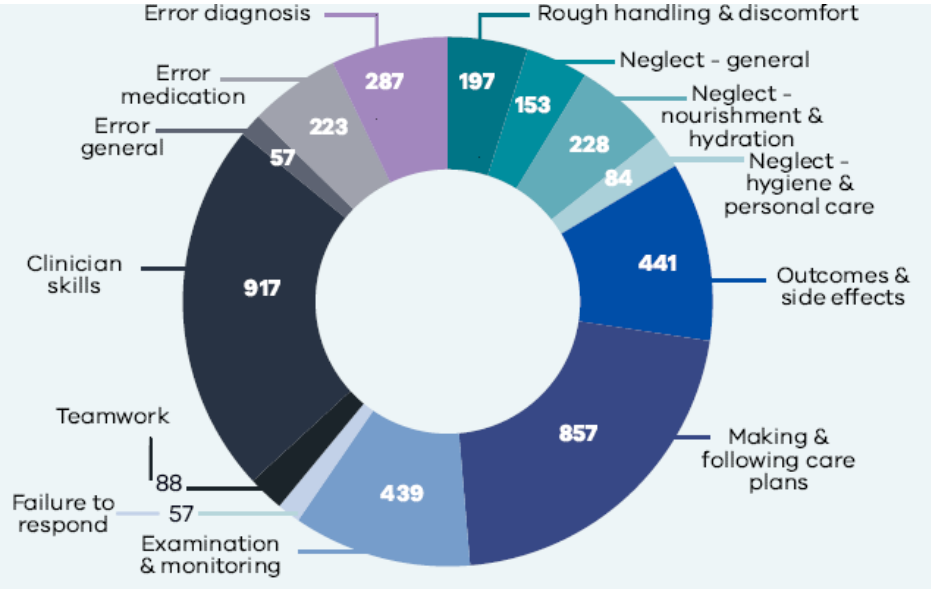



**Figure 2. Number of concerns coded per subcategory within the clinical domain**

## Key messages for health services to consider

Themes identified from this domain highlight the importance of partnering with patients to promote shared decision making.

In 2019, SCV developed the Partnering in Healthcare Framework to bring consistency to the way consumers are empowered to participate in their own healthcare. The factors raised in this framework, including shared decision making and working together, can improve patient experience and outcomes. The framework identifies priorities and actions where health services can make the most difference.

# Management complaints

Of the 12,049 total concerns identified in the complaints submitted to this project, 35 per cent (n=4,186) relate to management and administration. The management domain covers issues relating to the environment and organisation within which healthcare is provided. The categories underneath this are **institutional processes** (problems in bureaucracy, waiting times and accessing care) and **environment** (problems in the facilities, services, clinical equipment, and staffing levels).

Of the management complaints, 8 per cent (318 of 4,186) were rated as high severity and of these, 43 per cent (137 of 318) relate to *delay – access*. Concerns commonly referred to coordination of care through outpatients, delayed access to services, and denial or refusal of service.

**Environment**

Of the total concerns, 13 per cent (n=1,532) related to environment. Within this category, the most common subcategories were *equipment* and *security*.

**Institutional processes**

Of the total concerns, 22 per cent (n=2,654) related to institutional processes. Within this category, the most common subcategories were *delay – access* and *bureaucracy*.

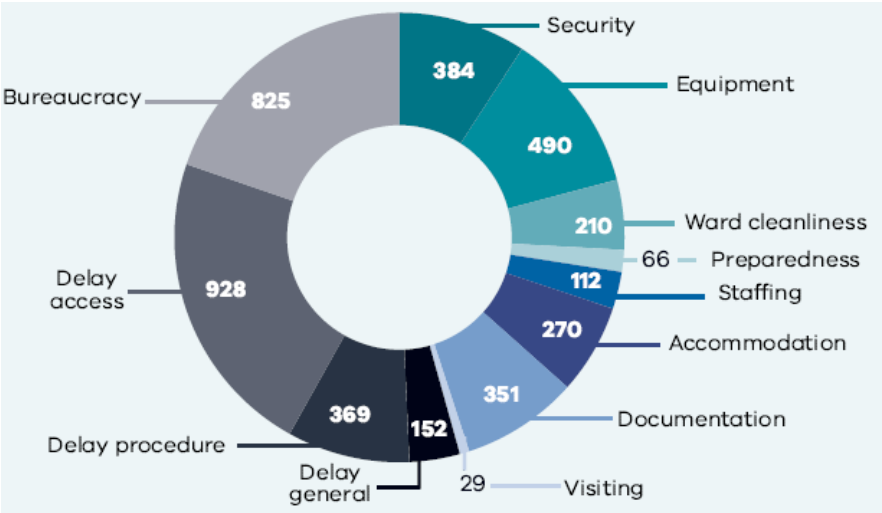



**Figure 3. Number of concerns coded per subcategory within the management domain**

## Key messages for health services to consider

Themes identified from this domain highlight the potential to improve overall complaints management processes and access to specialist clinics.

The *bureaucracy* subcategory often refers to **complaints management processes.** It may be useful to revisit the Health Complaints Commissioner's Complaint Handling Standards. These standards aim to strengthen and improve complaint handling systems across the Victorian health sector, providing a common benchmark for all health services to meet, including guiding principles for implementation.

**Specialist clinic access** remains a considerable challenge across the state. It is important to ensure there are consistent access and referral guidelines available to referring clinicians, so patients are ready for care on their first appointment. Health services also need to incorporate clear and consistent discharge guidelines from specialist clinic areas to promote good patient flow.

# Relationship complaints

Of the 12,049 total concerns identified in the complaints submitted to this project, 32 per cent (n=3,835) were related to staff-patient relationships. The relationship domain is about the behaviour of any member of staff towards the patient or their family/friends. The categories within this are **respect and patient rights, communication,** and **listening.**

Of the relationship complaints, 7 per cent (279 of 3,835) were rated as high severity and of these, 41 per cent (115 of 279) related to patient *rights*. The main issues identified were parking and accessibility for people with disabilities, rude conduct by staff, and cultural discrimination.

**Communication**

Of the total concerns, 13 per cent (n=1,553) related to communication. Within this category, the highest subcategory was *absent communication*, followed by *incorrect communication*.

**Respect and patient rights**

Of the total concerns, 14 per cent (n=1,624) related to respect and patient rights. Within this category, the highest subcategory was *disrespect* followed by *rights*.

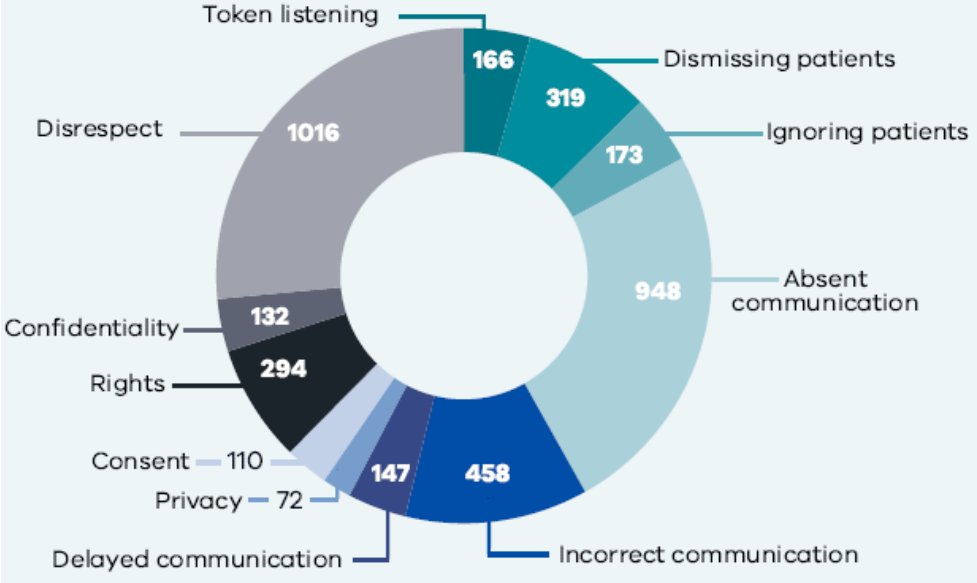



**Figure 4. Number of concerns coded per subcategory within the relationship domain**

**Listening**

Of the total concerns, 6 per cent (n=658) related to listening. Within this category, the highest subcategory was *dismissing patients*.

## Key messages for health services to consider

Themes identified from this domain highlight the impact of respectful and clear communication on a person's healthcare experience.

The Australian Charter of Healthcare Rights recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. It is important to recognise a person's care experience is influenced by the way they are treated as a person, and by the way they are treated for their condition. Health services should take steps to understand patients within their own contexts. Meeting the requirements of the charter will support health services to consistently provide patient centred care.

# Implementing the HCAT

## How complaints offer insights

The systematic analysis of healthcare complaints can be used to improve quality and safety by using patient-centred insights to identify problems. Patient-centred insights are not usually captured with traditional monitoring mechanisms (such as poor coordination of care, communication, and breaching clinical standards). The systematic analysis of complaints is crucial because it offers insights into the complete patient experience across the continuum of care, covering both macro and micro issues, and focusing on issues directly related to patient care[4].

Used effectively, healthcare complaints can act as an early warning system. Trends in complaint issues often precede safety incidents, allowing the opportunity to alter processes that will prevent avoidable patient harm[3]. Patient complaints and feedback about adverse events can help identify potential areas for improvement by providing a more nuanced picture of quality and safety risks in health services.

Encouraging patients to speak up about problems that occur during their care can improve patient experience and safety[5]. Health services should seek to establish a positive complaints culture (rather than attempting to reduce the number of complaints), supported by a robust data collection framework, in which patients and staff feel safe to resolve issues together. Integral to this is building complaint management capability of staff across all levels to resolve issues in the moment.

## How SCV uses the HCAT

The Patient Experience and Response Team at SCV has been using the HCAT to code and analyse Ministerial Correspondence since 2017. The HCAT enables complaints to be categorised based on their content, severity, patient reported harm, where and when the concerns arose. It is designed to use the patient voice to understand patterns of concerns from a patient perspective.

With access to aggregate complaint information, SCV can understand patient risk within organisations along the health care journey. This data can then be used to drive quality improvement initiatives through our program areas, partnering with health services and consumers to improve patient experience and outcomes. We also feed ministerial complaints data into the health service performance monitoring framework through the Department of Health. However, we acknowledge that complaints received through SCV do not offer a complete picture.

## Using the HCAT to learn from complaints

Using a standardised taxonomy to categorise and analyse healthcare complaints is integral to improving the quality and safety of care provision[6]. In a strong safety culture, patient complaints are routinely recorded and systematically analysed, enabling healthcare organisations to identify potential weaknesses in the way services are delivered as an opportunity for improvement[7].

The HCAT offers the ability to drill down and understand hot spots and blind spots in organisations, which can highlight areas for quality improvement[8]. It informs health service management by providing a means to recognise patterns of complaints and therefore develop targeted interventions and recommendations.

Aggregated data is more likely to address the system issues that often underpin quality and safety related problems, supporting a just culture of addressing macro care failures rather than focusing on the micro level[8].

The merit of the HCAT is its ability to help identify trends and areas within healthcare that could benefit from analysis across settings and departments[9]. The HCAT can provide greater insight when the analysis of the data is (and development of solutions are) informed by knowledge of the local staff.

## Suggestions

To inform quality improvement initiatives, patient complaints and feedback need to be collected and recorded in a consistent manner and systematically analysed. For this purpose, SCV encourages health services to integrate the HCAT into their complaints management framework.

Health services may wish to explore potential correlations of complaints themes with other relevant data sources, such as the People Matter Survey, Victorian Health Experience Survey, sentinel events and adverse patient safety event data. This will offer more in-depth insights into health service culture and potential systemic issues that are not captured by looking at the HCAT in isolation. The HCAT taxonomy has been built into VHIMS CS and is being considered for broader inclusion in future updates of the feedback module in VHIMS, to potentially inform the minimum dataset. The HCAT is most easily applied when integrated with online feedback modules or using an Excel form; however, we have included the HCAT paper-based coding form for reference (Appendix 2).

## Training and resources

There are several training resources available to understand and integrate the use of the HCAT into your complaints management framework. Applying the HCAT requires some training and practice to gain an understanding of the taxonomy, but it is straightforward and does not require an analyst or specialised experience.

The Patient Experience and Response team at SCV has offered to meet with health service teams to offer support and training on using the HCAT and complaints management best practice.

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# Appendices

## Appendix 1. HCAT taxonomy and severity indicators

| Domain | Category | Subcategory | Severity level (example indicators) | | |
|---|---|---|---|---|---|
| | | | Low | Medium | High |
| **Clinical** Issues relating to the quality and safety of clinical and nursing care provided by healthcare staff (i.e. doctors, nurses, radiologists, allied health professionals) | **Safety** Errors, incidents, staff competencies Keywords: *incorrect, medication error, did not notice, mistake, failed to act, wrong, poor coordination, unaware, missed the signs, diagnosis* | Error - diagnosis | Slight delay in making diagnosis | Clinician failed to diagnose a fracture | Clinician misunderstood critical illness |
| | | Error - medication | Slight delay administering medication | Staff forgot to administer medication | Incorrect medication was administered |
| | | Error - general | Minor error in recording patient progress | Delay noticing deteriorating condition | Onset of severe sepsis was not identified |
| | | Clinician skills | Minor error filling out the patient notes | Clinician overlooked information (e.g. previous experience of an illness) | Clinician overlooked critical information (e.g. serious drug allergy) |
| | | Teamwork | Minor misunderstanding among clinicians | Test results not shared with clinicians | Failure to coordinate time-critical decision |
| | | Failure to respond | Not responding to bell (isolated) | Not responding to bell (multiple) | Not responding to heart attack |
| | **Quality** Clinical standards of healthcare staff behaviour Keywords: *not provided, was not done, did not follow guidelines, poor standards, should have, not completed, unacceptable quality, not successful* | Examination & monitoring | Patient monitoring delayed | Patient not monitored properly | Discharge without sufficient examination |
| | | Making & following care plans | Patient not involved in care plan | Aspect of care plan overlooked | Failing to heed warnings in patient notes |
| | | Outcomes & side effects | Patient left with some scarring | Patient required follow-up operation | Patient left with unexpected disability |
| | | Neglect - hygiene and personal care | Delay changing dirty bedding | Patient dressed in dirty clothes | Patient left in own waste |
| | | Neglect - nourishment and hydration | Isolated lack of food or water | Nothing to eat or drink for one day | Patient dehydrated/malnourished |
| | | Neglect - general | Wound not dressed properly | Seeping wound ignored | Infected wound not tended to |
| | | Rough handling & discomfort | Rough handling patient | Patient briefly without pain relief | Force feeding baby, resulting in vomiting |
| **Management** Issues relating to the environment and organisation within which healthcare is provided (for which administrative, technical, facilities | **Institutional processes** Problems in bureaucracy, waiting times, and accessing care Keywords: *delayed, postponed, cancelled, lost, not admitted, administrative problems, not referred, confused notes, more paperwork, unaware of me* | Bureaucracy | Appointment cancelled and rescheduled | Chasing departments for an appointment | Refusal to give an appointment |
| | | Delay - access | Difficulty phoning healthcare unit | Waited in emergency room for hours | Unable to access specialist care |
| | | Delay - procedure | Non-urgent medical procedure delayed | Medical procedure delayed | Acute medical procedure delayed |
| | | Delay - general | Phone calls not returned | Complaint not responded to | Emergency phone call not responded to |
| | | Visiting | Visiting times unclear | Visiting unavailable | Family unable to visit dying patient |

| | | | | | |
|---|---|---|---|---|---|
| and management staff are usually responsible) | | Documentation | Patient notes not ready for consultation | Patient notes temporarily lost | Another patient's notes used as basis for consultation |
| | **Environment**<br>Problems in the facilities, services, clinical equipment, staffing levels<br>Keywords: *not available, shut, not enough, dirty, shortages, broken, poor equipment, soiled, used before, poorly signed* | Accommodation | Noisy ward surroundings | Patient was cold and uncomfortable | Fleas, bed bugs, rodents |
| | | Staffing | Midwife repeatedly called away | Specialist not available | Severe staff shortages |
| | | Preparedness | Patient bed not ready upon arrival | Patient placed in bed in corridor | Patient relocated due to bed shortage |
| | | Ward cleanliness | Dirt and cigarette ends on main floor | Blood stains in bathroom | Overflowing toilet, faeces on floor |
| | | Equipment | Parking meter not working | A temporary malfunction in an IT system | Medical equipment malfunctioned |
| | | Security | Argument between patients | One patient bullying another patient | Patient assaulted by another patient |
| **Relationship**<br>Issues relating to the behaviour of any specific member of staff towards the patient of their family/friends | **Listening**<br>Healthcare staff disregard or do not acknowledge information from patients<br>Keywords: *I said, I told, ignored, disregarded, battled to be heard, not acknowledged, excluded, uninterested, not taken seriously* | Ignoring patients | Staff ignored question | Staff ignored mild patient pain | Staff ignored severe distress |
| | | Dismissing patients | Patient's dietary preferences were dismissed | Patient provided information dismissed | Critical patient provided information repeatedly dismissed |
| | | Token listening | Question acknowledged, but not responded to | Patient anxieties acknowledged, but were not addressed | Patient pain acknowledged, but no follow through on pain relief |
| | **Communication**<br>Absent or incorrect communication from healthcare staff to patients<br>Keywords: *no-one said, I was not informed, he/she said X, they told me, no-one explained, contradictory, unanswered questions, confused, incorrect* | Delayed communication | Short delay communicating test results | Long delay communicating test results | Urgent test results delayed |
| | | Incorrect communication | Patient received incorrect directions | Patient received conflicting diagnoses | Patient given wrong test results |
| | | Absent communication | Staff did not communicate a ward change | Staff did not communicate care plan | Dementia patient discharged without the family being informed |
| | **Respect & patient rights**<br>Disrespect or violations of patient rights by staff<br>Keywords: *rude, attitude, humiliated, disrespectful, scared to ask, embarrassed, inappropriate, no consent, abused, assaulted, privacy* | Disrespect | Staff spoke in condescending manner | Rude behaviour | Humiliation in relation to incontinence |
| | | Confidentiality | Private information divulged to the receptionist | Private information divulged to family members | Private information shared with members of the public |
| | | Rights | Staff member lost temper | Patient intimidated by staff member | Patient discriminated against |
| | | Consent | Unclear information for consent | Consent was obtained just prior to a procedure, giving no discussion time | DNR decision without obtaining consent |
| | | Privacy | Lack of privacy during discussion | Lack of privacy during examination | Patient experienced miscarriage without privacy |

## Appendix 2. HCAT coding form[3]

| **Instructions** A. Use the manual to identify severity ratings for each problem category (from 0, not evident, to 3, high severity)<br>B. Please indicate the stage(s) of care to which the letter refers<br>C. Categorise the level of harm experienced by patients<br>D. Please provide descriptive information on the complaint | | | | **Reference number** |
|---|---|---|---|---|
| **(A) Domain** | **Category** | **Severity (0-3)** | **(B) Stages of Care** | **Tick relevant stages** |
| **CLINICAL PROBLEMS**<br>Issues relating to quality and safety of clinical and nursing care provided by healthcare staff (ie, doctors, nurses, radiologists, and allied health professionals) | **Quality:** *Clinical standards of healthcare staff behaviour* | | 1. Admissions | |
| | **Safety:** *Errors, incidents, and staff competencies* | | 2. Examination & diagnosis | |
| **MANAGEMENT PROBLEMS**<br>Issues relating to the environment and organisation within which healthcare is provided (for which administrative, technical, facilities and management staff are usually responsible) | **Environment:** *Problems in the facilities, services, clinical equipment, and staffing levels* | | 3. Care on the ward | |
| | **Institutional Processes:** *Problems in bureaucracy, waiting times, and accessing care* | | 4. Operation & procedures | |
| **RELATIONSHIP PROBLEMS**<br>Issues relating to the behaviour of any specific member of staff towards the patient or their family/friends | **Listening:** *Healthcare staff disregard or do not acknowledge information from patients* | | 5. Discharge & transfers | |
| | **Communication:** *Absent or incorrect communication from healthcare staff to patients* | | 6. Unspecified or other | |
| | **Respect and patient rights:** *Disrespect or violations of patient rights by staff* | | | |
| | **Unspecified/other** | | | |
| **(C) Please indicate the level of harm reported by the patient (1) negligible to (5) catastrophic** (use 0 for N/A or unspecified)<br>= | **(D) Please provide further details of:**<br>**1. Who made the complaint?**<br>☐ Family member ☐ Patient ☐ Unspecified/other<br>**2. Gender of patient?**<br>☐ Female ☐ Male ☐ Unspecified/other<br>**3. Which staff group(s) does the complaint refer to?**<br>☐ Admin ☐ Medical ☐ Nursing ☐ Unspecified/other | | | |

## Appendix 3. Examples of HCAT application[2]

- Illustrative excerpt 1:

**Stage**: admission
Patient waiting to be seen by clinical staff
**Harm**: minimal
Minimal harm experienced by patient

My daughter was recently referred to a specialist clinic due to some skin problems. **Having taken the day off work and collected my daughter from school I arrived at the Dermatology Department to be informed that her appointment had in fact been cancelled.** I received no email, no phone call, no text or letter to this effect so had therefore wasted a day and taken my daughter out of school for no reason.

The **receptionist said she would call back with an explanation. This did not happen,** so at about 4:30pm I called the secretary, and she told me that she had not had a chance to re-book the appointment, and again she said she would call me back.

She called me back later with an appointment date in another 4 weeks. I was not exactly happy about this, and **she had a bad attitude**. I asked her why the original date had been cancelled and she could not tell me. Why did someone not just call me and offer another date and when they realised that a mistake had been made?

**Problem**: institutional processes
Severity: 1
Appointment cancelled without notice
**Problem**: absent communication
Severity: 1
Did not follow up on promised call back
**Problem**: respect and patient rights
Severity: 1
Reports bad attitude, but little detail

- Illustrative excerpt 2:

**Stage**: examination and diagnosis
Misdiagnosis at A&E
**Harm**: major
Long term incapacity
Impacting daily

I am writing to complain about the treatment I received in Accident and Emergency. I presented at the hospital **telling them about my crippling abdominal pains, but I was sent home and told to take some painkillers. I returned the next day with the same complaint, and explained that the pain had increased and that I had been sick throughout the night. I was ignored and sent home again** so I went to my GP clinic the next day, and my GP sent me to hospital as an emergency admission. Here they diagnosed a burst appendix. **During the post-operative review with the consultant in charge I was informed that the appendix had probably burst at or around the time of my first visit to A&E. This might have been averted if my complaint had been taken seriously.**

I am still suffering a number of negative effects from this experience. I have regular bouts of stomach pain and vomiting, although less frequent now, they are unpredictable. Furthermore, my GP informed me that it is likely my condition will not improve.

**Problem**: listening
Severity: 3
Repeated requests for help from A&E were ignored
**Problem**: safety
Severity: 2
Failure to fully examine patient, potentially resulted in burst appendix

## Appendix 4. Further details about this study

### Methods

SCV invited all Victorian public health service CEOs to voluntarily submit their de-identified patient complaints data for this project. This included all the complaints registered in the health service's feedback module of VHIMS (or equivalent) from January 2015 to December 2017.

In the first phase of the project, the de-identified complaints from 2017 were reviewed and retrospectively coded according to the HCAT. Demographic information was collated, and two coders trained in the application of the HCAT used the taxonomy to independently code and analyse the free-text portion of each complaint received. The taxonomy was simplified into one spreadsheet which was used as a reference tool to code the complaints (Appendix 1).

The specific data fields received by SCV varied for each health service. We used the demographic information to create descriptive summaries, and the information in the free-text portions to identify the concerns, incident severity rating, stage of care, and patient reported harm. Multiple concerns could be coded per complaint, but for the purpose of this project, one severity rating was applied to each full complaint (based on the highest applicable severity of the concerns coded).

The HCAT states the coding process should be strictly empirical and focus on the actual words used in the letter of complaint. In some cases, the information recorded in the free-text fields of the complaints data referred to an attachment, but SCV did not have access to any of the attachments. In those cases, the complaint summary (an interpretation by the health service staff inputting the information into the VHIMs feedback module), was often used to code the complaint instead. This is not how the HCAT is designed to be used, but health services are able to rectify this by coding their complaints as they are received. This is an important consideration for health services wanting to apply the HCAT to their complaints process, as there will be a greater level of analysis available to them.

Complaints were coded onto a spreadsheet adapted from the HCAT, including complaint ID number, health service, complaint specialty department, date of complaint, HCAT domain, category, subcategory, incident severity, stage of care and patient harm (example below in the figure below).

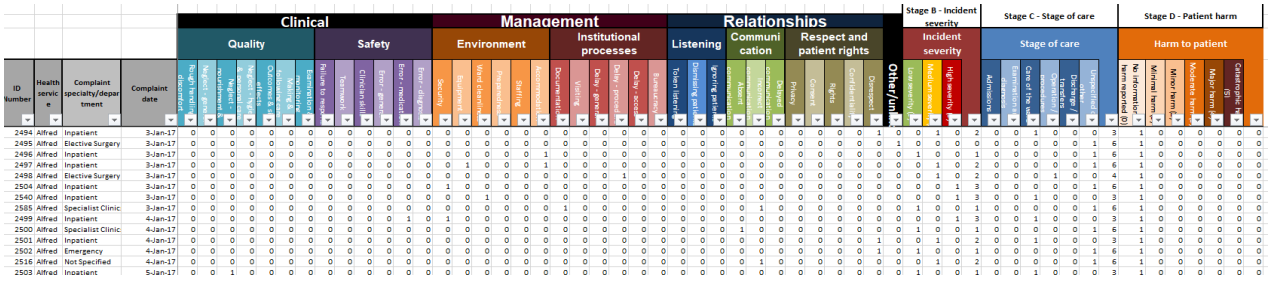


Figure 5. Spreadsheet used to code and record complaints

Once the complaints were coded, individual health service data was collated to analyse patterns of complaints within that service. Each service was also compared to participating peer health services and the

combined study cohort. Peer health service groupings were determined based on classifications from the Victorian Agency for Health Information (VAHI). Secondary data was also obtained from VAHI to calculate the complaint rate, as the number of complaints per 1,000 admissions. To allow for comparison, admissions or total activity was calculated as a sum of three separate factors – inpatient separations, outpatient occasions of service, and emergency presentations.

### Combined data overview

We received a total of 8,602 pieces of correspondence for the 2017 period, of which 8,052 were complaints (211 were requests, 41 repeated complaints, 295 compliments and 3 undefined). Of the 8,052 complaints received, 531 did not have enough detail to assess their severity, and of those, 511 did not have sufficient information to code any concerns, so they have been excluded from that section of analysis; however, their demographics, date, unit, and stage of care were included in the overall data.

The HCAT captures the stage of care, but this was unable to be determined for 46 per cent of the complaints. Of those that could be coded, 18 per cent were related to care on the ward (n=1,413), 11 per cent (n=917) to admissions, 9 per cent (n=730) were related to discharge/transfers, 9 per cent (n=720) to operation/procedure, and 7 per cent (n=584) to examination and diagnosis.

The HCAT enables the level of patient reported harm in complaints to be coded. Unfortunately, due to the nature of the data collected from health services, we were not able to access information originally included as an attachment, so this study was unable to analyse patient harm for 91 per cent of the complaints. For the 9 per cent of complaints where harm was able to be determined, 4 per cent (n=291) were minor harm, 2 per cent (n=149) moderate harm, 2 per cent (n=147) minimal harm, one per cent (n=64) catastrophic harm and one per cent (n=61) major harm.

### Inter-rater reliability

Two coders completed the HCAT coding for this study. To determine inter-rater reliability (IRR), a portion of the complaints were double coded. Ten per cent were randomly allocated, and if there was uncertainty over a specific complaint that would also be double coded. IRR for most categories was substantial (0.61-0.80), safety and listening were moderate (0.41-0.60).

### Study limitations

The original intent of this research project was to code the health service complaints data for 2015-2017. The projected timings were unable to be followed due to the variation in data integrity and presentation. Therefore, we only coded the information for the 2017 period. The original project protocol also outlined the intention to run a correlation analysis of patient complaints data with health service staff (People Matter Survey) data. The redeployment of staff and shifting priorities during the COVID-19 pandemic heavily impacted the timelines and available resources to complete this project. Therefore, SCV has instead provided a more in-depth report on the complaint component, to highlight the usefulness of the HCAT, and to demonstrate opportunities to apply it to internal feedback reporting.

Safer Care Victoria