

Using hospital complaints to improve patient safety

LSE colleagues from the Department of Social Psychology consider the untapped reserve of data that could be used to improve hospital patient safety: hospital complaints. Guest bloggers [Dr Tom Reader](#) and [Dr Alex Gillespie](#) explain how the analysis of this untapped data could inform future learning.

Improving patient safety in the NHS is a key priority for health policy specialists. To achieve this, the development of a '**learning culture**', whereby hospitals learn from adverse events (e.g. medical errors), has been identified as crucial. Our research suggests that one way in which further learning might be achieved is through the rigorous and systematic analysis of hospital complaints.

Hospital complaints refer to an expression of grievance (from patients or families) about the delivery of care. A complaint is typically submitted after a threshold of dissatisfaction has been crossed. Complaints can focus on a diverse range of issues (from car parking to wrong-site surgery), describe different types of harm (e.g. physical, emotional), and have different underlying aims (e.g. resolving upset, creating change, preventing future issues). Hospitals receive a great number of complaints annually. For example, 110,639 written complaints were submitted to Hospital and Community Health Services in England in 2012-13 – of these, 51,071 were classified as referring to "all aspects of clinical treatment".

Where major problems in healthcare institutions have occurred (such as at the mid-Staffordshire Foundation Trust), investigations show that patients recognise these problems and write letters of complaint about them. Yet, complaint data has not been pro-actively used to identify problems in healthcare delivery, and the protocols for analysing and learning from hospital complaints are poor. This is, in part, due to a lack of robust and theoretical-driven tools for analysing patient complaints, and also the way in which complaints are conceptualised by healthcare institutions (typically as individual concerns raised by patients).

Our recent research indicated that the thorough, systematic, and aggregated analysis of hospital complaints might be used to support the identification and prediction of risks to patient safety. Because hospital complaints are unvarnished reports on problems in healthcare systems, they are a valuable resource and can be used to identify problems in healthcare institutions as they occur. Crucially, because patients become 'expert' in their own care, and are present 'at the sharp end' of treatment, they identify problems in healthcare delivery that are missed by traditional data-capture systems (e.g. incident reports). Our systematic review of the hospital complaint literature (59 studies reporting 88,069 hospital complaints) shows around 33.7% of issues raised in hospital complaints focus on problems in the safety and quality of care. A further 35% focus on problems in hospital management with 29% focusing on poor relationships between healthcare staff and patients. This indicates patient complaints to be an under-utilised source of information for monitoring and improving patient safety.

Furthermore, there may be benefits in adopting techniques used to manage other forms of risk-related data in healthcare, such as adverse event analysis protocols. These allow for baseline figures on medical errors to be developed, for example on the number, type, severity, and causes of adverse events within hospitals. Through applying a similar standardized analytical process to patient complaints, an alternative and powerful metric of quality and safety in healthcare might be developed. For example, through detailing the typical number, type, and severity of hospital complaints (e.g. detailing safety concerns), it would be possible to monitor for deviations between or within institutions (e.g. increases in complaints), and use complaint data to detect problems in patient care and facilitate quality improvement based on patient experiences.

Our research to date provides a framework through which to begin this process, and our future work will develop and test system for analysing hospital complaints.

You can [read the paper in its entirety](#) online.

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September 24th, 2014 | [Health Care](#) | [0 Comments](#)

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