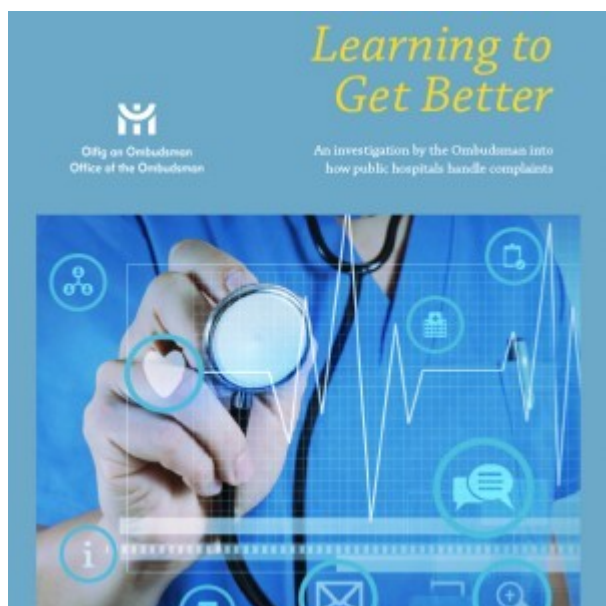


The Irish Medical Times

Unlocking the patient complaints box

June 4, 2015 by [Dara Gantly](#)



Dara Gantly looks at how a ‘root and branch’ reform of our complaints process can enhance patient safety and the provision of care.

This will unfortunately be one of those images that just sticks: a complaints box in one of our major hospitals locked, with the key lost by hospital management. This was just one of many failings witnessed and reported on by the Office of the Ombudsman Peter Tyndall, in a major ‘own initiative’ investigation into how our public hospitals handle complaints from patients.

The move was prompted by the realisation that while his Office received just 130 complaints in 2013, the Ombudsman for Wales — a post Tyndall held before returning to Ireland — received 682 complaints, in a country with approximately 1.5 million fewer people. Granted complaints doubled in 2014 to 262 — partly, Tyndall believes, due to the news coverage surrounding the launch of this investigation last year — but the numbers are still very low. In Northern Ireland, around 60 per cent of the Ombudsman’s caseload is to do with healthcare; the same figure here is 20 per cent. Is this because Irish patients have less to complain about?

Well, unsurprising, that doesn’t seem to be the case, particular if you listen to the patient experiences voiced in a [short but powerful video](#) produced by the Ombudsman to accompany the report ‘Learning to Get Better’, which hears directly from some of those who took part in his investigation.

“My Mum had dementia, she left hospital, arrived home on our doorstep, they didn’t even know she was missing,” one woman recalled, whose mother actually repeated her potentially dangerous wandering a second time. “We

were in the A&E for 12 hours without anyone asking how we were. I noted in the paperwork they put down religion as 'Muslim'. They never asked my religion once," another man noted.

"She said, 'Please don't say anything,' because she had witnessed a patient being severely reprimanded by a senior staff member, and she was afraid of the consequences," another gentleman recounted, with regard to his family member's hospital stay.

Common to so many of the patient voices was the complaint that answers were like "getting blood from the proverbial stone", or that nothing was ever done until they went to "Tony O'Brien's office, and 'then' you get answers". The whole, dysfunctional process was "exceedingly frustrating", "exceedingly pointless", a "complete and utter waste of my time". And unfortunately the rot would only stop if we had "honesty" and "transparency" from management, another contributor suggested.

So — if you still haven't guessed — why don't Irish patients complain? Leaving aside a possible cultural reluctance among Irish people to complain about anything, first and foremost, they fear that there will be negative repercussions for themselves or their families.

That is just an appalling state of affairs. And while the Ombudsman believed this fear might be groundless, the fact that people thought it says a lot. Yet he did have anecdotal evidence of some staff members giving out to patients and reports of people who had been able to visit when it was convenient to them, having their calls restricted to the official visiting times.

"We think that the way to deal with this is to change the culture of complaining. You have to make it obvious that you welcome complaints and encourage them, and allow them to be made confidentially or anonymously, and making sure independent advocacy is available and visible," Tyndall stated last week.

The second main reason why people don't complain is equally depressing: they simply don't believe that it will make any difference. 'Pointless' was how many participants in the investigation described it, as they believed professional allegiance interfered with objectivity, and that patients and carers/relatives could be worse off in terms of how they were treated — in short, it was simply "not worth the effort".

Among the many things HIQA's Portlaoise Report has highlighted is that complaints need to be put alongside learning from other sources — adverse events, whistle-blowing, near misses etc — so that patterns can be identified. As the Ombudsman explained, often in isolation you can have a series of communications about a particular issue, but when you put them together you can see a pattern.

Complaints were thus a vital early warning system for hospitals and other health services, stressed Tyndall. "I wonder if the tragic events seen in Áras Attracta and the Midlands Hospital Portlaoise could have been avoided if those complaints that were made were dealt with properly."

Was HIQA's finding that parents in Portlaoise were misled a one-off aberration? The Ombudsman said if not strictly misled, people in this investigation were certainly not told the whole story and sometimes it took the intervention of a third party to get answers.

Finally, the third main reason given for not complaining was that people found it difficult to know how to go about doing so: confusing hospital websites, brochures out of print, locked complaints boxes with lost keys as mentioned above, and a complete inconsistency in the complaints process. With anywhere between 800 and 900

people in the HSE currently dealing with complaints, what prospect is there of people getting a consistent response?

The Ombudsman has recommended that the HSE and each hospital put an action plan in place to: make it easy for people to complain; ensure that people have access to an effective independent advocacy service; establish a single, consistent complaints system; and investigate the most serious complaints independently. The Office of the Ombudsman will be monitoring the implementation of the action plans, although the HSE – which was represented at the report's launch by its Director General Tony O'Brien – has committed unequivocally to its implementation.

Among its 36 recommendations, 'Learning to Get Better' includes a call for a no 'wrong door' policy so that wherever a complaint is raised, it is the system and not the complainant that is responsible for re-routing it. An independent advocacy services should also be sufficiently supported and signposted within each hospital.

A standardised structure for collecting and documenting a complaint should be developed across the hospital groups, and importantly, the outcome of any investigation of a complaint, together with details of any proposed changes to hospital practices and procedures, should be conveyed in writing to the complainant with each issue in the complaint responded to.

Each hospital group is now being asked to provide a six-monthly report to the HSE on the operation of the complaints system, and the HSE should publish an annual commentary on these six monthly reports.

Each hospital group should also publicise — via the development of a casebook, like that published by the Ombudsman — of complaints received and dealt with within that hospital group.

The Ombudsman wants a "root and branch reform" of the complaints system, so as to ensure that mistakes are not repeated. Tyndall believes that if the complaints system is tied in with other sources of patient information — like whistle-blowing and adverse incident reporting — then one can get a comprehensive picture of what is going wrong, see trends and nip things in the bud before people are affected. All of which should mean this really is placed at the top of the HSE's agenda.

From the comments made by O'Brien, reported elsewhere in this week's issue, the Executive thankfully seems to be doing just that.