Learning to Get Better

Executive Summary and Recommendations

An investigation by the Ombudsman into how public hospitals handle complaints

Oifig an Ombudsman
Office of the Ombudsman

Executive Summary

This investigation by the Office of the Ombudsman looks at how public hospitals in Ireland handle complaints about their services. In particular, it looks at how well the HSE and public hospitals (including voluntary hospitals) listen to feedback and complaints and whether the HSE and public hospitals are learning from complaints to improve the services they provide.

At the outset of this investigation, this Office sought the views of members of the public who had complained about a hospital service, either as a patient or a relative and/or carer.

One of the key points that emerged from this public engagement was:

- many users of hospital services (whether patients or relatives/carers) **do not know how to make a complaint about a hospital service and are not aware of the support available** to help them to do so, including the right to escalate the complaint to this Office.

The main barriers to giving feedback or making a complaint were identified by participants as:

- **a fear of repercussions for their own or their relatives' treatment;**
- **a lack of confidence that anything would change as a result of complaining.**

This Office surveyed all public hospitals to gain a better understanding of the complaints process as it operates across the country and visited 8 randomly selected hospitals for a more in-depth study of their processes. We met with senior management from the HSE, the Department of Health, representative organisations and health sector regulators. We also received submissions from other representative organisations and patient advocacy groups.

The key findings that emerged from this investigation include:

1. Feedback should be encouraged – Members of the public reported a lack of knowledge about how to give feedback or make a complaint. The HSE and hospitals must publicise the information and supports available in order to encourage and assist people to share their experiences of hospital care and make the process more accessible for all. Complaints should be seen as a positive way of ensuring that healthcare services continually improve.

2. Learning from complaints is essential – Hospital staff reported to this Office that there was often a difficulty in getting internal feedback on the outcome of complaints. In view of this, and the belief among the focus group participants that nothing happens as a result of complaining, there is a need for a new focus on learning (and sharing the learning) from complaints. Responding effectively to complaints and learning from them is essential to providing a high quality service. In this regard, learning from complaints should sit alongside learning from other sources such as adverse events or "near misses".

3. There is a role for senior managers within the complaints process – Senior managers must be active and visible in promoting and reinforcing a positive complaints culture within hospitals.

4. Outcomes need to be publicised more – It is important that the HSE and hospitals highlight complaint outcomes which led to improvements and changes in procedures and inform people (the public, hospital staff and the hospitals) what these improvements are.

As a result of these findings, the Ombudsman has made a number of recommendations. These recommendations include:

- **A no "wrong door" policy should be developed** so that wherever a complaint is raised, it is the system and not the complainant that is responsible for routing it to the appropriate place to get it resolved.
- **Independent advocacy services should be sufficiently supported and signposted** within each hospital so patients and their families know where to get support if they want to raise a concern or issue.
- **A standard approach should be adopted by all hospitals in relation to the information available to the public.**
- **A standardised structure for collecting and documenting a complaint should be developed** across the hospital groups outlining the nature of the complaint, the preferred method of communication and desired outcomes.
- **The outcome of any investigation** of a complaint together with details of any proposed changes to be made to hospital practices and procedures arising from the investigation **should be conveyed in writing to the complainant** with each issue in the complaint responded to.
- Each hospital group should **provide a six monthly report to the HSE** on the operation of the complaints system detailing the issues giving rise to complaints and the steps taken to resolve them and the HSE should publish an annual commentary on these six monthly reports.
- Each hospital should **develop a learning implementation plan** arising from any recommendations from a complaint which should set out the action required, the person(s) responsible for implementing the action and the timescale required.
- Each hospital group should **publicise (via the development of a casebook) complaints received and dealt with within that hospital group.** This casebook should contain brief summaries of the complaint received and how it was concluded/resolved (including examples of resulting service improvements) and should be made available to all medical, nursing and administrative staff as well as senior management.

The Ombudsman intends to ask the HSE and each of the voluntary hospitals to develop an action plan in order to monitor the implementation of these recommendations.

Recommendations in full

Access

1. Multiple methods of making a complaint should be available and easily understood, both during and after treatment. These should include comment boxes within hospital wards (if not already in place). A fully accessible online version of Your Service Your Say should be developed to allow complainants to make a complaint online.

2. The HSE should undertake a review of Your Service Your Say with a view to making sure that service users have greater clarity, guidance and information on how the complaints system works.

3. A standard approach should be adopted by all hospitals in relation to the information available to the public when viewing their website, particularly those hospitals availing of the HSE website – hospital details on this site should all contain the same information and the same links for ease of reference.

4. Complaints Officers should be provided with appropriate and accessible facilities within each hospital to meet complainants.

5. Independent advocacy services should be sufficiently supported and signposted within each hospital so patients and their families know where to get support if they want to raise a concern or issue.

6. Each hospital should actively develop and encourage volunteer advocates with the hospital who can help support patients who wish to express a concern or make a complaint.

7. A no "wrong door" policy should be developed so that wherever a complaint is raised, it is the system and not the complainant that is responsible for routing it to the appropriate place to get it resolved.

8. Regulators and the Ombudsman should work more closely together to co-ordinate access for patients to the complaints system. In this regard, the online platform healthcomplaints.ie should be extended to provide a better publicised point of information and access for complainants.

9. Each hospital group should develop a process to allow for the consideration of anonymous complaints.

10. Each hospital should appoint an Access Officer (as statutorily required under the Disability Act 2005) who should attend all necessary training as provided by the HSE.

11. A detailed complaints policy statement should be displayed in public areas within all hospitals, on the hospital website, and in, or near, the Complaints Officer's office. Induction and other training for staff should include a reference to the policy. Staff should also be periodically reminded of the provisions of the policy.

12. Each hospital that has not yet done so, should include a reference to this Office:

- In **any** letter or correspondence notifying the patient/family of the outcome of the complaint to the hospital;
- On websites, booklets and information leaflets where the hospital refers to their complaints system;
- Verbally if explaining how to make a complaint to a patient or their family.

Process

13. The HSE should introduce a standard approach to implementing Your Service Your Say across the public health service. This should include standard forms, standard guidance for patients and staff, standard categorisation of complaints and standard reporting to give certainty to complainants and to allow for comparison on complaint handling, subjects and outcomes between hospitals and hospital groups.

14. Addressing concerns at ward level should be a main focus for each hospital. All hospital staff should be provided with the appropriate training to allow them to deal with issues as they arise.

15. Consideration should be given on a wider front to amending the statutory complaints process (and the remit of the Ombudsman) to allow for the inclusion of clinical judgement as a subject about which a complaint can be made.

16. Each hospital group should have a Complaints Officer to take overall responsibility for the complaints process and co-ordinate the work of complaints staff in each hospital in the group.

17. A standardised process and template for recording and documenting complaints at ward level should be embedded via a standardised system across the hospital groups.

18. A standardised structure and template for collecting and documenting a complaint should be developed across the hospital groups outlining the nature of the complaint, preferred method of communication and desired outcomes.

19. A standardised information system for the recording of complaints, comments and compliments should be developed across the hospital groups.

20. Each hospital group should implement mandatory training on complaints handling for all Complaints Officers and other staff involved in the complaints process.

21. Each hospital group should provide an induction module for all new hospital staff on the hospital complaints process and its underlying statutory framework.

22. Each hospital group should implement a bi-monthly audit of the complaints dealt with within the group in order to assess the quality of the process, including the response.

23. Each hospital group should develop a facility to allow for independent (i.e. outside the HSE) investigation of complaints where the complaint received is of sufficient seriousness and where appropriate.

24. The HSE and the hospital groups should take steps to ensure that all complaints are thoroughly, properly and objectively investigated and comprehensively responded to.

25. Each hospital group should develop an Open Disclosure training programme in line with the HSE National Guidelines and make it available to all staff.

26. The Department of Health should undertake a full review of the Health Act 2004 (Complaints) Regulations 2006. This Office looks forward to working with the Department in this regard.

Response

27. The outcome of any investigation of a complaint together with details of any proposed changes to be made to hospital practices and procedures arising from the investigation should be conveyed in writing to the complainant with each issue in the complaint responded to.

28. Each hospital group should develop a standardised policy on redress.

Leadership

29. Each hospital group should redevelop standardised reporting on complaints with greater attention paid to the narrative contained within complaints data so that senior management can identify recurring themes / issues and take action where appropriate.

30. Each hospital group should provide a six monthly report to the HSE on the operation of the complaints system detailing the numbers received, issues giving rise to complaints, the steps taken to resolve them and the outcomes.

31. The HSE should publish an annual commentary on these six monthly reports alongside detailed statistical data (using the reports published in the United Kingdom by the HSCIC as a model)

32. Each hospital group should appoint a senior member of staff to assume an active and visible leadership role in the complaints process with key involvement in education, training and reporting arrangements.

33. Senior managers in each hospital should foster and encourage positive attitudes towards complaints to ensure that each hospital is open to feedback and is responsive to complaints.

Learning

34. Each hospital group should develop a standardised learning implementation plan arising from any recommendations from a complaint which should set out the action required, the person(s) responsible for implementing the action and the timescale required.

35. Each hospital group should put in place arrangements (both within and across the hospital groups) for sharing good practice on complaint handling. This should include a formal network of Complaints Officers to ensure that learning and best practice is shared throughout the public hospital sector.

36. Each hospital group should publicise (via the development of a casebook) complaints received and dealt with within that hospital group. This casebook should contain brief summaries of the complaint received and how it was concluded/resolved (including examples of resulting service improvements) and should be made available to all medical, nursing and administrative staff as well as senior management. This could usefully form part of a larger digest incorporating all information on adverse incidents whether arising from complaints, whistle blowing or litigation to ensure that there is a comprehensive approach to learning from mistakes.

The Ombudsman intends to ask the HSE and each of the voluntary hospitals to develop an action plan in order to monitor the implementation of these recommendations.

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