

***Health Care Complaints Recorded by
WA Health Services***

1 July 2005 to 30 June 2008



Office of Safety and Quality in Healthcare

June 2011

Executive Summary

The provision of health care is taking place in an increasingly complex and challenging environment, in tandem with rising community expectation and scrutiny of hospital/health services.

Complaint handling and management is increasingly recognised as a valuable source of information that can contribute towards quality improvement and risk minimisation in health care. It is also an important part of the trend towards engaging consumers as partners in health care and building trust within the community through accountability and transparency.

WA Health promotes complaint management as an important part of consumer engagement, a mainly valuable quality improvement tool. This report presents complaint data collected from WA health services over the 2005-06, 2006-07 and 2007-08 financial years. The data are based on complaints that are categorised and classified in accordance with the Department of Health *WA Complaint Management Policy*.

A total of 8,700 complaints resulted in registration of 12,791 complaint issues between 1 July 2005 and 30 June 2008 in WA Health. As a proportion of activity, annual numbers of complaints and complaint issues have both decreased over this period (figures 2.1 and 2.2).

The proportion of complaint issues recorded under each category was relatively consistent in each year. The top five complaint categories recorded over the three years were (3-year total of complaint issues; percentage of total):

1. Quality of clinical care (3,627 or 28.4%)
2. Access (2,635 or 20.6%)
3. Rights, respect and dignity (2,328 or 18.2%)
4. Communication (2,200 or 17.2%)
5. Corporate services (791 or 6.2%).

There is a notable downward trend in the rate of complaint issues recorded as a proportion of activity at the Child and Adolescent Health Service (CAHS) over the three years. The South Metropolitan Area Health Service (SMAHS) data show consistent numbers and rates of complaint issues recorded over the three years. The WA Country Health Service's (WACHS) numbers display a 'dip' in the middle year (2006-07). Complaint issues recorded at the North Metropolitan Area Health Service (NMAHS) are relatively consistent over the three years with a small downward trend.

The most prominent complaint issue categories at the health services reflect the 'top five' list of categories above. WACHS recorded a comparatively higher percentage in the *Corporate Service* complaint issue category.

Consistent with previous reports, data from BreastScreen WA (BSWA) and the Dental Health Service (DHS) display much lower rates of complaints and complaint issues recorded as a proportion of activity. At BSWA, the *Rights Respect and Dignity* and *Communication* categories display similar numbers of complaint issues recorded as *Quality of Clinical Services*. *Access* was by far the most frequent complaint category recorded at the DHS.

Overall, the majority of complaints were resolved within 30 working days, the timeframe specified in the *WA Complaint Management Policy*. CAHS and WACHS were the only two health services where less than 80 per cent of complaints were resolved within this timeframe.

A complaints management process is fundamental to delivery of quality health care. An effective and efficient complaints management process enables providers to resolve disputes, obtain feedback from consumers/carers and provide strategies for hospital/health service improvement.

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1. Introduction

“Consumers (including patients and carers) have a unique expertise in relation to their own health and their perspective on how care is actually provided. Consumer complaints are, therefore, a unique source of information for health care services on how and why adverse events occur and how to prevent them. As well as reducing future harm to patients, better management of complaints should restore trust and reduce the risk of litigation, through open communication and a commitment to learn from the problem and prevent its recurrence”.¹

1.1 Complaint management in context

Modern health systems are highly complex organisations where the delivery of health services takes place in an increasingly challenging environment. Although the vast majority of patients and carers are satisfied with the treatment they receive, in terms of both the clinical and non-clinical components, it is inevitable that some episodes of care result in dissatisfaction. This may lead to negative feedback and complaints. However it is important to note:

- The motivation for consumers to lodge complaints appears to be founded on the desire to prevent clinical incidents from happening to others.²
- Rarely are consumer complaints motivated by litigation and the lure of financial compensation.²
- Complaints are in response to incidents ranging from the relatively minor to serious clinical incidents.
- It is accepted practice that health care consumer feedback, including complaints, should be encouraged as this can provide a useful ‘window’ into system deficiencies.
- Complaints are valued as a source of useful information that can enhance quality improvement processes and clinical safety.¹⁻⁵

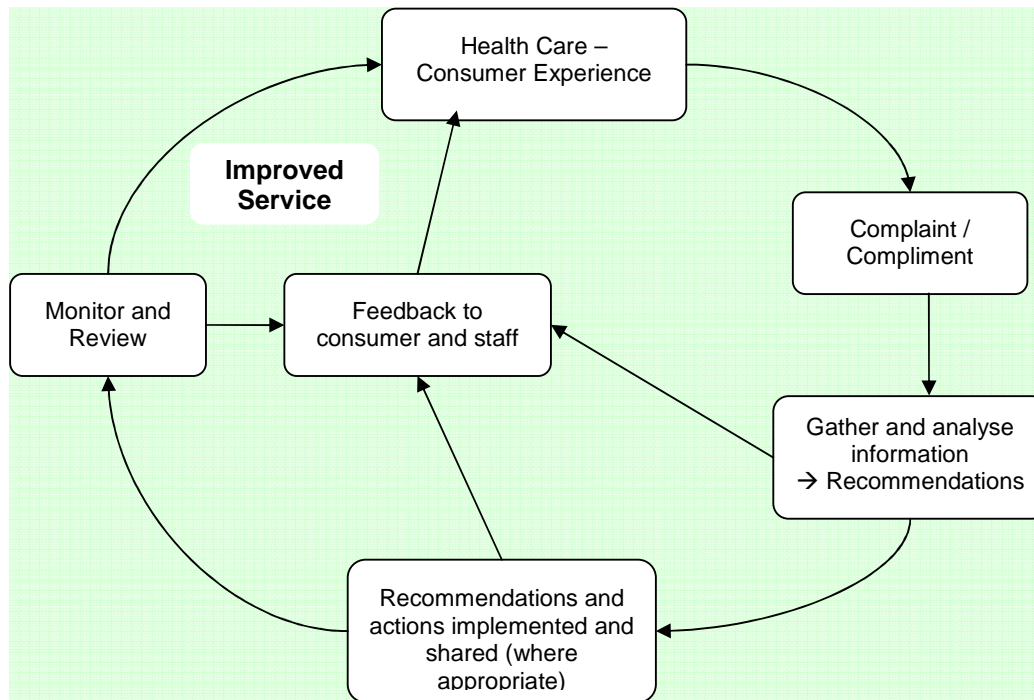
It has been recognised that effective complaint handling and management has also been linked to the reduction of claims for medico-legal compensation.⁵ The mechanisms at play here may align with the internal processes put forward to explain the restorative effect of open disclosure, the “open discussion of incidents that result in harm (or might result in future harm) to a patient while receiving health care”.⁶ The recognition of the harm caused and the redress created through assurances that something will be, or has been done, lessens the drive for recompense. Importantly, it may also improve clinical and non-clinical outcomes. Consumer satisfaction with the process in which their grievance is handled can be a powerful determinant of the internal and external resolution of the harm caused by the contributory incident.⁷

Effective complaint management across entire health systems and evidence of responsiveness to consumer needs and concerns carries the potential to increase levels of the public’s trust in health services. Increased trust at a macro-level can translate to improved service utilisation, uptake and compliance with treatment. This can result in better clinical outcomes, improved population health and more efficient use of resources devoted to health care.^{4, 5} A patient-centred culture of transparency and responsiveness

to feedback may especially build trust within marginalised communities and population groups.

Figure 1 illustrates schematically how effective complaint management can lead to improved service quality.

Figure 1. Complaint management 'Feedback Loop'



1.2 Complaint management in WA Health

“..the [WA Complaint Management] Policy does not seek to apportion blame but requires improvement through appropriate action. Ideally, a partnership between hospitals, health services and consumers will develop, with the common aim of improving the safety and quality of health services in WA.”⁸

Providing safe, high quality hospitals/health services is a central priority for WA Health. A transparent, consumer-focused and patient-centred approach to health care provision is an important part of this objective, as set out in the WA Health Operational Plan 2008-09 and detailed in the WA Strategic Plan for Safety and Quality in Health Care 2008-2013.

The *WA Complaint Management Policy*⁸ calls for hospitals/health services to actively promote and encourage consumers to provide feedback about the perceived quality of health care received. Promoting effective complaint management reflects an open, transparent culture within the hospital/health services.

Complaint management in WA Health is thus based on two primary objectives:

1. **Effective management of individual complaints:** ensuring that all complaints are effectively handled and resolved in a consistent and just fashion.

2. **Facilitation of service and system improvements:** ensuring that information gathered from complaints is systematically recorded, analysed and used to improve health service delivery.

Examples of individual complaints, as well as aggregate complaint data leading to real organisational quality improvement, can be found in all of WA's health services and across Australia. The following is a short case study describing one such incident. Other examples of individual complaint management can be found throughout this report.

Case Study:

'Wendy' attended the Emergency Department of a Perth metropolitan hospital. She was discharged and instructed to follow up with her General Practitioner (GP). A discharge letter to the GP was given to Wendy by the treating medical officer.

Upon returning home, Wendy's partner removed the letter from the unsealed envelope to find that it related to an unknown individual and contained personal medical information. The hospital was notified immediately but it was not possible to determine if another patient had received Wendy's discharge letter.

Outcomes:

- The medical officer involved was counselled about confidentiality and patient/clinician trust.
- The issue was raised at a subsequent Emergency Department team meeting.
- A policy was implemented whereby correspondence with other off-site clinicians and GPs is sent via facsimile. If no GP is nominated, letters are checked by the discharge nurse to ensure it relates to the correct patient.

In WA hospitals/health services, a proactive approach to complaint management is built on intra-organisational relationship building (e.g. between administrative and clinical staff), and early intervention and communication with complainants. The aim is to:

- encourage an open, communicative culture that frames complaint management as a quality improvement tool
- minimise the risk of complaints being unnecessarily escalated to medico-legal proceedings by recognising that
 - complaints correlate with clinical incidents
 - prevention of future harm is the principal motivation behind health care complaints
 - an open expression of regret can ameliorate the effects of incidents that result in complaints.²⁻⁶

The Open Disclosure Process, as outlined in the *WA Open Disclosure Policy* released in May 2009, will guide health practitioners in WA to continue to deliver best practice clinical care for patients by informing them in an open and timely manner if a clinical incident occurs.⁹

Through this process of honest and open discussion with patients and their nominated relatives/carers following a clinical incident, WA Health will continue to promote a patient centred culture that encourages learning from errors and continuous improvement in the delivery of safe and high quality health care.⁹

This report provides a summary and analysis of complaint data recorded in WA public hospitals/health services between 1 July 2005 and 30 June 2008. Data are collected and provided by the following health services:

1. BreastScreen WA (BSWA)
2. Child and Adolescent Health Service (CAHS)
3. Dental Health Service (DHS)
4. North Metropolitan Area Health Service (NMAHS)
5. South Metropolitan Area Health Service (SMAHS)
6. WA Country Health Service (WACHS).

Note: During the period covered in this report King Edward Memorial Hospital (KEMH) was transferred from Women's and Children's Health Service (WCHS) (which included CAHS) to NMAHS. This occurred in July 2006. KEMH is now incorporated into the Women and Newborn Health Service (WNHS). The 2005-06 CAHS complaint data *includes* KEMH, while the remaining two years do not. NMAHS 2006-07 and 2007-08 data include KEMH complaints; 2005-06 does not. In addition, CAHS data for 2006-07 and 2007-08 also includes complaints recorded by Community Health Services, whereas these were apportioned throughout the health services in 2005-06. These irregularities should be taken into account when interpreting and drawing conclusions from the data contained in this report.

2. Three Years at a Glance

“Complaints provide an opportunity to examine errors and to try and prevent them happening again.” Health Care Complaints Commission (NSW) Annual Report 2007-08

2.1 Complaints and complaint issues

A total of 8,700 complaints were recorded by public health services in WA between 1 July 2005 and 30 June 2008. There was an approximate average of 1.47 complaint issues per complainant.

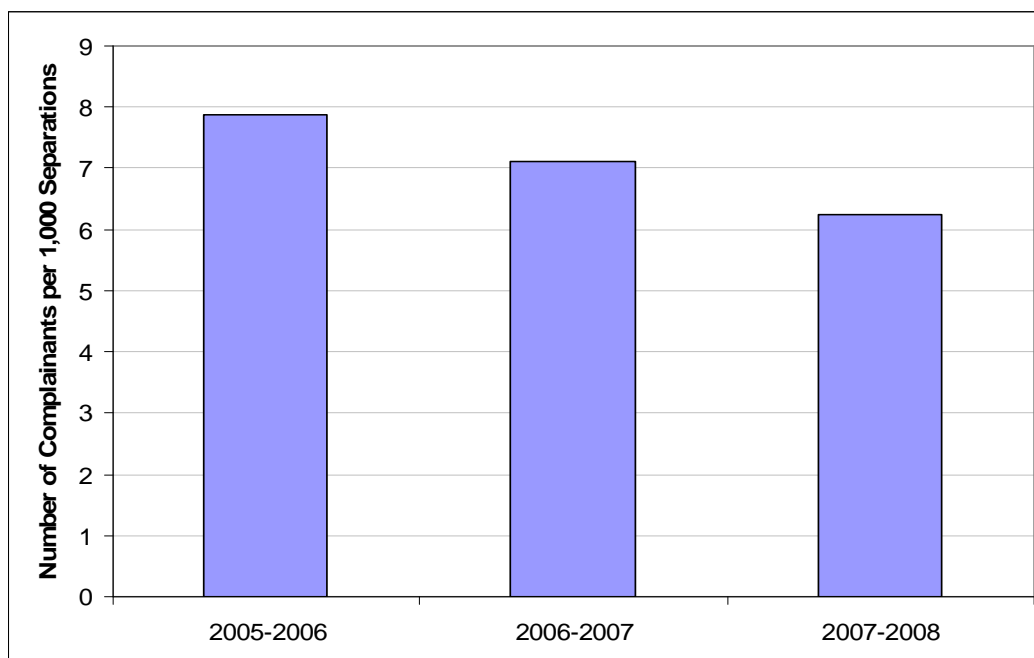
Table 2.1 displays the number of complaints and the number of complaint issues for each of the three financial years examined in this report. It should be noted that 4,428 complaint issues were recorded in the 2004-05 period.

Table 2.1 Complaints and Complaint Issues – WA Health Total

	2005-2006	2006-2007	2007-2008	TOTAL
Complaints	3,077	2,827	2,796	8,700
Complaint Issues	4,435	4,058	4,298	12,791

Over the three years analysed, the annual number of recorded complaints fell by 9.1 per cent. This statistically significant downward trend is evident in Figure 2.1, which presents the number of complaints as a proportion of total activity across the health services, measured in separations or occasions of service.¹

Figure 2.1 Complaints per 1,000 separations



¹ See Appendix 1 for definitions of ‘occasions of service’ and ‘separations’ which are used interchangeably throughout this report.

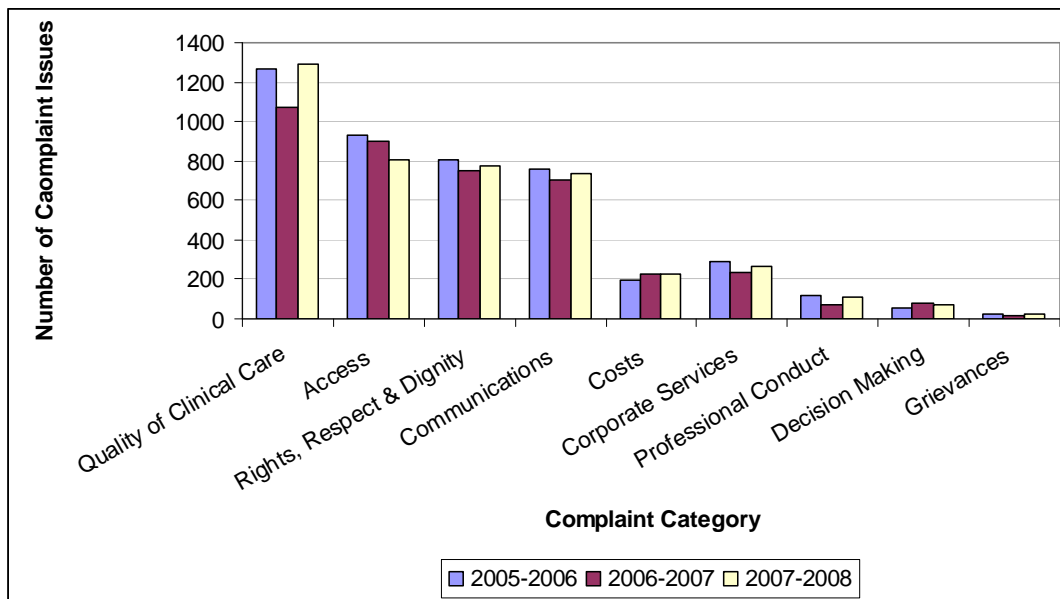
2.2 Complaint categories

Figure 2.2 displays the annual number of complaint issues recorded under the nine complaint categories. There is a degree of consistency in the pattern and distribution of complaint issues among categories over the three years examined. The following observations are noteworthy:

- The *Quality of Clinical Care* category consistently accounted for the highest number of complaint issues recorded over the three years (2005-06=1,266, 2006-07=1,074, 2007-08= 1,287).
- The *Access* category consistently accounted for the second highest number of complaint issues recorded (2005-06=927, 2006-07=900, 2007-08=808).
- *Rights, Respect and Dignity* and *Communications* were the third and fourth most common complaint categories respectively with similar total numbers and proportion of complaint issues recorded over the three years (see appendix Table 3.1).

Section 3.1 examines data by complaint category in more detail.

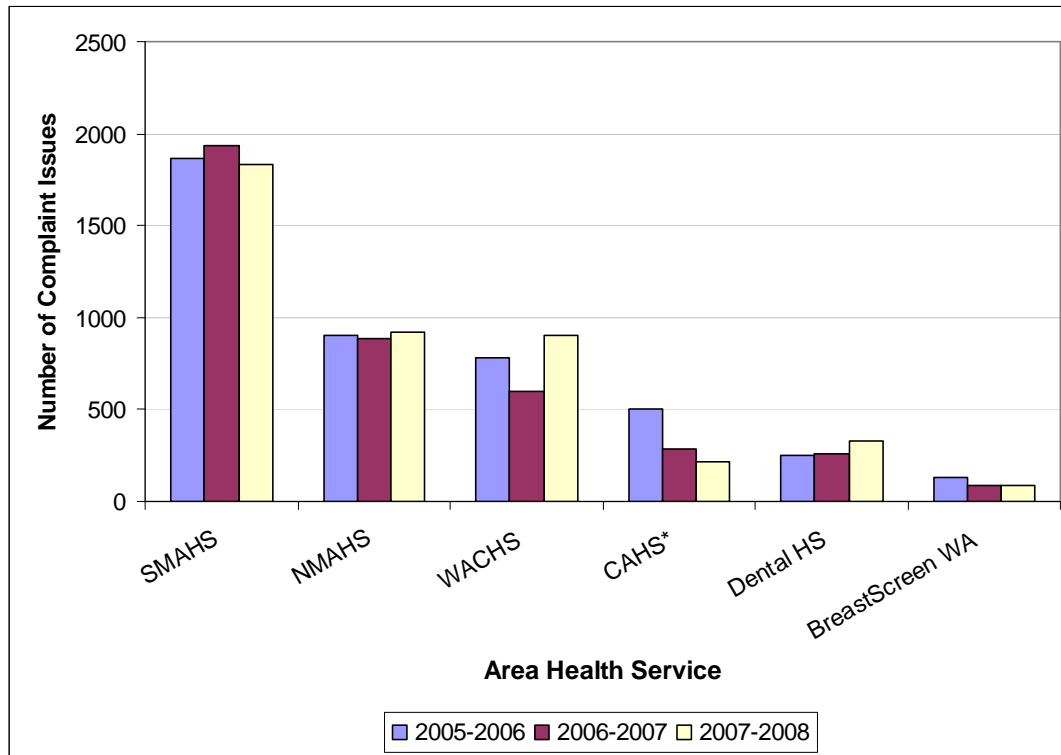
Figure 2.2 Number of complaint issues by complaint category



2.3 Complaints by Health Service

Figure 2.3 displays the total number complaint issues recorded in each year examined at each health service. Figure 2.4 expresses these as a proportion of activity.²

Figure 2.3 Number of complaint issues by health service

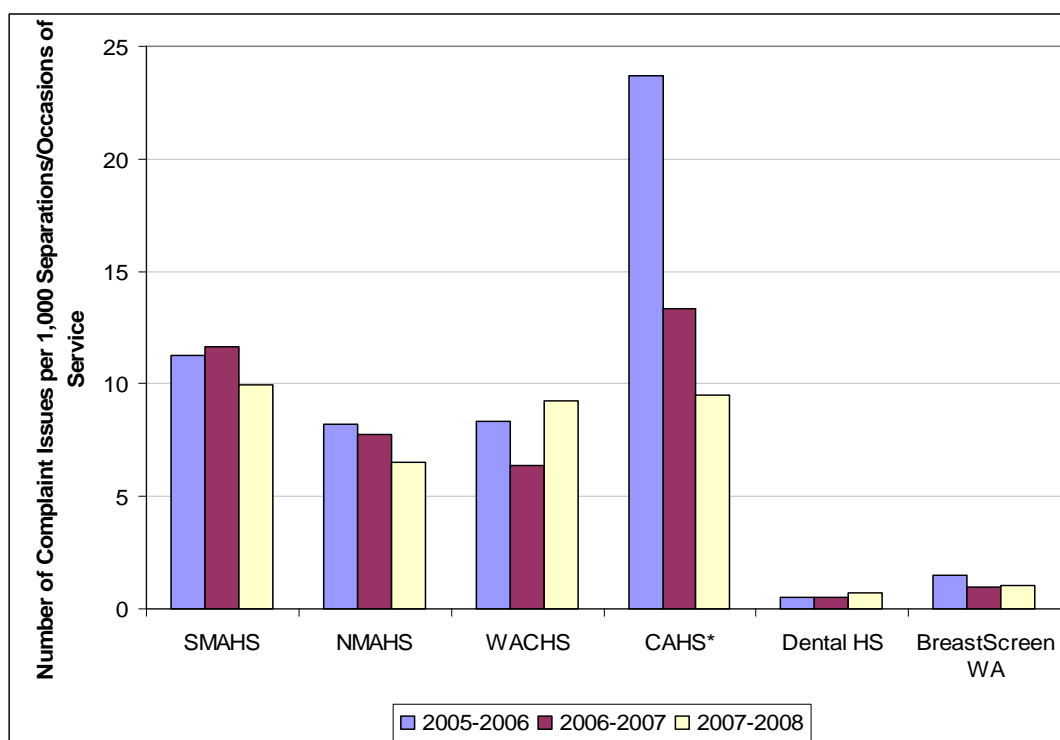


Refer to Section 3.2 for a more detailed analysis of complaints by health service.

² Comparisons between health services should be made with considerable caution due, in part, to:

- The non-homogenous nature of the health services in relation to factors such as the number of patients, patient demographics (e.g. paediatric patients at CAHS), medical specialties, types of activities/procedures performed and geographical considerations (e.g. WACHS).
- The fact that each health service and hospital is responsible for collecting, interpreting and entering its own complaints. Any differences in the complaint management process may result in variance in the way complaints are categorised and separated into complaint issues.
- Differences in how the opportunity for consumers to lodge complaints is promoted. The number of complaints is likely to be, in part, a function of how strongly consumer feedback is encouraged by a health service.
- Jurisdictional changes (e.g. hospitals / facilities moving between health services).

Figure 2.4 Number of complaint issues per 1,000 separations/occasions of service by health service



The comparative results presented in Figure 2.3 are generally consistent with previous years if the transfer of Royal Perth Hospital (a high-activity teaching hospital) from NMAHS to SMAHS in the year 2004-05 is considered.

Figure 2.4 (complaint issues as a proportion of activity) contains some notable features, including:

- CAHS displayed relatively high complaint issue rates for the first two years examined compared to the other health services (noting that 2005-06 data included complaints recorded at KEMH). There was a downward trend in the complaint issues recorded at CAHS over the three years examined. By 2007-08, rates at CAHS were at a similar level as the three large health services (SMAHS, NMAHS and WACHS).
- WACHS data show a notable fluctuation in aggregate complaint issue numbers and rates over the three years reported, with a 'dip' in 2006-07 (2005-06=783, 2006-07=602, 2007-08=903).
- SMAHS and NMAHS recorded consistent complaint issue numbers and rates over the three years. NMAHS data exhibited a downward trend over the time period, notable as the second two years examined (2006-07 and 2007-08) included complaints recorded at KEMH.
- Breast Screen WA (BSWA) displayed a reduction in complaint issues recorded from 2005-06 to the latter two years (2005-06=131, 2006-07=84, 2007-08=87). This reduction is also reflected in complaint issue rates at that health service (Figure 2.4).
- The Dental Health Service (DHS) exhibited the lowest rates of complaint issues recorded as a proportion of activity (Figure 2.4). There was an upward trend in this rate over the three years examined, beginning at just below 5 complaint issues per 10,000 occasions of service in 2005-06 and rising to just over 7 by 2007-08.

2.4 Complaint resolution

A complaint is considered resolved when all the complaint issues have been addressed and a final communication is dispatched to the complainant. This should occur within 30 working days from when the initial complaint is lodged, as specified in the *WA Complaint Management Policy*.⁸ The complaint resolution data for WA Health (Table 2.2 and Figure 2.5) indicate that across WA Health:

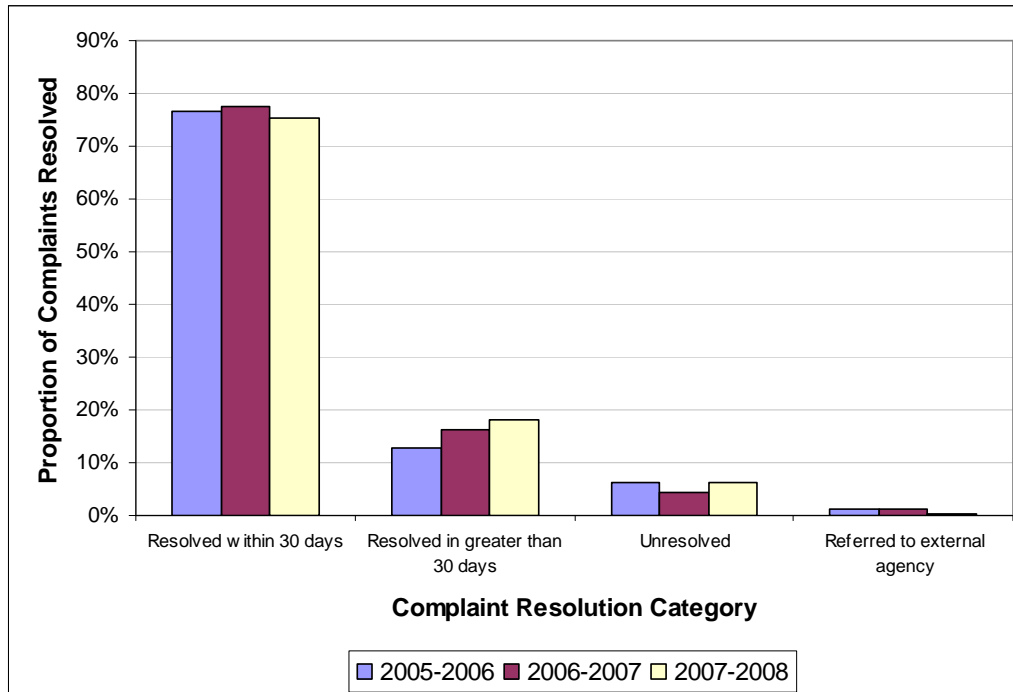
- Over 75 per cent of complaints were consistently resolved within 30 working days in each of the three years examined.
- Less than 7 per cent of complaints remained unresolved at the end of each year.
- Referrals to external agencies remained very low and tended to be reducing.

Complaint resolution rates for each health service are provided in Section 3.2.

Table 2.2 Complaint resolution times in WA Health

	2005-2006	2006-2007	2007-2008
Resolved within 30 days	2,417 (76.6%)	2,307 (77.5%)	2,200 (75.3%)
Resolved in more than 30 days	407 (12.9%)	485 (16.3%)	530 (18.1%)
Unresolved	198 (6.3%)	129 (4.3%)	179 (6.1%)
Referred to external agency	40 (1.3%)	33 (1.1%)	13 (0.4%)

Figure 2.5 Complaint resolution times in WA Health*



* Please note that due to technical problems with data collection consistency, data collected in 2005-06 may not add up to 100%.

3. Trends in Complaints in WA 2005-2008

3.1 Complaint categories

The nine complaint categories allow analysis and classification of complaints, which often involve more than one aspect of the care received. Each category is further separated into complaint issues (see Appendix 2).

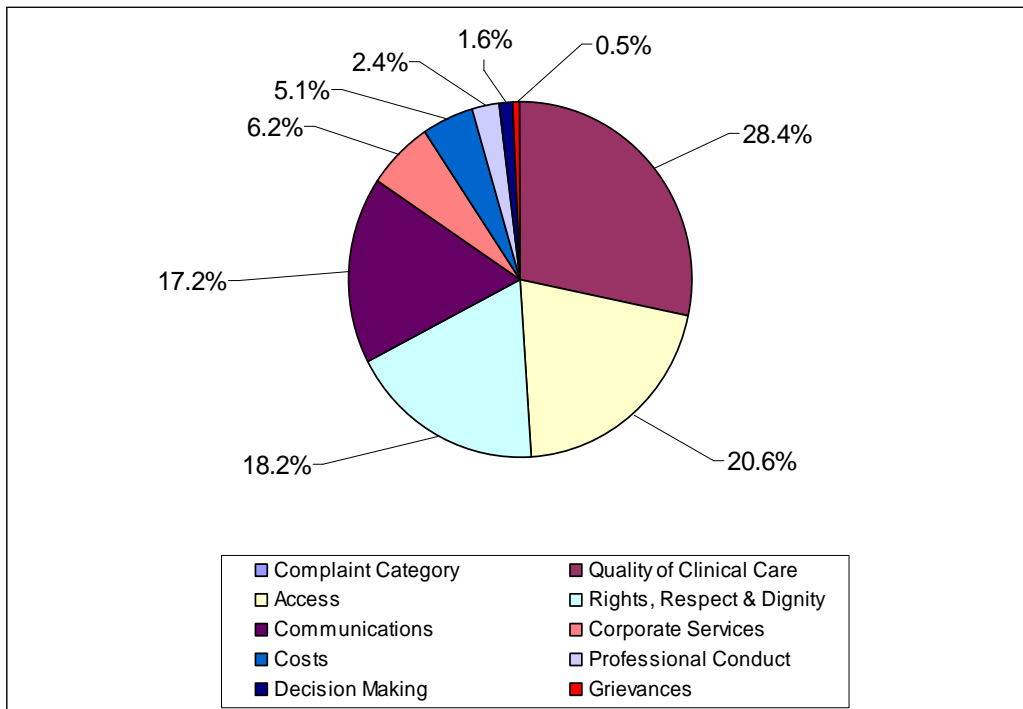
A total of 12,791 complaint issues were recorded for the three year period across WA Health. Table 3.1 contains the number and percentage of complaint issues by complaint category for each year. The proportion of complaint issues recorded under each of the nine complaint categories were relatively consistent for each of the three years examined in this report. These proportions are similar to those provided in the Report on WA State-wide Complaint Data, 2004-05, which reported the same 'top five' complaint categories as the data in the three years examined here.

Figure 3.1 displays the average percentage of complaint issues related to each complaint category over the three years. Each category is discussed individually below.

Table 3.1 Number of complaint issues by complaint category (in order of number of complaint issues recorded)

Complaint Category	2005-2006	2006-2007	2007-2008
<i>Quality of Clinical Care</i>	1,266 (28.5%)	1,074 (26.5%)	1,287 (29.9%)
<i>Access</i>	927 (20.9%)	900 (22.2%)	808 (18.8%)
<i>Rights, Respect and Dignity</i>	803 (18.1%)	753 (18.6%)	772 (18.0%)
<i>Communication</i>	758 (17.1%)	706 (17.4%)	736 (17.1%)
<i>Corporate Services</i>	291 (6.6%)	235 (5.8%)	265 (6.2%)
<i>Costs</i>	194 (4.4%)	229 (5.6%)	226 (5.3%)
<i>Professional Conduct</i>	120 (2.7%)	72 (1.8%)	111 (2.6%)
<i>Decision Making</i>	52 (1.2%)	75 (1.8%)	72 (1.7%)
<i>Grievances</i>	24 (0.5%)	14 (0.3%)	21 (0.5%)
TOTAL	4,435	4,058	4,298

**Figure 3.1 Proportion of complaint issues by complaint category
1 July 2005 – 30 June 2008**



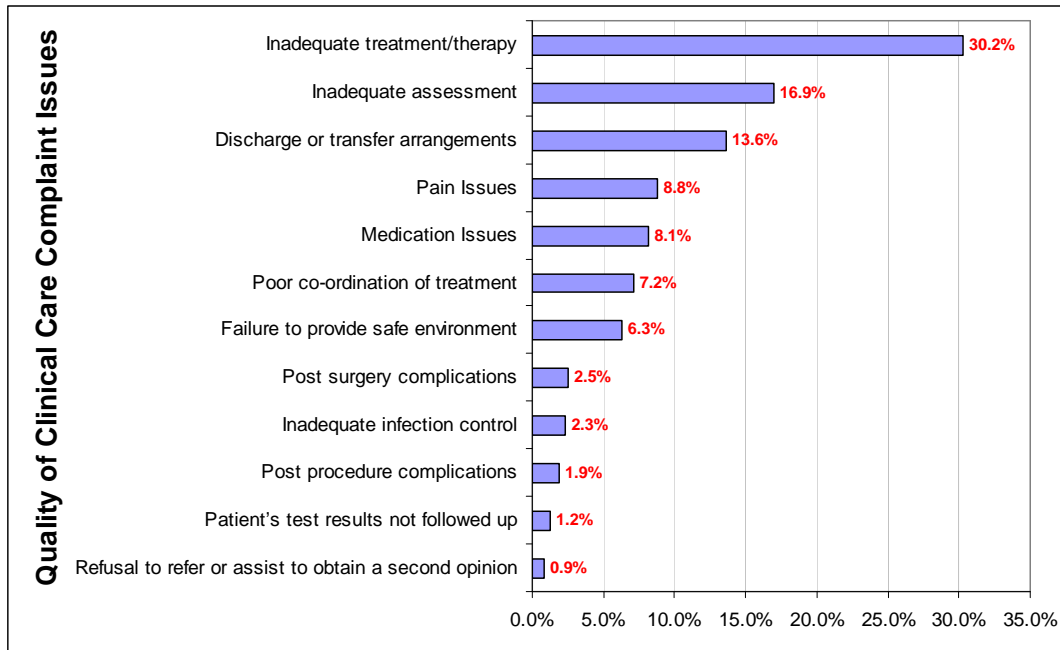
* Due to rounding of decimal places, the percentages in this figure do not exactly add up to 100%.

3.1.1 Quality of Clinical Care

Quality of Clinical Care (QCC) relates to the assessment, planning, implementation and evaluation of clinical care by health professionals. This category was associated with the largest number of complaints, accounting for approximately 28 per cent of complaint issues recorded over the three years examined. The total number of complaints in the QCC category over the three years was 3,627 with a range of 1,074 to 1,287 complaint issues per year.

Twelve complaint issues constitute the QCC category as shown in Figure 3.2.

Figure 3.2 Proportion of complaint issues in the *Quality of Clinical Care* complaint category (2005 – 2008)



Case Study:

15-year-old 'David', accompanied by his father, presented to a Perth metropolitan Emergency Department with left ear pain. A diagnosis of ear wax obstruction was made by the treating medical officer and David was sent home with ear drops to clear the occlusion. The symptoms worsened overnight forcing David's father to take him to another hospital for a second opinion, where the problem was diagnosed as a middle ear infection and treated accordingly.

David's father made a complaint to the first hospital. As the error was not registered as a clinical incident (because the second opinion was obtained at another hospital) the complaint was the only source of information about the incident available to the hospital. Investigation of the complaint found that the treating medical officer was a junior doctor on his first shift and that inexperience and lack of supervision/communication contributed to the incorrect diagnosis being made.

Outcome:

The hospital changed its policy regarding supervision of Emergency Department junior medical staff to prevent similar errors from occurring.

Figure 3.3 displays the number of QCC complaint issues by health service. The distribution displayed here is similar to the spread of the aggregate complaint data, both across and within the health services (see Figure 2.3). A similar pattern to the system-wide distribution of complaint data is evident in Figure 3.4 where the number of complaint issues recorded under the QCC category is presented as a proportion of activity.

Figure 3.3 Number of *Quality of Clinical Care* complaint issues by health service

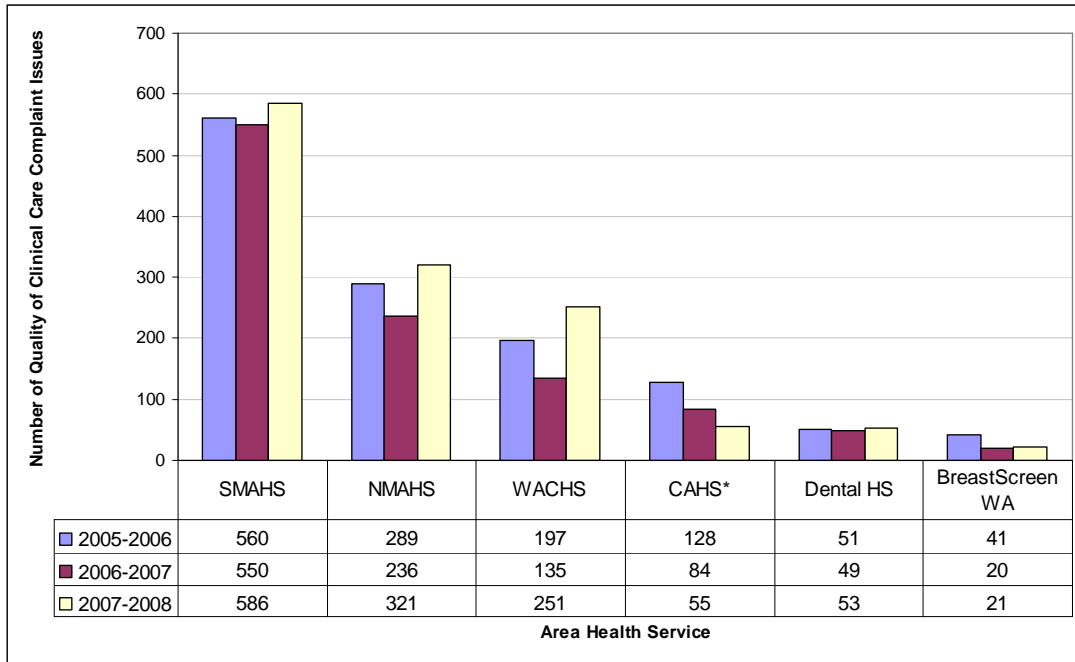
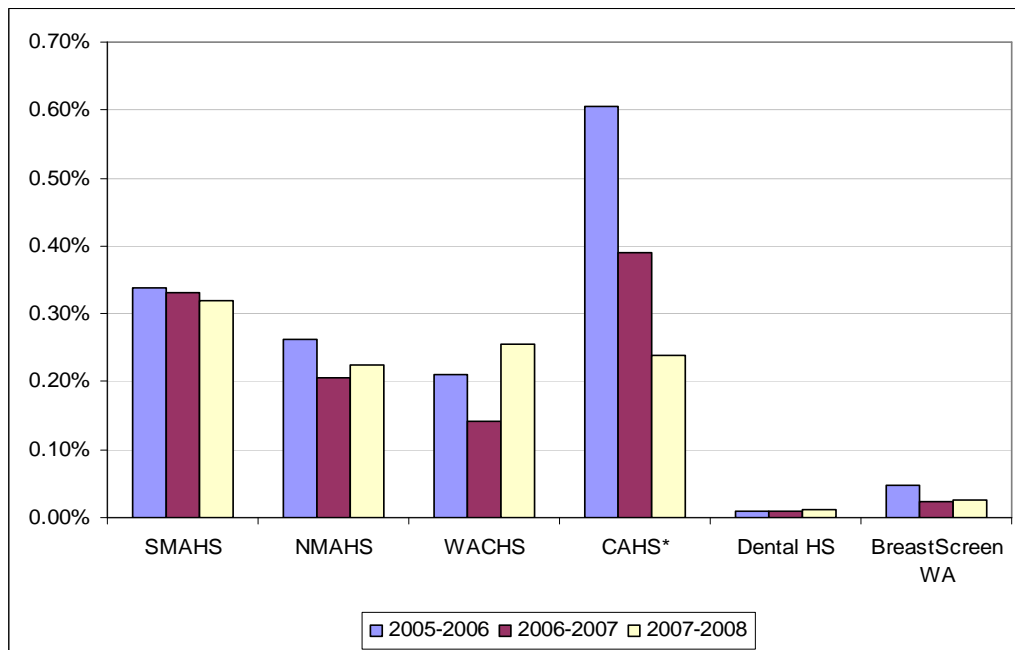


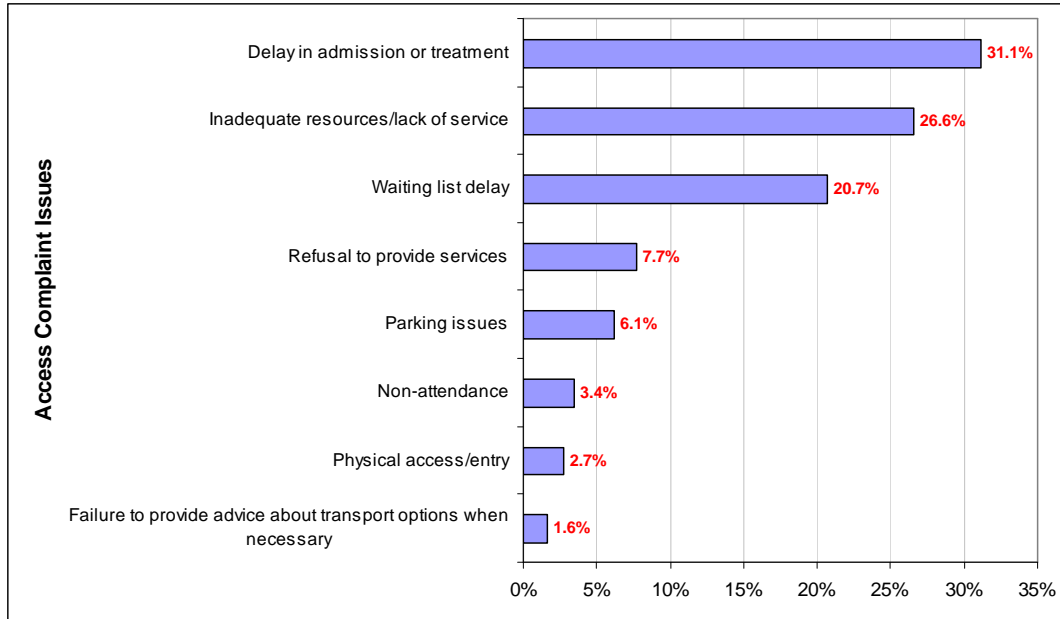
Figure 3.4 *Quality of Clinical Care* complaint issues as a percentage of total activity by health service



3.1.2 Access

Access refers to availability of services in terms of location, waiting times and other constraints that limit consumers' opportunity to utilise the service. This category is comprised of eight complaint issues. Access complaint issues were associated with the second largest category, constituting approximately 20 per cent of total complaint issues recorded. The total number of complaint issues recorded under this category over the three years examined was 2,635, with a range of 808 to 927 per year (Table 3.1).

Figure 3.5 Proportion of Access complaint issues (2005 - 2008)



Case Study:

A complaint was received relating to eligibility for a Patient Assisted Travel Scheme (PATS) payment. The complainant's request for assistance had been declined and the complainant was seeking clarification of the eligibility criteria. As part of the investigation, the process for reviewing exemption applications was considered.

Outcomes:

- Applications for exemptions are now reviewed by the Executive Director. Where there is a requirement for clinical clarification in order to determine eligibility, the Director of Clinical Services is consulted.
- The letter provided to applicants who do not meet the eligibility criteria has been revised and provides specific information related to their individual circumstance.
- These improvements have enabled increased ability to meet the needs of the regional community and improved how information is provided by the health service on concerns related to PATS.

The distribution of Access complaint issues throughout the health services is different to the distribution of QCC complaint issues (figures 3.6 and 3.7). There was a notable 'spike' in Access complaint issues recorded by SMAHS in 2006-07 (n=437; +22% from 2005-06). The number of Access complaint issues recorded at WACHS was relatively stable over the three years. This is in contrast to the pattern for aggregate complaint data at WACHS, which displays a notable 'dip' for the middle year 2006-07.

Also notable is the relative prominence of Access complaint issues for the DHS, especially in 2007-08 (n=197). It should be noted that the DHS recorded a noticeable increase of complaints related to Access in 2004-05 (n=140, +102%).

Figure 3.6 Number of Access complaint issues by health service

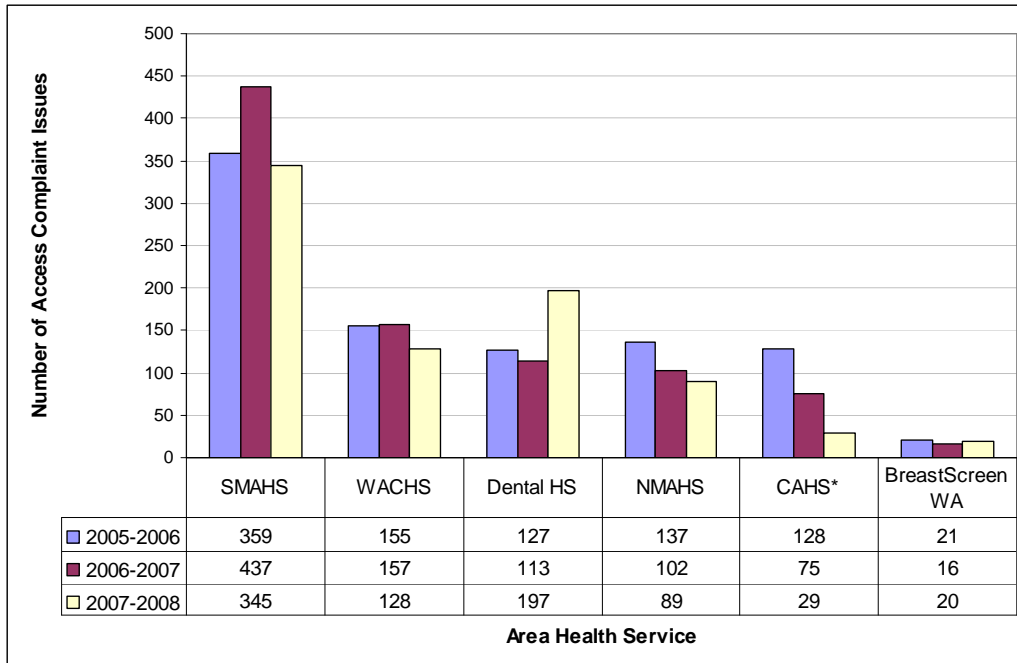
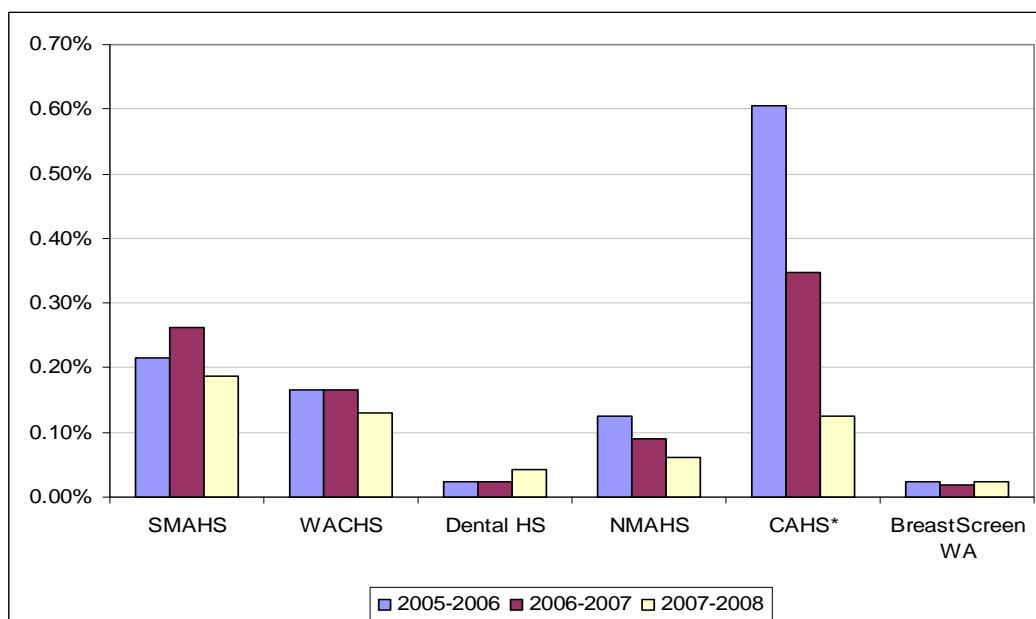


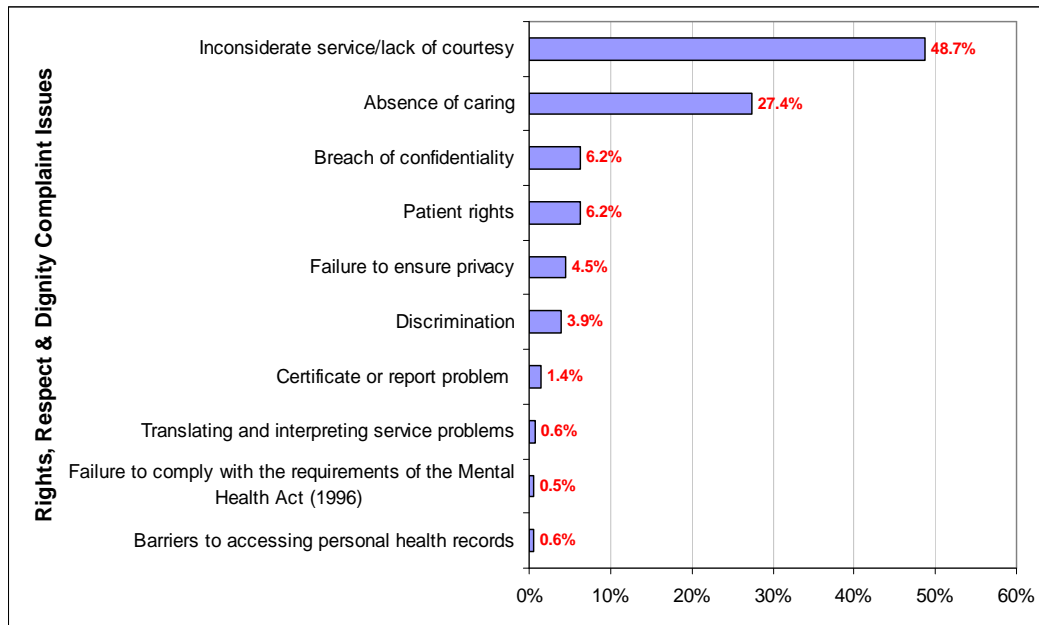
Figure 3.7 Access complaint issues as a percentage of total activity by health service



3.1.3 Rights, Respect and Dignity

The *Rights, Respect and Dignity* (RRD) category refers to health care consumers' legislated human and health care rights.⁷ Complaints falling under one of the ten complaint issues within this category comprised the third highest number recorded over the three years, constituting approximately 18 per cent of the total complaint issues. The total number of RRD complaint issues recorded over the three years was 2,328 with a range of 753 to 803 complaints per year.

Figure 3.8 Proportion of *Rights, Respect and Dignity* complaint issues (2005 – 2008)



Case Study:

'Mary' complained that a male doctor had not offered her a gown and had stayed in the room when he asked her to undress. She complied but felt intimidated and thought that the behaviour was inappropriate.

The matter was referred to the Victorian Medical Practitioners Board for investigation.

Outcome:

The doctor was counselled on the need to respect patients' privacy and on ways in which he can make them feel more comfortable in situations where they need to undress.

Office of the Health Services Commissioner (Victoria) Annual Report 2007

As displayed in figures 3.9 and 3.10, the pattern of complaints relating to RRD across the health services is similar to the distribution of the aggregate complaint data. For CAHS there was an increase in 2007-08 from the previous year, both in total numbers and as a proportion of activity (2005-06=82 or 0.39%; 2006-07=46 or 0.21%; 2007-08=57 or 0.25%). This is in contrast to the overall downward trend in complaint issues recorded at that health service.

Figure 3.9 Number of *Rights, Respect and Dignity* complaint issues by health service

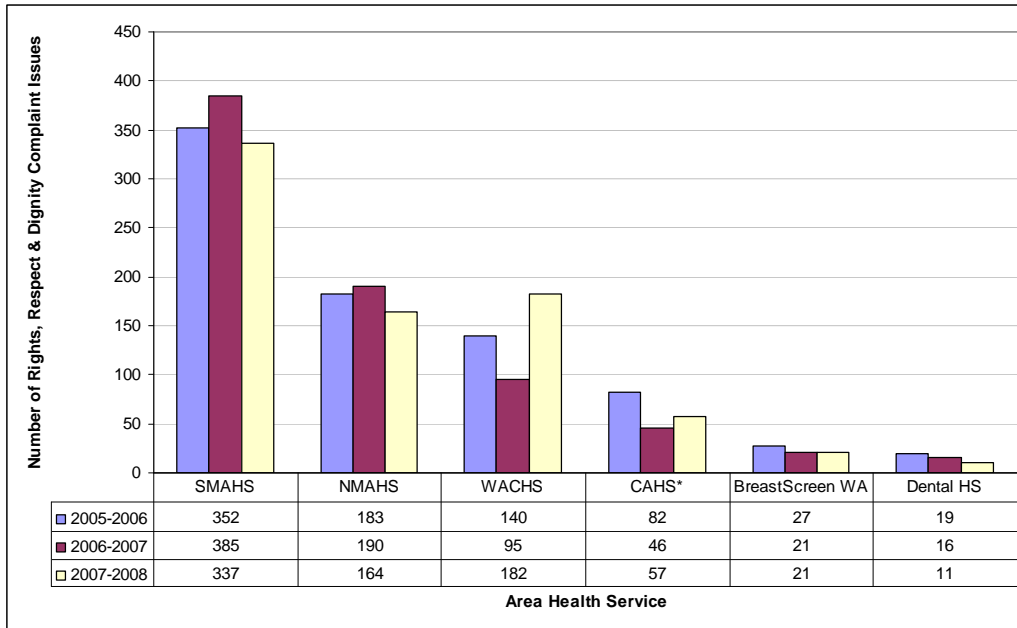
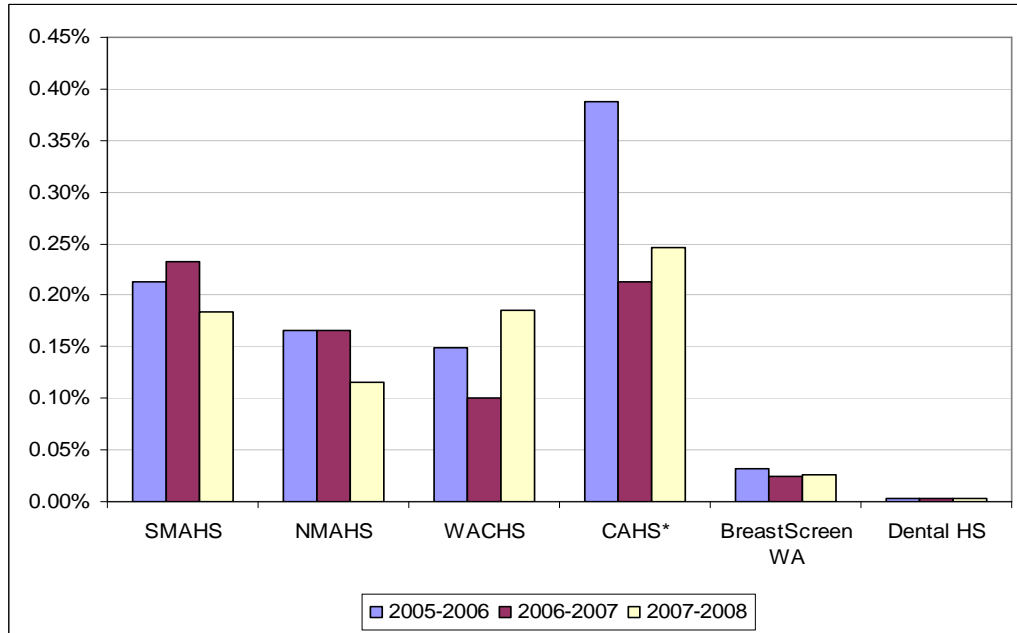


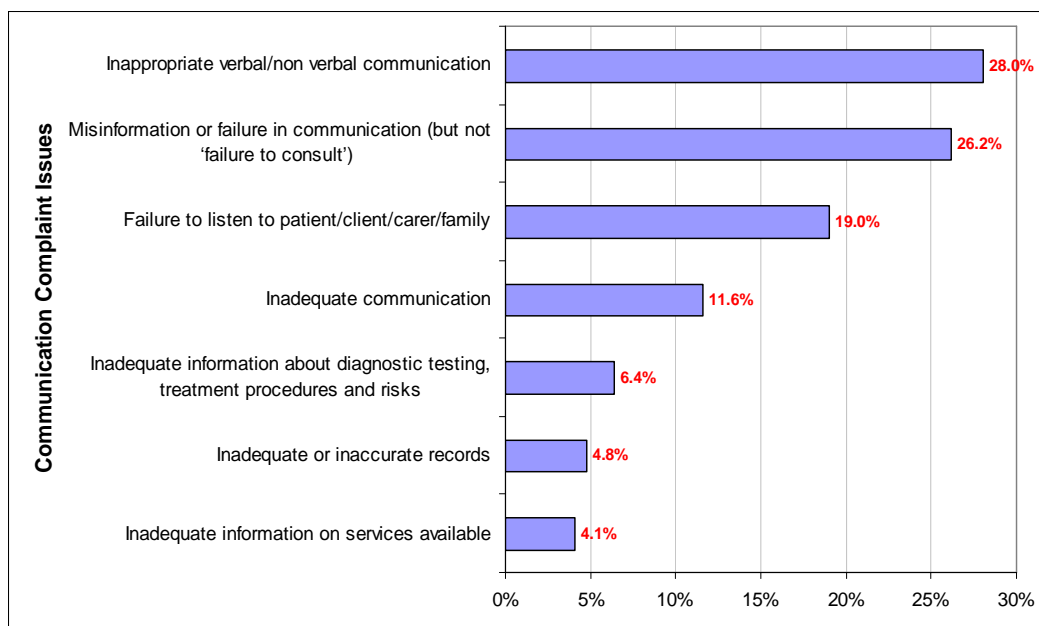
Figure 3.10 *Rights, Respect and Dignity* complaint issues as a percentage of total activity by health service



3.1.4 Communication

Communication refers to the quality and quantity of information provided about treatment, risks and outcomes, and is comprised of seven complaint issues. *Communication* was the fourth most common category over the three years with approximately 17% of all complaint issues recorded. The three year total for *Communication* complaint issues was 2,324 with a range of 706 and 758 complaint issues per year.

Figure 3.11 Proportion of *Communication* complaint issues (2005-2008)



The distribution of *Communication* complaint issues by health service shows more year-to-year variability and inconsistency compared to trends in the total complaint issue numbers (figures 3.12 and 3.13). SMAHS displays a downward trend in *Communication* complaint issue numbers and rates over the three years examined, whereas NMAHS shows a sharp increase in 2006-07.

Communication complaint issues recorded in CAHS rose in 2007-08 in contrast to the downward trend in aggregate data at CAHS. This increase is especially evident in Figure 3.13 which presents numbers as a proportion of activity (2005-06=103 or 0.49%; 2006-07=63 or 0.29%; 2007-08=188 or 0.81%). This figure also highlights the relatively high number of *Communication* complaint issues recorded as a proportion of activity at CAHS in comparison to the other complaint categories and the other health services.

Figure 3.12 Number of *Communication* complaint issues by health service

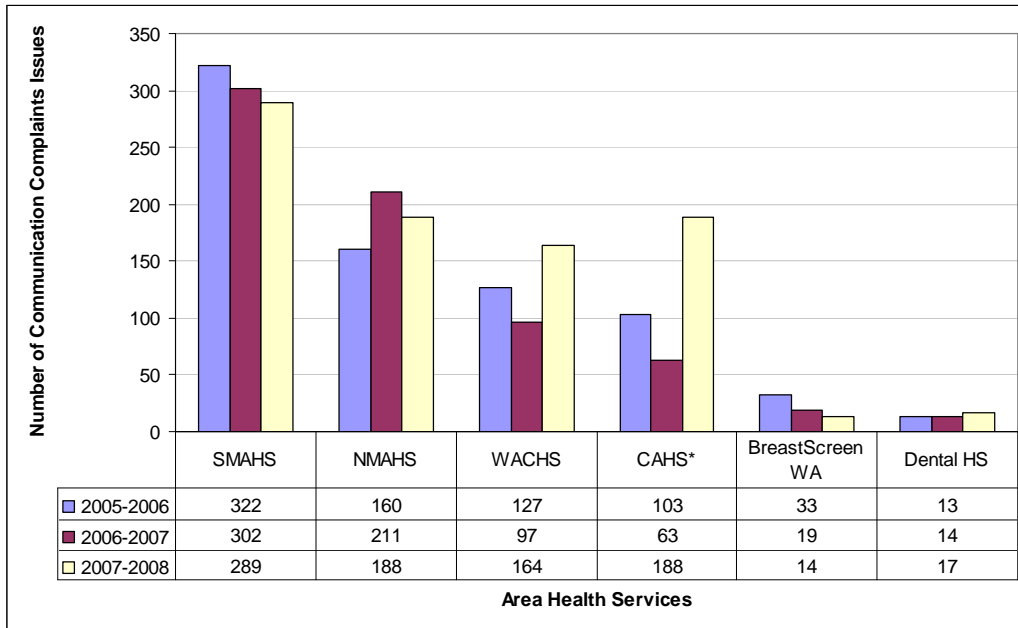
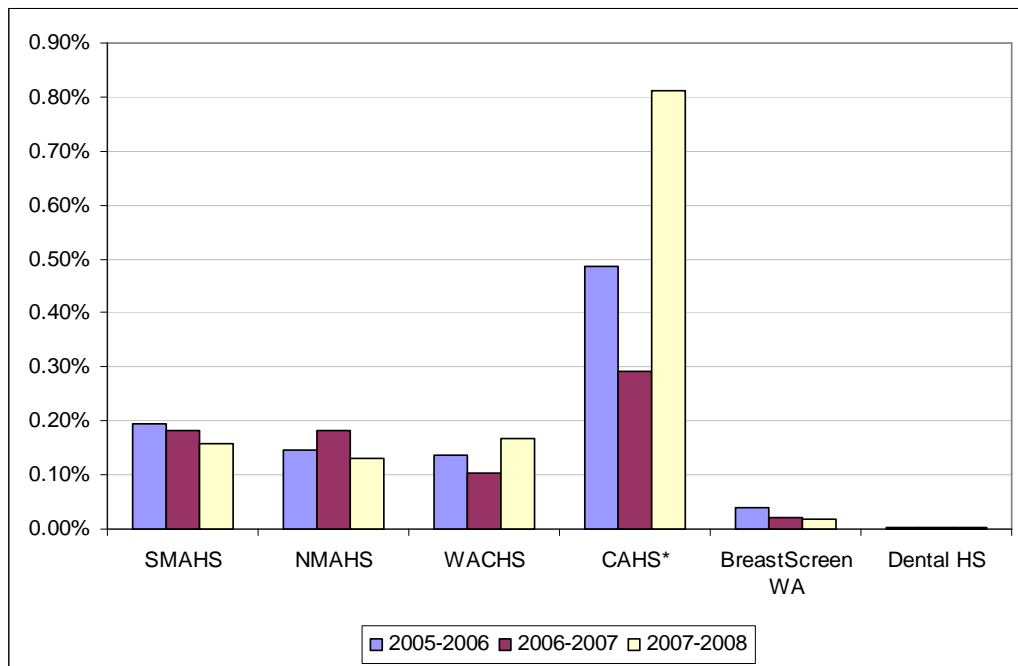


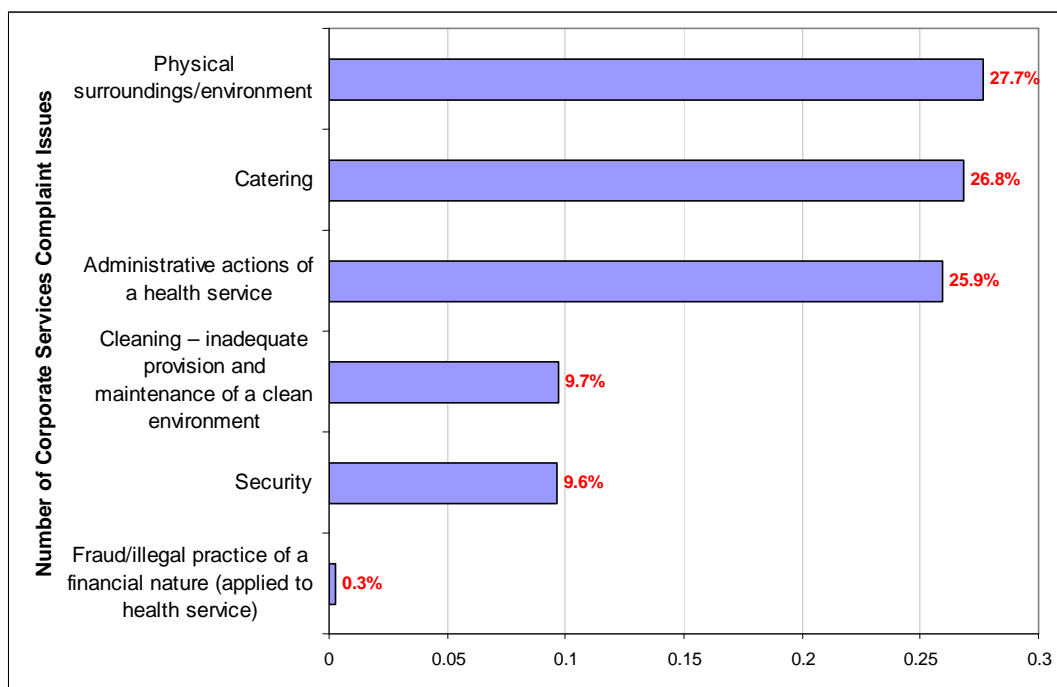
Figure 3.13 *Communication* complaint issues as a percentage of total activity by health service



3.1.5 Corporate Services

Corporate Services (CS) refers to factors such as the physical / environmental surroundings, administrative actions taken by a health service, catering and security. It is made up of six complaint issues. This was the fifth most common category with a relatively small total number of complaint issues recorded (791 over the three years with between 235 and 291 complaint issues per year). It comprises approximately 6 per cent of total complaint issues recorded in WA Health.

Figure 3.14 Proportion of *Corporate Service* complaint issues (2005-2008)



The distribution of CS complaints issues throughout the health services is displayed in figures 3.15 and 3.16. The downward trend in overall complaint issues recorded at CAHS is particularly evident in this category, especially when viewed as a proportion of activity. WACHS recorded the highest number of CS complaint issues in this category as a proportion of activity over the three years examined, except for 2005-06 where the rate at CAHS was slightly higher (2005-06=0.115% at WACHS & 0.123% at CAHS; 2006-07=0.075% at WACHS; 2007-08=0.097% at WACHS).

Figure 3.15 Number of Corporate Services complaint issues by health service

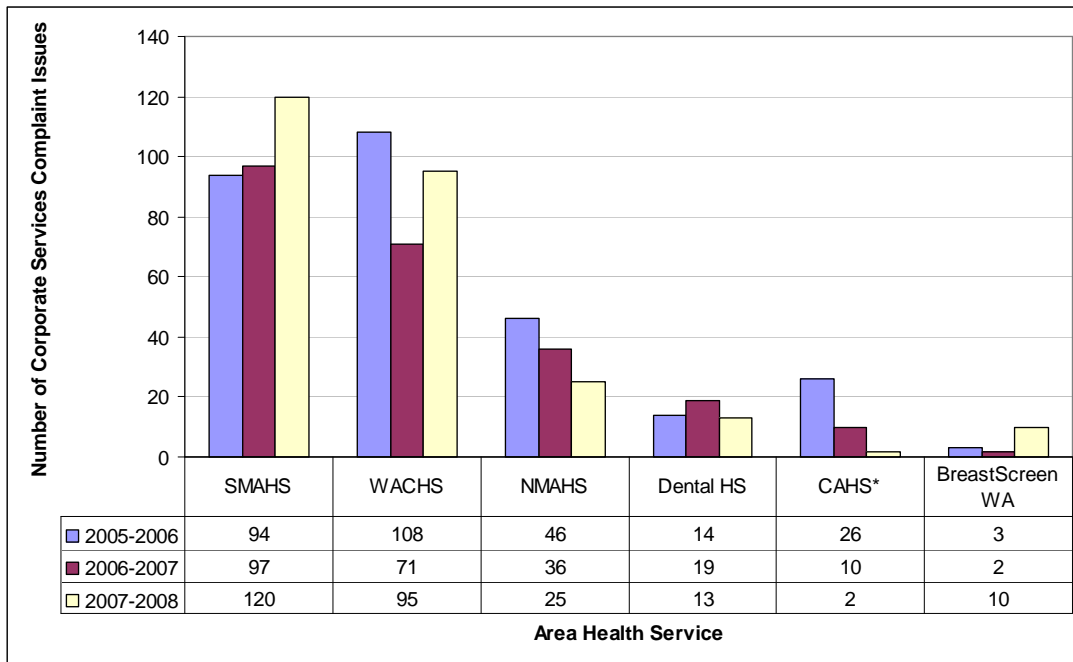
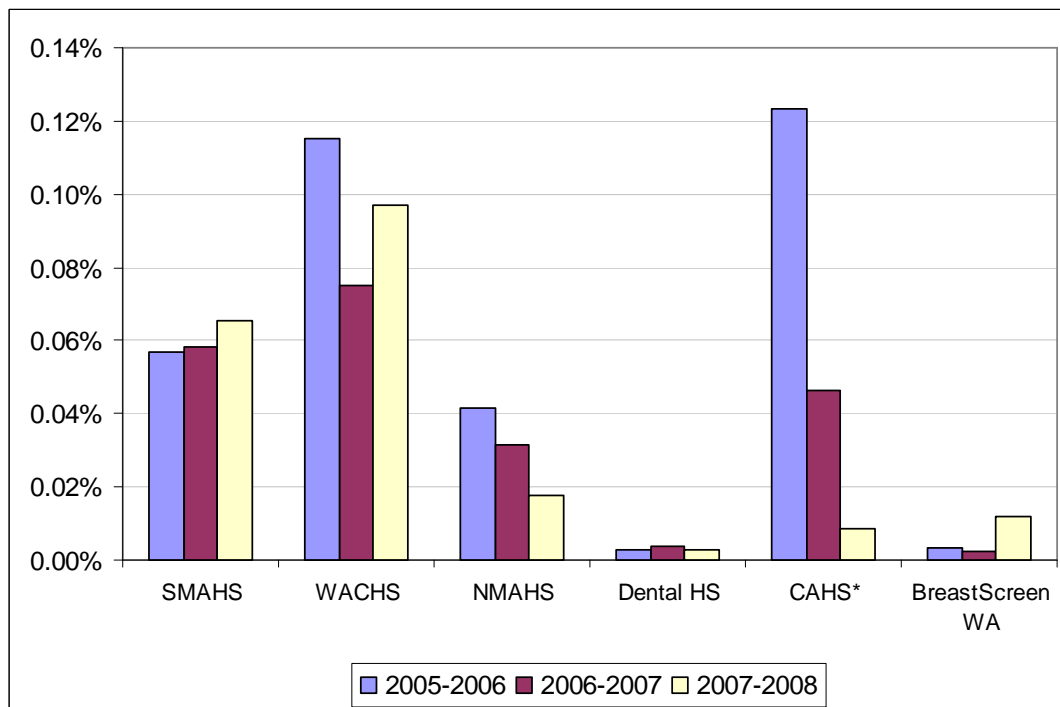


Figure 3.16 Corporate Services complaint issues as a percentage of total activity by health service



3.1.6 Costs; Professional Conduct; Decision Making; Grievances

Each of the remaining four complaint categories (*Costs, Professional Conduct, Decision Making, Grievances*) accounted for less than 5 per cent of total complaint issues recorded over the three years examined. No trends in the system-wide data were identified for these categories.

Case Study:

'Lisa's 3 month old daughter has a chronic illness and was being treated in hospital for infection. After staying in the hospital for nearly a week, Lisa had left the hospital for the first time to collect personal belongings. When Lisa returned she found her baby on the floor crying after falling out of her pram. Lisa felt disregarded by nurses when she complained. Lisa did not accept the hospital's apology, or action taken after an incident report was made and improvements identified.

Although a doctor examined her baby and found no injuries, Lisa felt that the fall should not have happened. She also felt that staff had a racist attitude towards her. Lisa no longer felt confident that she could trust the hospital staff to care for her baby.

Outcome:

A meeting was arranged with hospital staff to address Lisa's concerns and to restore her trust so that she would feel confident when she needed to use the hospital's services again. This also included making sure that an Aboriginal Liaison Officer would be contacted if Lisa or her baby were admitted.

Health and Community Complaints Commissioner (South Australia), Annual Report 2006/07

3.2 Complaints by Health Service

"I challenge all service providers to see good complaints handling as one way to improve the safety and quality of their services." Leena Sudano, Health and Community Services Complaints Commissioner (Queensland), Annual Report 2006/07

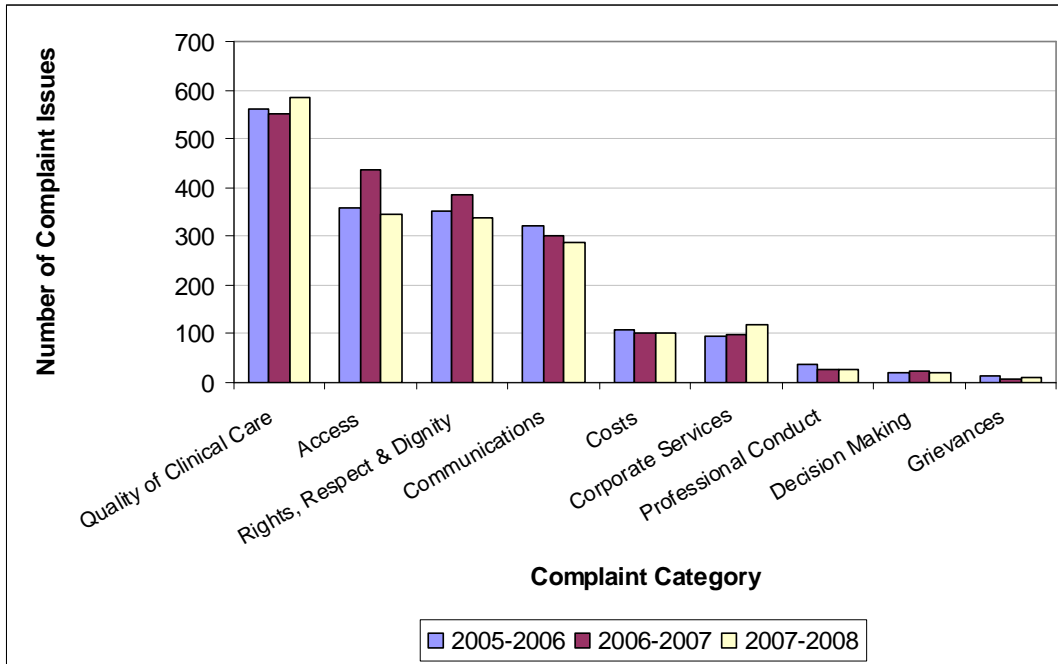
It should be noted that data on the number of separations and occasions of service for individual hospitals are not available. Complaint issue rates can therefore not be calculated and comparisons between differences in complaint numbers both within and across hospitals have not been made. However, it may not necessarily be instructive to compare hospitals with one another (see footnote, page 12).

3.2.1 South Metropolitan Area Health Service (SMAHS)

General trends in the complaint data at SMAHS were discussed in Section 2. Overall, the total number of complaint issues recorded at SMAHS was relatively stable, with a variation of just over 5 per cent (around the mean figure) over the three years examined (2005-06=1866; 2006-07=1932; 2007-08=1834).

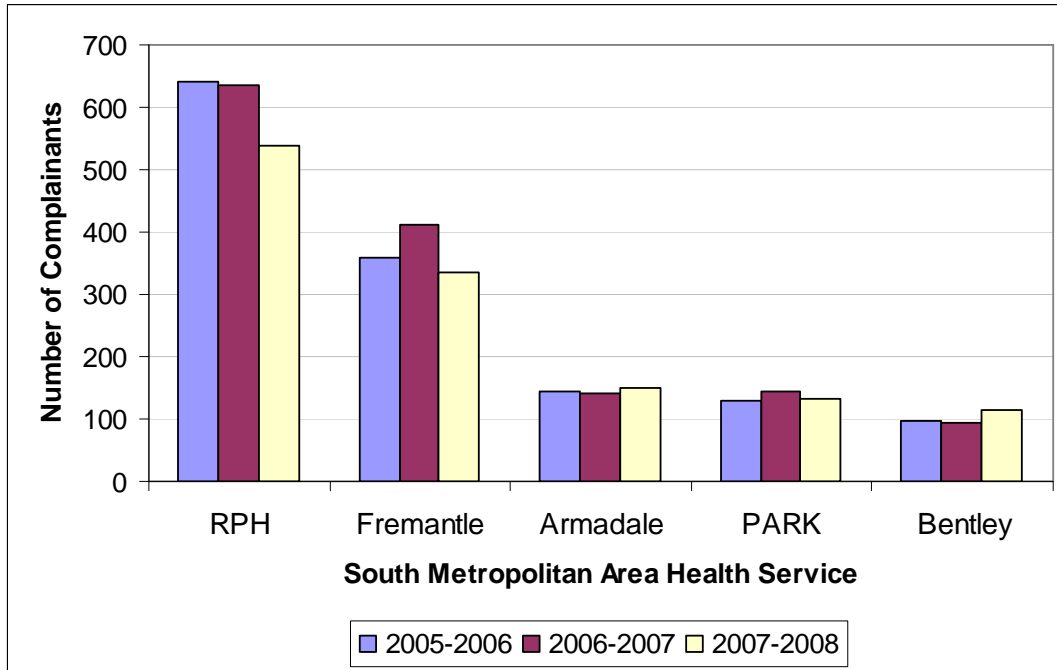
Figure 3.17 demonstrates that the distribution of complaint issues among complaint categories at SMAHS reflected aggregate trends. The exception is the *Costs* category, which was more prominent in SMAHS and recorded the same total number of complaint issues as the *Corporate Services* category over the three years examined (n=311). In the year 2006-07, there was a notable increase in complaint issues recorded under *Access* (n=437; +21.7%) and, to a lesser extent, *Rights, Respect and Dignity* (n=385; +9.3%) at SMAHS.

Figure 3.17 Number of complaint issues by complaint category (SMAHS)



The number of complaint issues by hospital at SMAHS over the three years is displayed in Figure 3.18.

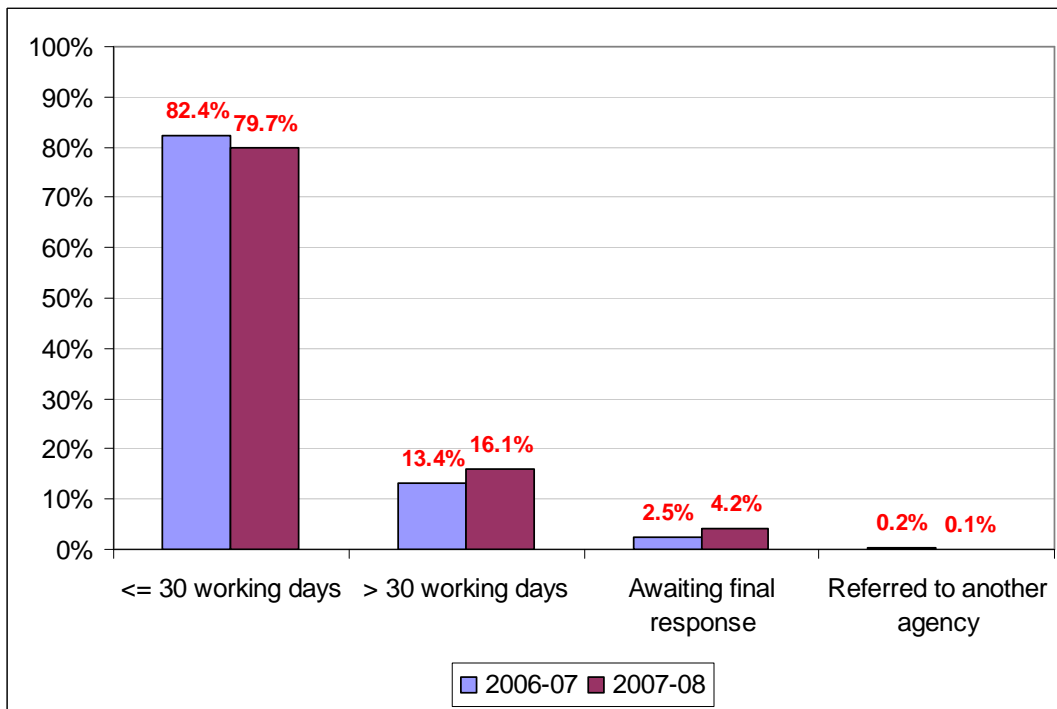
Figure 3.18 Number of complaint issues by hospital (SMAHS)



* PARK - Peel and Rockingham Kwinana Health Service

Complaint resolution rates at SMAHS were similar to system-wide rates, with approximately 80% of complaints resolved within 30 working days (Figure 3.19).

Figure 3.19 Timeliness of response to complaints 2006-07 and 2007-08 (SMAHS)*



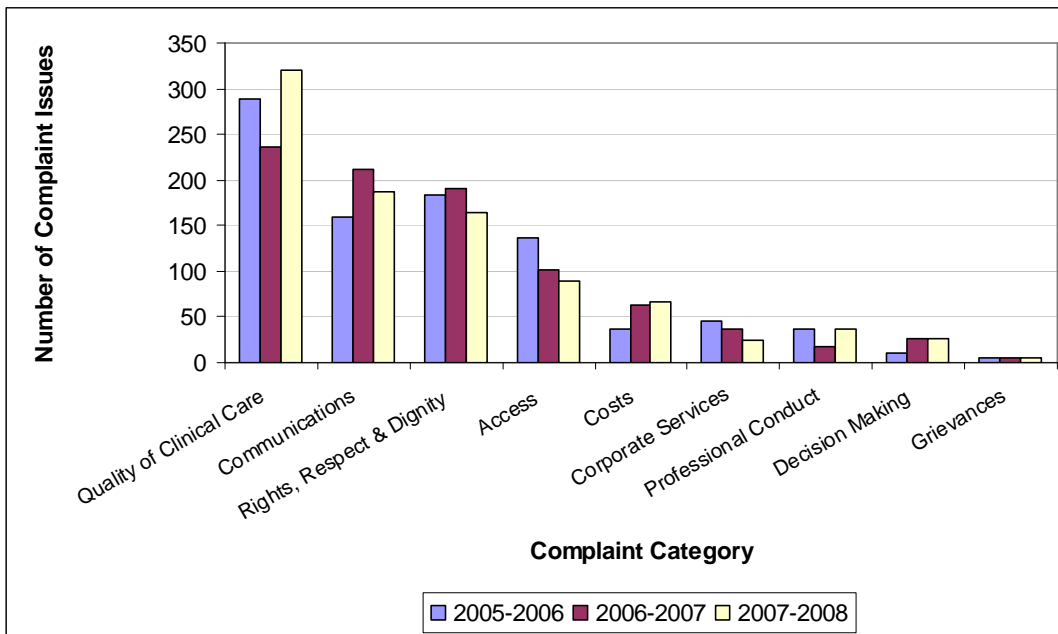
* Complaint resolution data provided by health services for 2005-06 were inconsistent and have been omitted.

3.2.2 North Metropolitan Area Health Service (NMAHS)

As outlined in Section 2, NMAHS has displayed a steady decline in complaint issues as a proportion of activity over the three years examined (see Figure 2.4). This trend may be notable because data for the latter two years (2006-07 and 2007-08) include KEMH (although it should be remembered that this amalgamation would also have an associated increase in total activity).

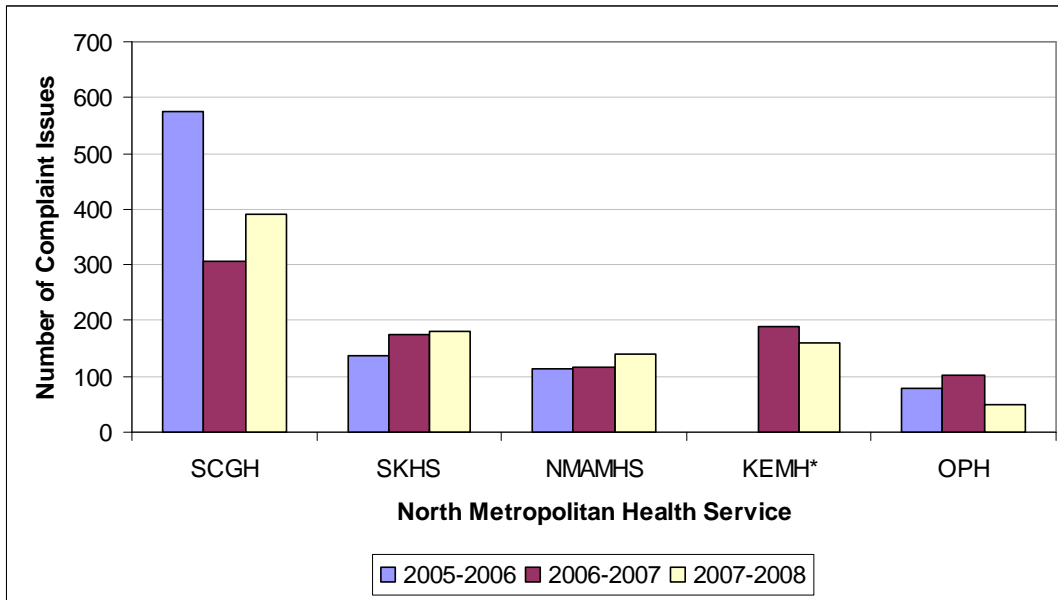
Figure 3.20 displays that the distribution of complaint issues by complaint category at NMAHS, which generally reflects the aggregate pattern across WA Health. There was a relatively higher proportion of *Communication* and fewer *Access* complaint issues recorded at NMAHS over the three years compared to system-wide data. The *Access* category also displayed a downward trend over the three years (2005-06=137; 2006-07=102; 2007-08=89). Complaint issues recorded under *Costs* were proportionally higher at NMAHS than in the system-wide data (2005-06=4%; 2006-07=7.1%; 2007-08=7.3%)

Figure 3.20 Number of complaint issues by complaint category (NMAHS)



The number of complaint issues recorded at each NMAHS hospital / health service are shown in Figure 3.21

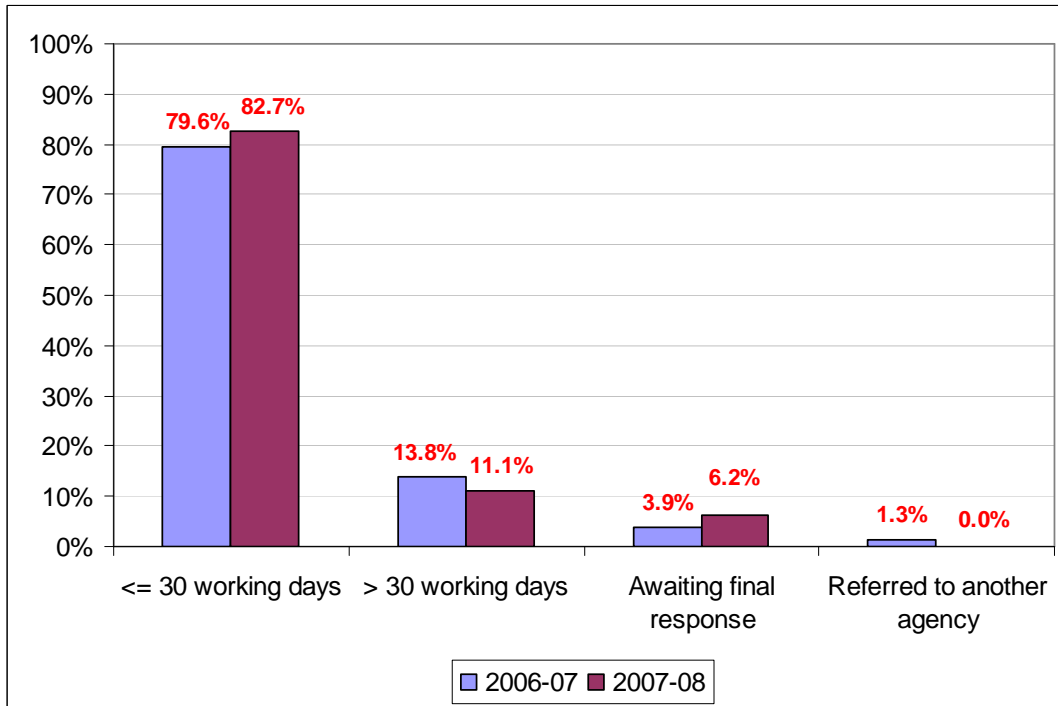
Figure 3.21 Number of complaint issues by hospital (NMAHS)



* KEMH was part of Women's and Children's Health Service in 2005-06

Complaint resolution times for the NMAHS reflect system-wide data, with the majority (approximately 80%) of final responses sent to complainants within 30 working days (Figure 3.22).

Figure 3.22 Timeliness of response to complaints 2006-07 and 2007-08 (NMAHS)**



** Complaint resolution data provided by health services for 2005-06 were inconsistent and have been omitted.

3.2.3 WA Country Health Service (WACHS)

As outlined in Section 2, the number of complaint issues recorded by WACHS fluctuated over the three years examined. This pattern is reflected in Figure 3.23, which displays complaint issues recorded at WACHS by complaint category. The exception is for *Access* complaint issues, which increased slightly in 2006-07 (2005-06=155; 2006-07=157; 2007-08=128). As mentioned in section 3.1, WACHS recorded more *Corporate Services* complaint issues as a proportion of the total (10-13%) when compared to the system-wide data (6.2-6.6%) over the three years.

Figure 3.23 Number of complaint issues by complaint category (WACHS)

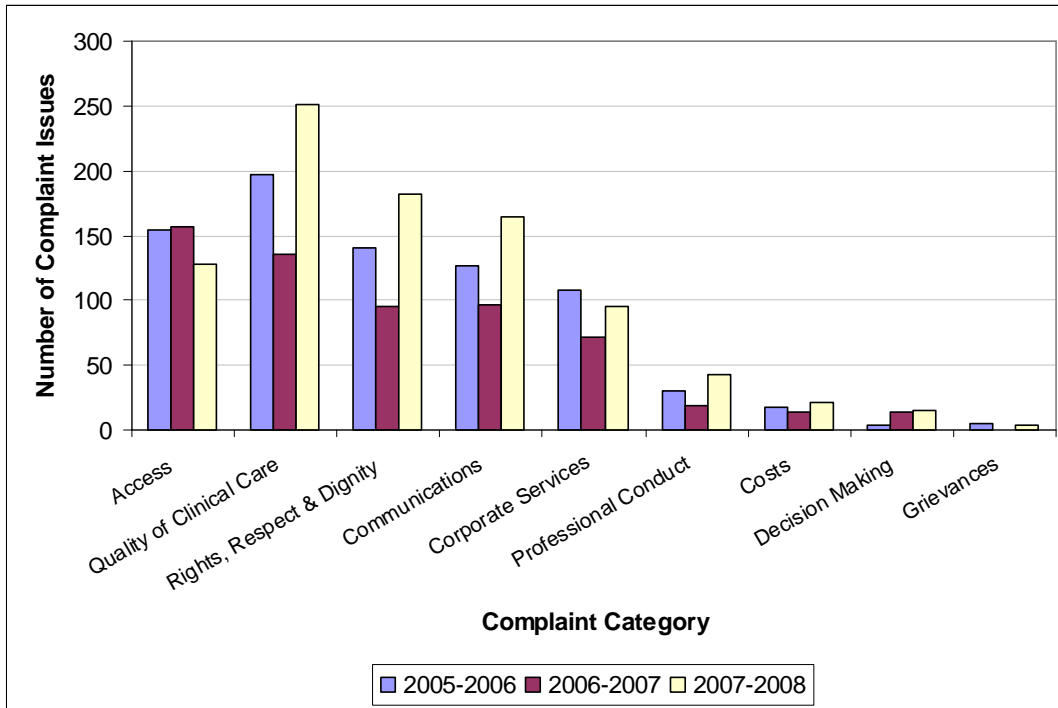


Figure 3.24 displays the total number of complaint issues by WACHS region, which reflects the fluctuations observed in the overall data for this health service. Complaint issues in the Kimberley more than doubled over the three year period (2005-06=16, 2006-07=37, 2007-08=40). However, as indicated earlier, information on activity was not available at the regional level making it difficult to draw conclusions from these data.

As displayed in Figure 3.25, WACHS complaint resolution times deviate from the pattern exhibited in system-wide data. While more than half (64%) of complaints in WACHS were resolved within thirty working days, approximately 30 per cent required longer, and 12 per cent were awaiting final response at 30 June 2008. Less than 3 per cent were referred to an external agency.

Figure 3.24 Number of complaint issues by WACHS Region

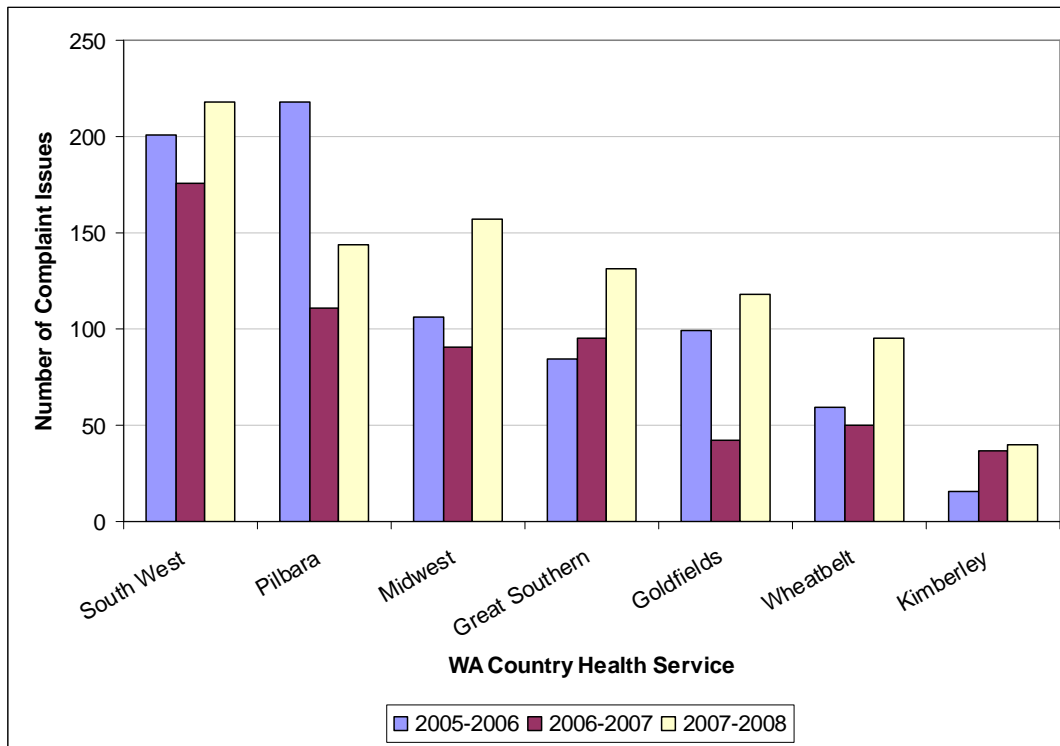
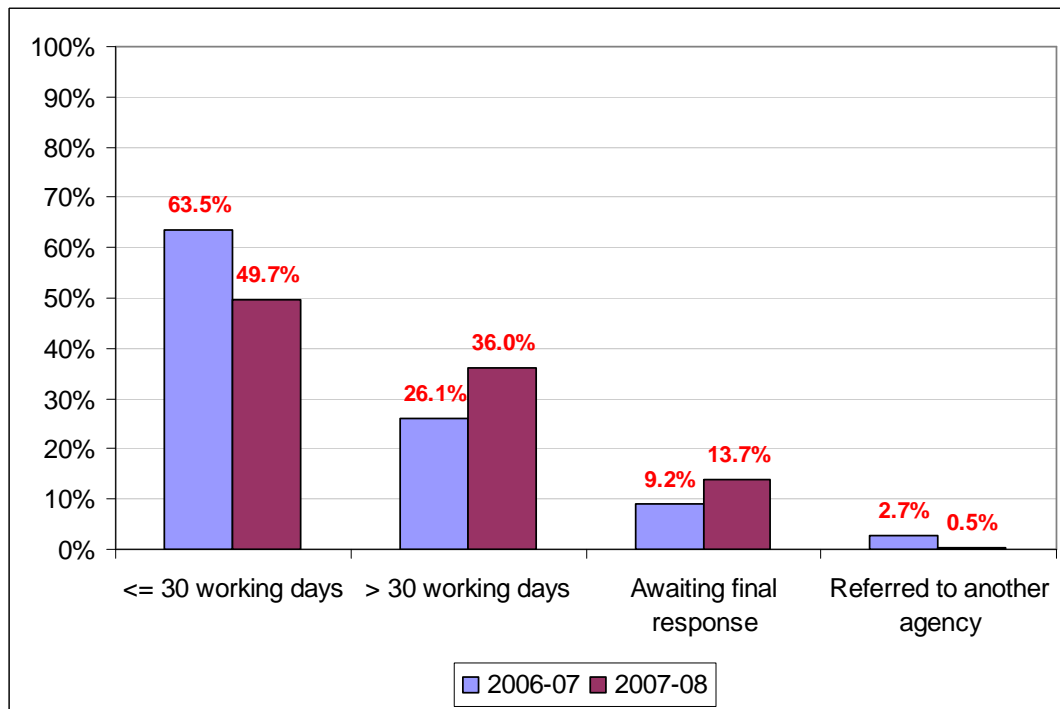


Figure 3.25 Timeliness of response to complaints 2006-07 and 2007-08 (WACHS)*



* Complaint resolution data provided by health services for 2005-06 were inconsistent and have been omitted.

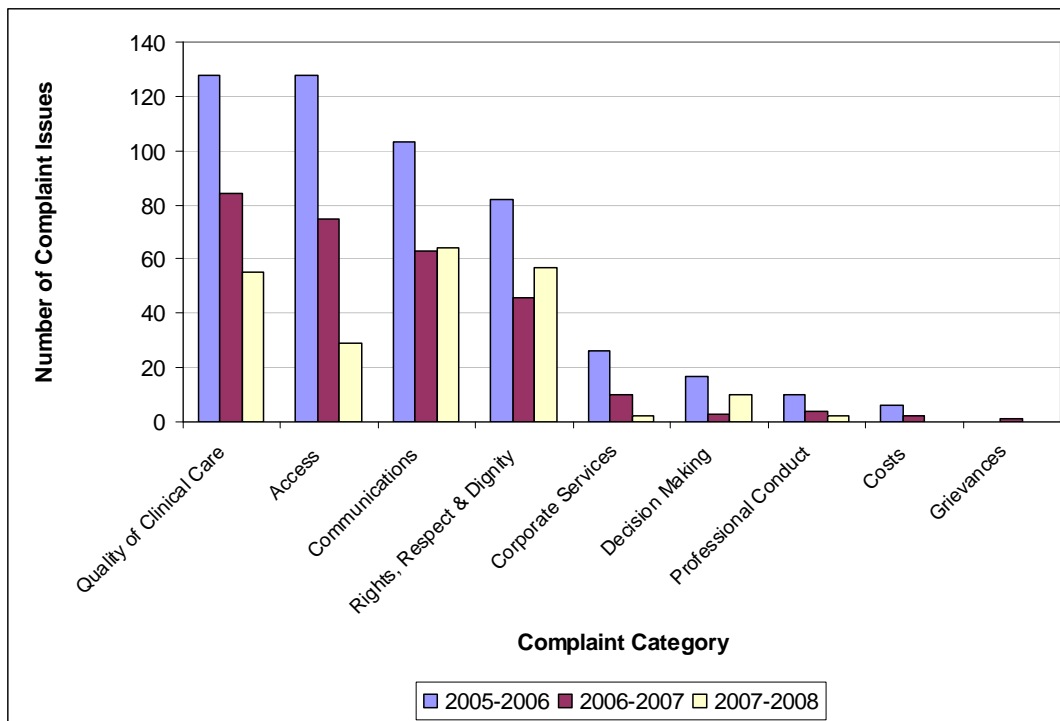
3.2.4 Child and Adolescent Health Service (CAHS)

As discussed in Section 2 and displayed in figures 2.3 and 2.4, complaint issues recorded at CAHS show a notable downward trend over the three years examined (2005-06=500; 2006-07=288; 2007-08=219). It should be noted that 2005-06 CAHS data include complaints recorded at KEMH, which was subsequently transferred to NMAHS for 2006-07 and 2007-08.

Examining CAHS data by complaint category (Figure 3.26) reveals a similar three-year trend in most categories, with the exception of *Communication* and *Rights, Respect and Dignity* where the proportion of complaint issues rose in 2007-08, especially for the latter (*Communication*: 2005-06=103 or 20.6%; 2006-07=63 or 21.9%; 2007-08=64 or 29.2%; *Rights, Respect and Dignity*: 2005-06=82 or 16.4%; 2006-07=46 or 16%; 2007-08=57 or 26%).

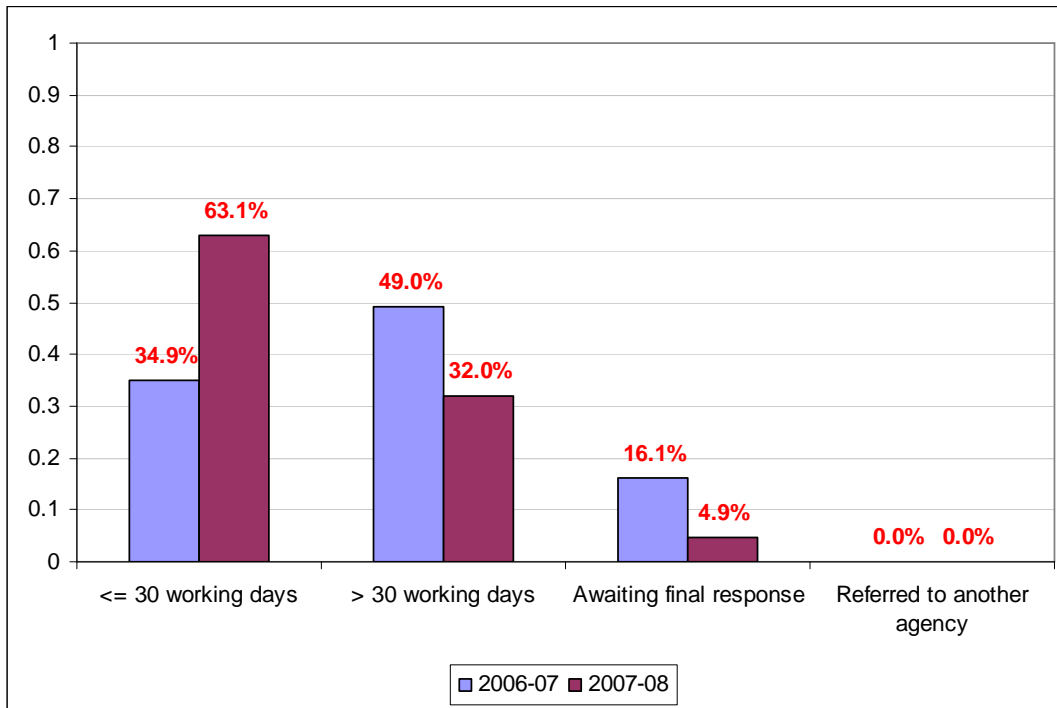
The number of complaint issues recorded against the top two categories of *Quality of Clinical Care* (QCC) and *Access* was similar in each of the three years, except for 2007-08 where approximately half as many *Access* complaint issues as QCC complaint issues were recorded (n=29 and n=55 respectively).

Figure 3.26 Number of complaint issues by complaint category (CAHS)



Complaint resolution data from CAHS indicate that in 2006-07, only 34.9% of complaints were resolved within thirty working days (Figure 3.27). This rose to 63.1% in 2007-08 (it should be noted that the total number of complaints recorded at CAHS was considerably lower that year). Consequent decreases in 2007-08 are evident in the number of complaints taking longer than thirty days to be resolved and still awaiting final response (32% and 4.9% respectively). No complaints were referred to an external agency at CAHS in either year.

Figure 3.27 Timeliness of response to complaints 2006-07 and 2007-08 (CAHS)*



* Complaint resolution data provided by health services for 2005-06 were inconsistent and have been omitted.

3.2.5 Dental Health Service (DHS)

The DHS is not disaggregated into regions or hospitals and is therefore analysed as one entity. As the figures in Section 2 do not represent trends at DHS adequately due to the relatively low aggregates, these data are re-illustrated in figures 3.28 and 3.29. The total number of complaints and complaint issues at the DHS has risen steadily over the three years examined (2005-06=252; 2006-07=264; 2006-07=331). This trend extends to the previous two financial years (2004-05 and 2003-04), where the total number of complaint issues recorded at the DHS were 239 and 174 respectively. A similar upward trend is evident in complaint issues as a proportion of activity over the three years (Figure 3.29).

Figure 3.28 Number of Complaints and Complaint Issues (DHS)

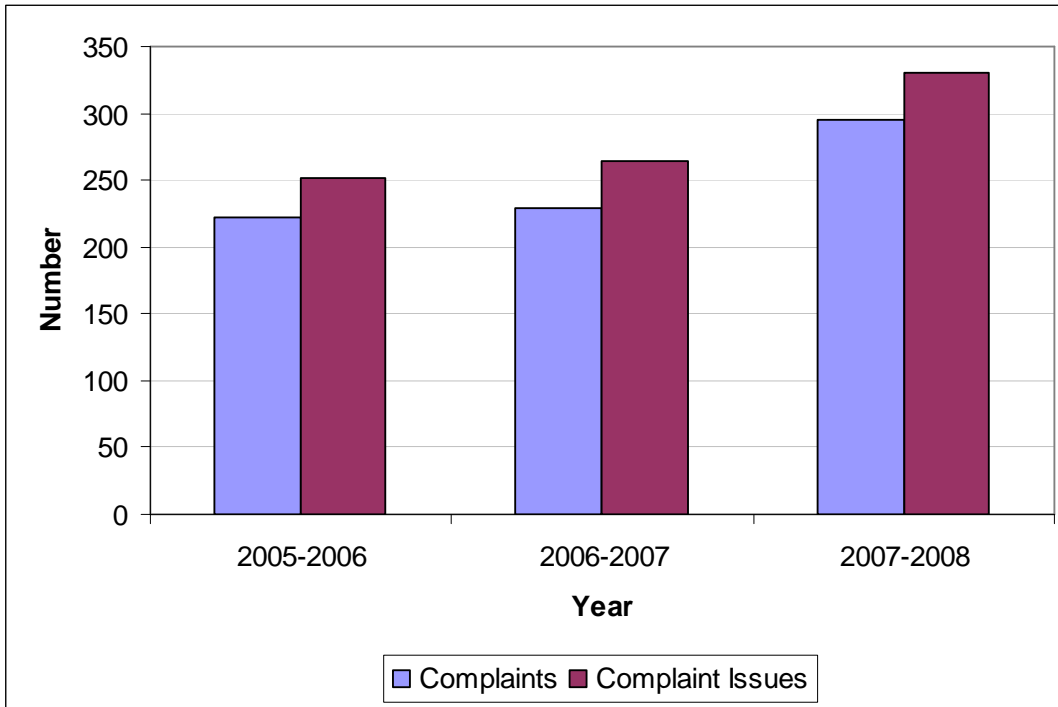


Figure 3.29 Number of complaint issues per 10,000 occasions of service (DHS)

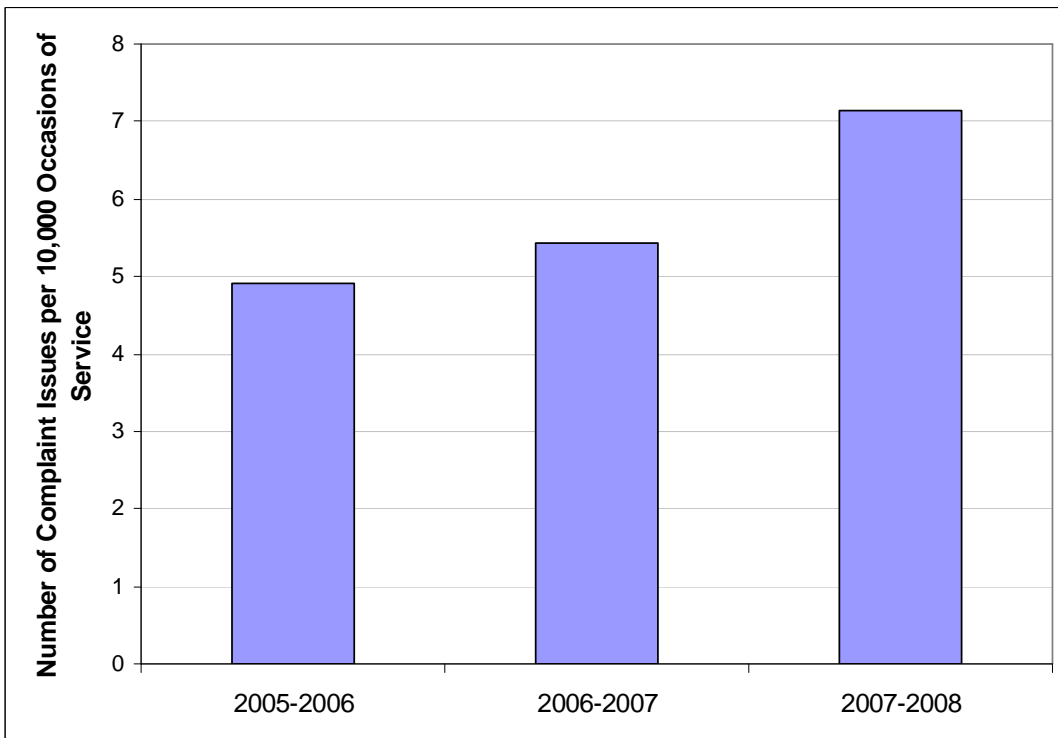
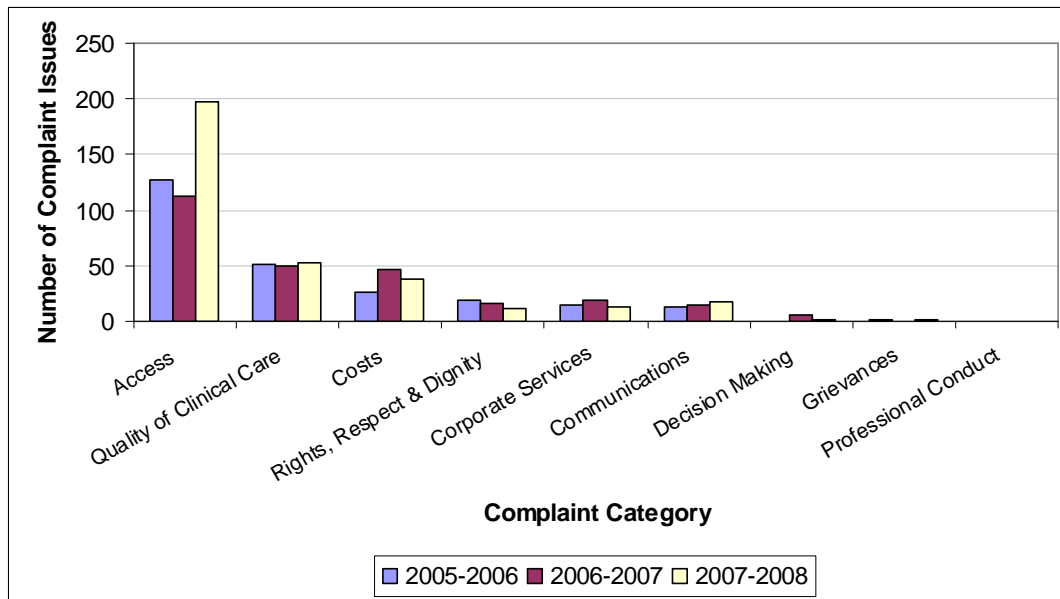


Figure 3.30 shows that the distribution of complaint issues among the complaint categories differs to the system-wide pattern. The majority of complaint issues at the DHS were recorded under the *Access* category, with a notable increase in 2007-08 (2005-06=127 or 50.4%; 2006-07=113 or 42.8%; 2007-08=197 or 59.5%). Within this category, the 'waiting list delay' was consistently the most frequently recorded complaint issue.

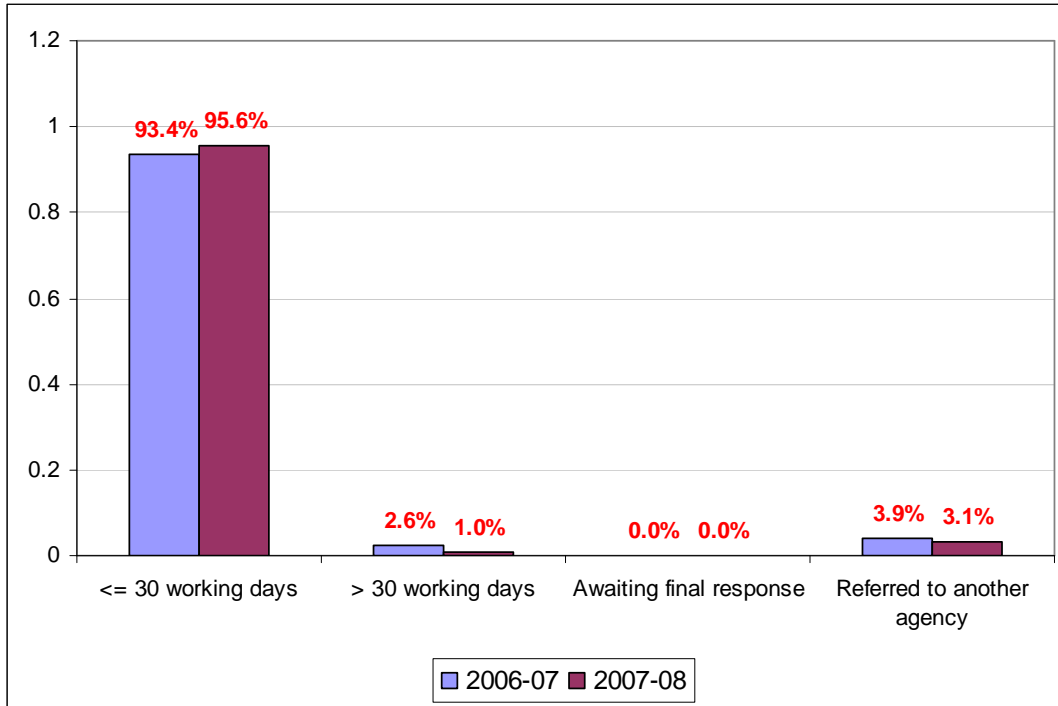
Quality of Clinical Care consistently accounted for approximately 20 per cent of complaint issues recorded by the DHS (2005-06=51; 2006-07=49; 2007-08=53), with the *Inadequate Treatment/Therapy* complaint issue making up approximately 70 per cent of these. Complaint issues in the *Costs* category varied from 10.7 to 17.8 per cent of all complaint issues recorded in the DHS. Each of the remaining complaint categories represented less than 8 per cent of the total.

Figure 3.30 Number of complaint issues by complaint category (DHS)



The majority (approximately 95%) of complaints in the DHS were consistently resolved within 30 working days (Figure 3.31). Approximately 3-4 per cent of complaints were referred to an external agency.

Figure 3.31: Timeliness of response to complaints 2006-07 and 2007-08 (DHS)*



* Complaint resolution data provided by health services for 2005-06 were inconsistent and have been omitted.

3.2.6 BreastScreen WA (BSWA)

BSWA is not disaggregated into regions or hospitals and is therefore analysed as one entity. As the figures in Section 2 do not display overall trends at BSWA adequately, these data are presented again in Figure 3.32. The number of complaints and complaint issues at BSWA was higher in 2005-06 (n=131) compared to 2006-07 (n=84) and 2007-08 (n=87). The number of complaint issues recorded in 2004-05 was 91, which may indicate that the 2005-06 data represent a 'spike' in an otherwise even pattern of total complaint issues recorded at BSWA. A reduction in complaint issues as a proportion of total activity was observed over the three years (Figure 3.33).

Figure 3.32 Number of complaints and complaint issues (BSWA)

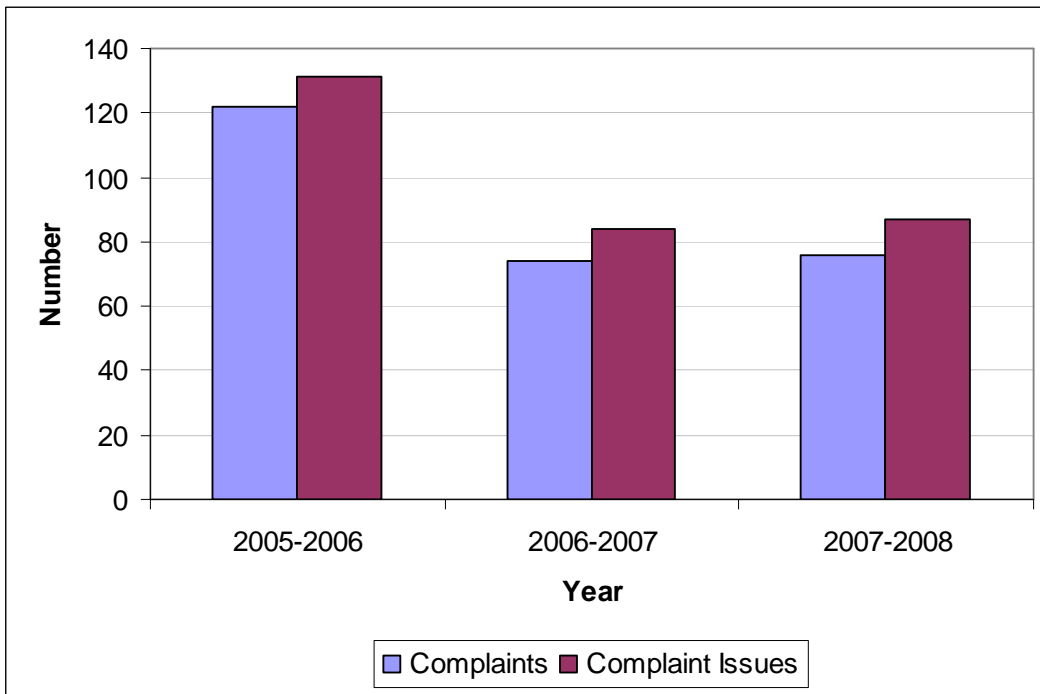
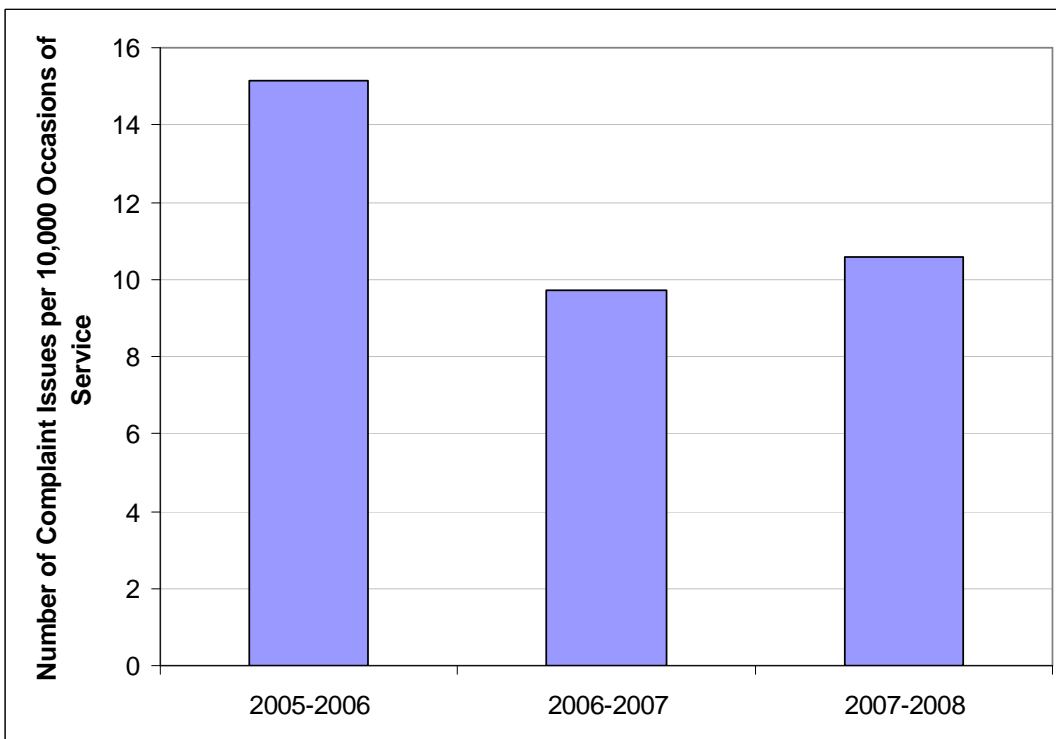


Figure 3.33 Number of complaint issues per 10,000 occasions of service (BSWA)



The distribution of complaint issues by category in BSWA is presented in Figure 3.34. The top three categories (*Quality of Clinical Care*, *Rights, Respect and Dignity* and *Communication*) all display a reduction from 2005-06 to the latter two years examined, reflecting the overall pattern of the BSWA complaint data.

Pain Issues was consistently the most numerous complaint issue recorded in the *Quality of Clinical Care* category (55-60%) over the three years. 'Inconsiderate service/lack of courtesy' was the complaint issue most often recorded in the *Rights, Respect and Dignity* category.

The *Communication* category exhibited a downward trend over the three years examined here. This was the top category for BSWA in 2004-05 with a total of 44 complaint issues recorded and demonstrates a consistent downward four year trend in *Communication* complaint issues at BSWA (2004-05=44; 2005-06=33; 2006-07=19; 2007-08=14).

Figure 3.34 Number of complaint issues by complaint category (BSWA)

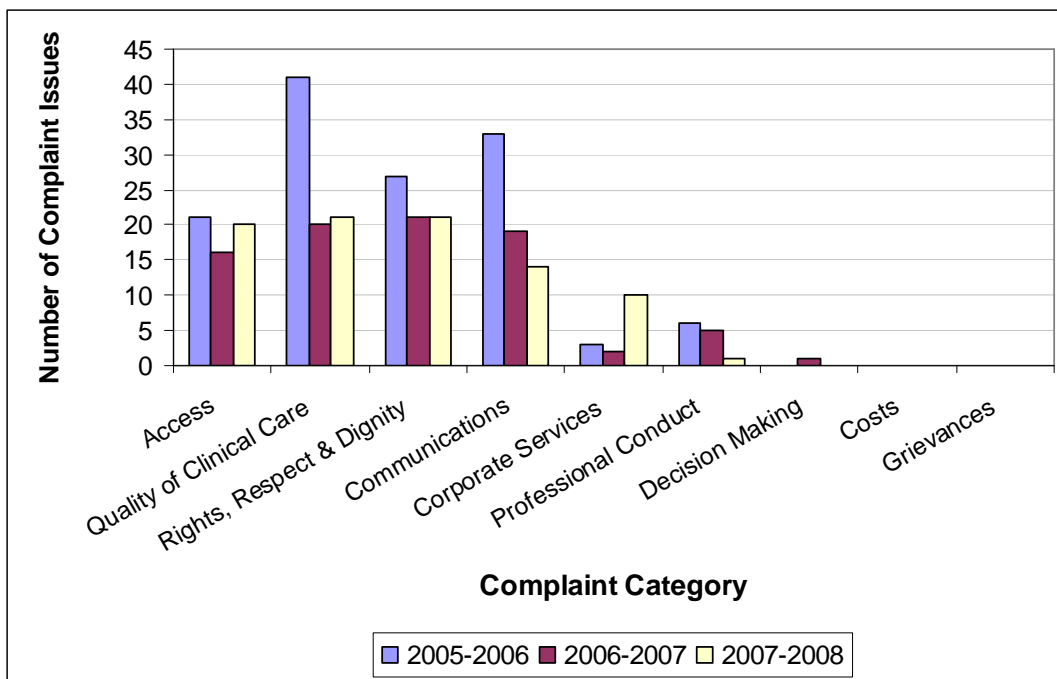
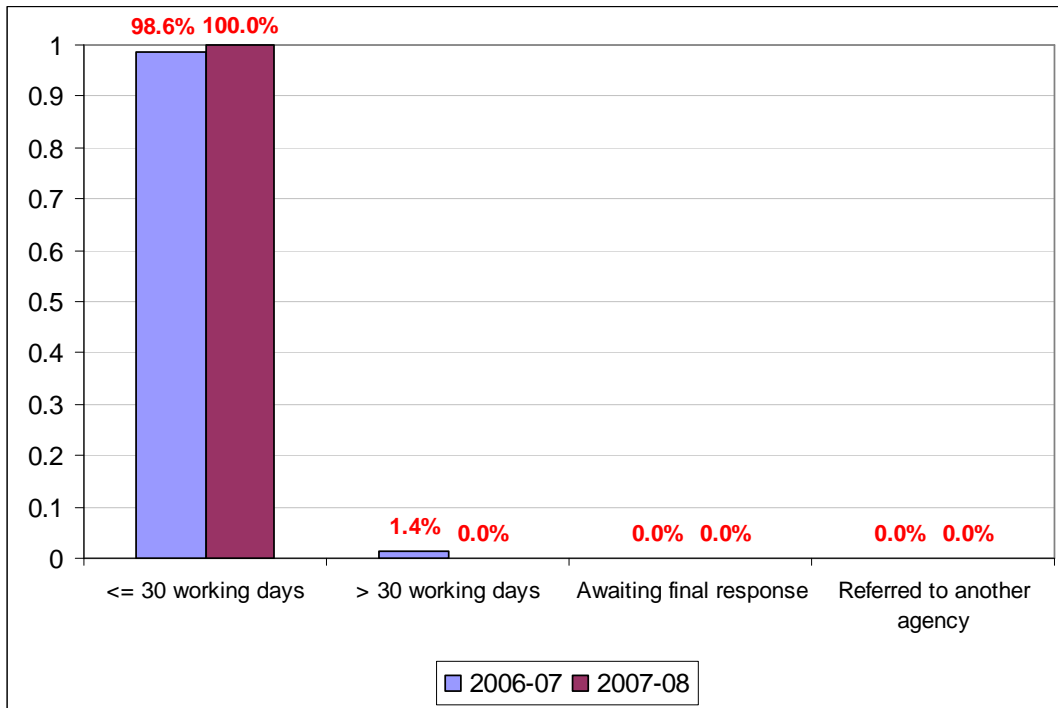


Figure 3.35 illustrates that virtually 100 per cent of complaints were resolved within 30 working days at BSWA in all three years examined.

Figure 3.35 Timeliness of response to complaints 2006-07 & 2007-08 (BSWA) *



* Complaint resolution data provided by health services for 2005-06 were inconsistent and have been omitted.

4. Conclusion

“Patient satisfaction correlates with improved medical compliance, decreased utilization of medical services, less malpractice litigation and greater willingness to return to the health service provider.”⁴

Comparing the rates of complaints and complaint issues recorded (as a proportion of activity) between health services should be approached with caution. There was a notable downward trend in the number of complaint issues recorded at Child and Adolescent Health Service (CAHS) over the three years. It should be noted that the composition of CAHS and the North Metropolitan Health Service (NMAHS) changed after the financial year 2005-06 due to the break-up of the Women’s and Children’s Health Service.

Complaint issue rates (complaint issues as a proportion of activity) at the South Metropolitan Area Health Service (SMAHS) remained fairly constant, while the WA Country Health Service (WACHS) displayed notable fluctuation in complaint issues over the three years. There was also a downward trend in the rate of complaint issues recorded over the three years at NMAHS (note King Edward Memorial Hospital complaint data was included in the latter two years but not the first).

The Dental Health Service (DHS) and BreastScreen WA (BSWA) displayed comparatively very low numbers and rates of complaint issues recorded.

Overall, the majority of complaints were consistently resolved within 30 working days of notification across the health services, in accordance with the *WA Complaint Management Policy*.^{8, 10} WACHS and CAHS displayed comparatively lower resolution rates within that timeframe. Internal processes within these health services may require review to ensure that complaints are resolved within this timeframe.

Analysis of the data collected from health services between 1 July 2005 and 30 June 2008 highlights the following points for review in future years.

1. All health services continue to focus on the quality of clinical care as this category consistently attracts the highest number of complaints. In particular, issues regarding inadequate therapy and assessment feature prominently in consumer complaints.
2. Health services need to review and address issues related to access, as it attracts a relatively high proportion of complaints from consumers (this is especially the case at the DHS).
3. WACHS and CAHS need to review compliance with the *WA Complaint Management Policy* with regard to timeliness of responding to complaints and complaint resolution.
4. Investigation of the reason for the dramatic reduction in complaints over the three years examined in this report at CAHS, including the sharing of the lessons learned and reasons for this trend.
5. Review CAHS processes and guidelines for communication with patients/carers/family.
6. DHS review and update policies and procedures regarding:
 - o management of waitlist delays

- admission to treatment
 - billing practices.
7. BSWA review:
- how consumer rights and dignity are protected
 - communication processes with patients/carers/family.

All health services are encouraged to continue to promote consumer, carer and community feedback and use complaint management as a legitimate mechanism for identifying systemic problems, managing risk and improving the quality of health services.

References

1. Australian Council for Safety and Quality in Health Care. **Complaints Management Handbook for Health Care Services**. 2005.
2. Cave J, Dacre J. Dealing with complaints. **BMJ**. 2008 Feb 9;336 (7639):326-8.
3. Bismark MM, Brennan TA, Paterson RJ, Davis PB, Studdert DM. Relationship between complaints and quality of care in New Zealand: a descriptive analysis of complainants and non-complainants following adverse events. **Quality and Safety in Health Care**. 2006 Feb;15(1):17-22.
4. Taylor BB, Marcantonio ER, Pagovich O, Carbo A, Bergmann M, Davis RB, et al. Do medical inpatients who report poor service quality experience more adverse events and medical errors? **Medical Care**. 2008 Feb;46(2):224-8.
5. Taylor DM, Wolfe RS, Cameron PA. Analysis of complaints lodged by patients attending Victorian hospitals, 1997-2001. **Medical Journal of Australia**. 2004 Jul 5;181(1):31-5.
6. Australian Council for Safety and Quality in Health Care. Open Disclosure Standard: A national standard for open communication in public and private hospitals, following an adverse event in health care 2003: Available from: www.safetyandquality.health.
7. Kachalia A. Disclosure of Medical Error. **Agency for Healthcare Research and Quality**. 2009; Perspective - January.
8. WA Department of Health. **Western Australian Complaint Management Policy: Driving Quality Improvement by effective Complaints Management**. In: Office of Safety and Quality in Healthcare, editor. Perth: Government of Western Australia; 2005.
9. WA Department of Health. **WA Open Disclosure Policy: Communication and Disclosure Requirements for Health Professionals Working in Western Australia**. In: Office of Safety and Quality in Healthcare, editor. Perth: Government of Western Australia; 2009.
10. WA Department of Health. **Western Australian Complaint Management Policy: Driving Quality Improvement by effective Complaints Management**. 2005.
11. WA Department of Health. **Clinical Risk Management Guidelines for Western Australian Health Services**. In: Office of Safety and Quality in Healthcare, editor. Perth: Government of Western Australia; 2005.

Appendix 1

Definitions

Complainant - A person (or organisation) that makes a complaint regarding any aspect of a service provided by a hospital/health service.

Complaint - an expression of dissatisfaction or concern by or on behalf of an individual patient or consumer with respect to any aspect of a service provided by a hospital/health service. A complaint can:

- be made verbally or in writing
- involve and include a number of complaint categories or complaint issues.

A complaint is considered resolved when all the complaint issues have been addressed and a final letter/ communication is sent to the complainant.

Complaint category - For complaint data collection to be compatible across a range of health services, nine complaint categories have been developed to assist in identifying common factors in complaints. See Appendix 2 for a list of complaint categories.

Complaint issue - Complaint categories are further subdivided into complaint issues, which aim to accurately identify and reflect the specific matters relating to each complaint. Complaint issues are the basic units of a complaint. The majority of data in this report is presented in terms of complaint issues as this more accurately reflects the specific matters raised in a complaint.³ See Appendix 2 for a list of complaint issues under each complaint category.

Clinical incident - an event or circumstance resulting from health care which could have, or did lead to unintended harm to a person, loss or damage, and/or a complaint. In the context of this definition, a 'person' includes a patient or client. Clinical incidents include:

- **near misses** – incidents that may have, but did not cause harm
- **adverse events** - an incident in which harm resulted to a person. Harm includes death, disease, injury, suffering and/or disability.¹¹

Occasions of service – units to measure activity in services where care does not require overnight stay in hospital (e.g. breast screening, dental care). Separations and occasions of service are used interchangeably throughout this report.

Separation – signifies the end of an episode of care (single or multi-day) and is a common unit to measure activity. Separations and occasions of service are used interchangeably throughout this report.

³ 'Complaints' as defined above are not referred to in this report as these may contain more than one topic or complaint issue. Complaint issues are thus used as a reporting 'unit' throughout this document.

Appendix 2

Complaint Categories and Respective Complaint Issues⁸

1. Access

Refers to availability of services in terms of location, waiting times and other constraints that limit the service

- 1.1 Delay in admission or treatment
- 1.2 Waiting list delay
- 1.3 Non-attendance
- 1.4 Inadequate resources/lack of service
- 1.5 Refusal to provide services
- 1.6 Failure to provide advice about transport options when necessary
- 1.7 Physical access/entry
- 1.8 Parking issues

2. Communication

Refers to the quality and quantity of information provided about treatment, risks and outcomes

- 2.1 Inadequate information about diagnostic testing, treatment options, alternative procedures and risks
- 2.2 Inadequate information on services available
- 2.3 Misinformation or failure in communication
- 2.4 Inadequate or inaccurate records
- 2.5 Inadequate communication
- 2.6 Inappropriate verbal/non verbal communication
- 2.7 Failure to listen to patient/client/carer/family/other

3. Decision making

Refers to the consultation with the patient/client in the decision making process

- 3.1 Failure to consult patient/client
- 3.2 Public/private choice
- 3.3 Consent not informed
- 3.4 Consent not obtained
- 3.5 Consent invalid

4. Quality of clinical care

Refers to assessment, diagnosis, planning, implementation and evaluation of clinical care by any health professional

- 4.1 Inadequate assessment
- 4.2 Inadequate treatment/therapy
- 4.3 Poor co-ordination of treatment
- 4.4 Failure to provide safe environment
- 4.5 Pain issues
- 4.6 Medication issues
- 4.7 Post surgery complications
- 4.8 Post procedure complications
- 4.9 Inadequate infection control
- 4.10 Patient's/client's test results not followed up
- 4.11 Discharge or transfer arrangements
- 4.12 Refusal to refer or assist to obtain a second opinion

5. Costs

Refers to issues about costs and fee structures

- 5.1 Inadequate information about costs

- 5.2 Unsatisfactory billing practice
- 5.3 Amount charged
- 5.4 Over-servicing
- 5.5 Private health insurance
- 5.6 Lost property
- 5.7 Responsibility for costs and resourcing

6. Rights, respect and dignity

Refers to the patient/client's legislated human and health care rights

- 6.1 Patient/client rights
- 6.2 Inconsiderate service/lack of courtesy
- 6.3 Absence of caring
- 6.4 Failure to ensure privacy
- 6.5 Breach of confidentiality
- 6.6 Discrimination
- 6.7 Failure to comply with the requirements of the *Mental Health Act (1996)*
- 6.8 Translating and interpreting service problems
- 6.9 Certificate or report problem
- 6.10 Barriers to accessing personal health records

7. Grievances

Refers to the individual's rights to have timely and fair management of complaint

- 7.1 Response to a complaint
- 7.2 Reprisal following a complaint

8. Corporate services

Corporate issues resulting in complaint

- 8.1 Administrative actions of a health service
- 8.2 Catering
- 8.3 Physical surroundings/environment
- 8.4 Security
- 8.5 Cleaning – inadequate provision and maintenance of a clean environment
- 8.6 Fraud/illegal practice of financial nature

9. Professional conduct

Refers to alleged unethical and alleged illegal practices

- 9.1 Inaccuracy of records
- 9.2 Illegal practices – any illegal practices e.g. abortion, sterilization or euthanasia
- 9.3 Physical or mental impairment of health professional
- 9.4 Sexual impropriety – behaviour that is sexually demeaning to a patient/client, including comments and gestures
- 9.5 Sexual misconduct
- 9.6 Aggression/assault
- 9.7 Unprofessional behaviour e.g. loud, noisy language, swearing, inappropriate comments or gestures

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