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Looking Back, Moving Forward: An Analysis of Complaints Submitted to a Canadian Tertiary Care Radiology Department and Lessons Learned

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Abstract

Purpose: We present an analysis of various types and strata of complaints received in a geographically isolated tertiary care center over a 2.5-year period.
Methods: Research ethics board approval was obtained. The institution described is a closed system with formalized procedures for submitting complaints. All complaints submitted between November 2010 and March 2013 were collected retrospectively. The following data were extracted: type of complainant, nature of the complaint, site or modality of concern, dates in question, and the response. The data were analysed in multiple subgroups and compared with patient and study volume data.
Results: The frequency of complaints equalled 0.01% (100/1,050,000). The largest group of those who submitted complaints were patients (69% [69/100]), followed by referring physicians (16%). Examination scheduling and interpersonal conflicts were equally of greatest frequency of concern (21% [21/100]), followed by issues with study reporting (16%). The average time interval between complaint submission and formal address was 15 days.
Conclusions: We present a low frequency of complaints, with the majority of these complaints submitted by patients; scheduling and personal interactions were most often involved. Effective communication, both with patients and referring physicians, was identified as a particular focus for improving satisfaction.

Résumé

Objectif : Nous avons analysé les plaintes qui ont été adressées à un centre de soins tertiaires situé dans une région isolée au cours d'une période de 2,5 ans, en nous penchant sur les divers types et domaines de plainte.
Méthodes : Le projet a été approuvé par le comité d'éthique de la recherche. L'établissement en question constitue un système fermé doté de procédures officielles visant la soumission des plaintes. De façon rétrospective, nous avons réuni toutes les plaintes reçues entre novembre 2010 et mars 2013. Nous en avons ensuite extrait les données suivantes : type de plaignant, nature de la plainte, partie du corps ou modalité visée par la plainte, dates et mesures prises à l'égard de la plainte. Enfin, nous avons analysé les données en les répartissant en de nombreux sous-groupes et en les comparant aux données sur les patients et les volumes d'examens.
Résultats : La fréquence des plaintes a été établie à 0,01 % (100/1 050 000). Les patients ont été les plus nombreux à déposer une plainte (69 % [69/100]), suivi des médecins traitants (16 %). Dans une proportion égale (21% [21/100]), la planification des examens et les conflits interpersonnels se sont avérés les motifs de plainte les plus souvent invoqués, suivis des problèmes liés aux rapports d'examens (16 %). Le délai moyen entre le dépôt de la plainte et la prise de mesures officielles était par ailleurs de 15 jours.
Conclusion : Nous avons relevé une fréquence de plaintes peu élevée. Dans la majorité des cas, les plaintes ont été déposées par des patients, le plus souvent pour des questions de planification des examens et d'interactions entre personnes. Nous avons déterminé qu'il y avait moyen d'améliorer la satisfaction en mettant l'accent sur une communication efficace avec les patients et les médecins traitants.
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Key Words: Quality assurance; Patient-centered care; Communication; Education

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Although radiology departments strive to provide excellent patient care and service to referring physicians, instances do occur in which members of these groups are dissatisfied with their encounters. Complaints submitted as a result of these interactions warrant consideration, both in terms of addressing concerns in a timely and appropriate manner as well as of representing a resource in the assessment of quality. With the shifting focus towards more patient-centered care, there is a need to understand what issues arise in terms of service. Through investigation of the nature of these complaints, one may establish the best areas to target to improve. We present a unique experience in a closed-loop system in which all individuals in a geographic area use a single institution and where there are specific, well-recognized legal avenues for each stakeholder to express concerns. What follows is an analysis of various types and strata of complaints received over a 2.5-year period.

Materials and Methods

Research ethics board approval was obtained. In our system, all tertiary care and most secondary care occur in 1 single institution that serves a geographic region of slightly more than 1 million individuals. In addition, there is a formal structure mandated to receive complaints. Complaints submitted by patients are directed through the hospital's Department of Patient Advocacy. This department is advertised at various locations within the hospital, including information desks and is readily identified on the institution's public Web site; contact can be made by telephone, fax, e-mail, or post. It is recommended to patients that they first discuss their concerns with the involved care team and/or member; if they are not satisfied or if they are uncomfortable doing this, a patient advocacy specialist will be involved to further investigate. Complaints from referring physicians and other employees are addressed directly to the radiology department chair or are funneled through the administrative director; both have their names, telephone numbers, and e-mail addresses listed within the hospital directory, and on the department Web site. This information is publicly available as well for patients who choose to contact them directly.

Methodology was informed by our local experience as well as the UK Royal College of Radiology's audit template collection [1]. All complaints submitted within the time period of November 2010 through March 2013 were collected retrospectively, as well as any correspondence related to these, before anonymization of patient information. The investigators then extracted from each submission the following data: the type of complainant, the nature of the complaint, the site or modality of concern (if specified), and the dates of the interaction in question and of the formal complaint submission. In addition, for those cases in which a response was documented, the nature and timing of this response was assessed as well.

After extraction, the data were analysed in reference to volume and referring clinician data, in multiple subgroups, to best identify relative importance, trends, and, consequently, areas on which to focus for greatest quality improvement. This included but was not limited to relative proportions of roles of those who submitted complaints, the frequency of different natures of complaints, and the intervals between initial submission and the complaint being addressed.

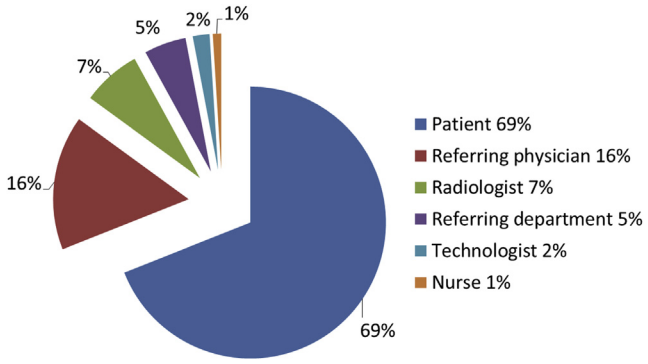

Figure 1. Distribution of complainant type.

Results

A total of 106 complaint submissions were available for initial evaluation. Four of these entries lacked sufficient information regarding complainant type and the nature of the complaint; 2 entries reflected duplication between databases. After exclusion of these entries, the final sample included 100 complaint submissions, the earliest from January 13, 2011, and the latest from March 14, 2013. Approximately 1,050,000 radiologic examinations were performed at the involved institution during the period of review; the frequency of complaint, therefore, was 0.01% (100/1,050,000).

Complainant Type

Complainant types are listed in Figure 1. The largest group of those submitting complaints were patients themselves, which represented 69% of entries (69/100); 62 of these were submitted through the Department of Patient Advocacy, 5 directly to the radiology department, 1 through a clinical manager, and 1 through an investigator (in the case of a serious adverse event). This group was followed by individual referring physicians (16%), radiologists from within the department (7%), referring departments (5%), technologists (2%), and, finally, 1 nurse (1%).

Nature of Complaint

The nature of complaints are listed in Figure 2. Examination scheduling and interpersonal conflicts were equally of greatest frequency of concern (21% of entries [21/100]). Subgroup analysis demonstrated that the largest proportion of complaints submitted by patients were related to interpersonal conflicts (27% [19/69]), whereas interpretation errors were the focus of those submitted by physicians (31% [5/16]). Further details on these categories follow, with demonstrative examples.

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