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Complaints in long-term care facilities for older persons: Why residents do not give ‘free advice’

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ABSTRACT

In health care policies, the right to complain is presented as a key patient right. Complaints are also seen as a potential vehicle for quality improvement. However, in long-term care facilities for older persons in the Netherlands, relatively few complaints are registered.

An explorative qualitative study was performed at three long-term care facilities to examine the ways in which different relevant actors define and relate to complaints. We conducted observations and semi-structured interviews with 76 persons: residents, their family members, nurses, volunteers, middle (facility) and upper (institutional) managers and complaint handling personnel.

Long-term care facilities are social contexts obeying complex social and cultural norms. There are great differences in how complaining and complaints are perceived. For most residents, ‘complaining’ had strong negative connotations: they expected it would lead to undesirable social consequences that could not outweigh possible advantages. To nurses it was important to hear of residents’ dissatisfactions but communicative aspects were challenging. Institutional managers saw complaints as ‘free advice’ they wished to use to enhance the quality of the care provision. Complaint managers underlined the procedural aspects to complaints.

A more appropriate and productive policy on complaints in this health care sector should take these differences into account.

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1. Introduction

According to Hirschman’s often quoted theory on voice and exit, unsatisfied consumers can choose to leave, or complain [1]. In long-term health care however, exit options are often quite limited. Therefore policy makers in many countries have tried to strengthen consumers’ position and enable them to voice their dissatisfaction directly

[2]. The right to complain is seen as a key right of patients. Within this legal perspective on complaints, most emphasis is placed on the complaints-handling aspects and redress strategies embedded in the ‘rule of law’ and ‘due process’ features of a citizen-oriented public administration [3]. The legal model is complemented by a managerial model that views complaint-handling as a way of retaining customers and as a form of organisational learning [4]. Complaints are thereby expected to act as a form of social regulation [5], and as instruments for improving the quality of care [6]. This results in an emphasis on registration systems and feedback loops [7]. Two different perspectives on complaints thus inform health care policy. On the one

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hand, complaints are seen as a central patients' right. On the other hand, complaints are seen as a way for consumers to use *voice* to exert power and thereby impact quality [1]. Several scholars have already pointed out that reality is more complex. Very few persons address their dissatisfactions through a complaint [8]. Formal complaints are not representative for how quality is perceived and should therefore be approached with caution [9,10] not only because complainants are not necessarily representative for all healthcare users, but also because some topics are more likely to get complaints, than others [11]. It has also been found that what complainants expect and what is achieved by submitting a complaint may differ greatly [12,13].

In the Netherlands, a law guaranteeing the right to complain has been in place since 1995. In long-term care facilities for older persons, however, relatively few complaints are registered. This is noteworthy since this specific care sector is not rated more positively by patients than other sectors. If anything, it is a sector that tends to have a negative image in public opinion and media coverage.

It is important to understand why so few complaints are filed in this health care sector. If complaints are seen as a quality indicator, low numbers could signal satisfied health consumers. On the other hand, if complaints are seen as a form of public involvement or consumer power, low numbers of complaints could be a signal of problematic power structures. Finally, from a legal perspective, low numbers of complaints might indicate that complaint procedures are inaccessible. From both of these latter perspectives, low numbers of complaints may be worrisome.

The question is however whether these perspectives are also shared by the different actors who actually make up the context for complaints. There is a need to understand complaints from the perspective of the patients themselves. Most research in the health care sector takes policy paradigms as a starting point and focuses on complaint handling in hospitals [14]. From this research we have learned that complainants primarily want a validation of their complaint, an explanation, an apology and the promise of change [15,16]. However, most of this research focuses on patients who have already filed a complaint, not on all potential complainers.

Research into voiced dissatisfaction is complicated by definitional problems. These definitional problems become especially acute when the focus shifts towards the perspective of patients. Legal definitions of complaints or definitions used in policy making do not necessarily match the patients' definitions. This difficulty in researching and recording dissatisfaction has been emphasised by others [17]. Expressions of dissatisfaction can be dynamic, fluid and responsive and are difficult to record, classify or interpret [18]. Unvoiced dissatisfaction is, by definition, even more difficult to observe [19]. Various authors have demonstrated that dissatisfaction and satisfaction are not necessarily opposite ends of the same continuum but form distinct phenomena. Thus, the non-expression of dissatisfaction cannot be equated with the expression of satisfaction [20–22].

The possible variation in how complaints are conceptualised makes it important to explicitly research definitional

questions, especially when dealing with low numbers of 'official' complaints. In this article we report on research performed on the different perspectives on complaints in three facilities for long-term care for older persons in the Netherlands. We explore possible reasons for the low number of registered complaints. Thereby we investigate the perspectives of the different actors that make up the social context of long-term care facilities to see whether the policy perspectives are shared in practice.

2. Methods

Explorative research was conducted in three facilities in the Netherlands during the second half of 2012. In total, thirteen facilities were approached and ten declined. The most often mentioned reason for refusal was the number of studies the facilities were already involved in and the strain this was putting on their staff. The three facilities that did respond were located in different regions, rural and urban. Two of the facilities were 'care homes' in which residents were assisted and basic care was provided and one facility was a 'nursing home'. Residents in this facility were much more dependent on (medical) care and assistance in daily life. All three facilities were part of a larger institution including ten to twenty other facilities, and they were visited by two researchers over the course of four to six days. In order to avoid selection-bias, two selected facilities had a relatively positive (upper 20%) and one had a relatively negative (lowest 20%) ranking on a Dutch quality-information site. During the visits, the researchers approached possible respondents in public places like a restaurant, café or waiting area and used the snowball method.

It is important to underline that the focus of this study was on residents, not on complainants. Most research on complaints is conducted among officially registered complainants and records their expectations and experiences. However, since so few residents actually file complaints, the focus of this research was much broader. In Dutch, the word 'klager' can mean 'complainer' as well as 'complainant'. It can thus have the negative connotation of a person who whines, or complains a lot, and the more formalistic and neutral meaning of a person who has issued a formal complaint. Although the same word is used, we found that different persons attached different meanings. Therefore, in translation both words are used.

The main research methods in this study were observations and interviews. Observations were used to document interactions and experience the accessibility of formal and informal complaint handling procedures. Interviews were conducted in all three facilities with different actors in these settings. In total, 28 residents, 8 family members, 16 nurses, 5 middle managers (at the facility), 3 upper managers (from the organisation) and 3 complaint handling managers were interviewed. In every facility, a selection of other persons was also interviewed such as a priest, receptionists, volunteers, a hairdresser and a physiotherapist. In total 76 persons were interviewed in the course of 68 interviews, as some interviews involved multiple respondents. The interviews were semi-structured and informed by scholarly literature. Standard topics of conversation included attitudes towards complaints and complainers,

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