**Submission No 66**

# INQUIRY INTO COMPLAINTS HANDLING WITHIN NSW HEALTH


**Organisation**: NSW Heath Department

**Name**: Ms Robyn Kruk

**Position**: Director General

**Telephone**: (02) 9391 9328


**Date Received**: 16/03/2004

---

**Subject**:

**Summary** Contact: Leanne Wallace

# Submission to the Legislative Council Standing Committee Inquiry into Complaints Handling Procedures within NSW Health

NSW HEALTH
Working as a Team

March 2004

# 1. Introduction

## 1.1 Terms of Reference of Inquiry

General Purpose Standing Committee No. 2 is to inquire into and report upon the complaints handling procedures within NSW Health, and in particular:

- the culture of learning and the willingness to share information about errors and the failure of systems, and
- an assessment of whether the system encourages open and active discussion and improvement in clinical care.

NSW Health has made significant progress in recent years in handling complaints. The system to identify the root causes of incidents and workable solutions introduced since late 2002, and the positive response to this from doctors and nurses, set us clearly on the path that best practice in handling complaints prescribes.

NSW Health is now seeking to build on these developments: to build a culture of trust where there is greater openness about mistakes - a health service where there is good communication between all involved in a complaint; where the correct procedures for managing complaints from staff are followed; where *all* incidents are carefully examined and sound solutions implemented, and where safety for patients is the first priority.

This submission sets out NSW Health's achievements in handling complaints. It also explores the challenges NSW Health is currently facing.

This submission should be read in conjunction with the background paper *Complaints Handling Procedures and the Quality Agenda in the NSW Health System,* (the 'background paper') which provides an overview of the current complaints handling procedures within NSW Health.

## 1.2 Definitions

Outlined below are definitions for the key terms used in the submission, referenced where a reference is available.

| | |
|---|---|
| 'Complaint' | An expression of dissatisfaction by a complainant.[i] The complainant can be a consumer (a patient, their family, a member of the broader public) or staff. |
| 'Complaints handling' | The structures, guidelines and procedures that are used to report and respond to complaints. |
| 'Incident' | Any unplanned event resulting in, or with the potential to result in, death, injury, ill health, damage or other loss.[ii] |
| 'Adverse event' | An unintended injury or complication which results in disability, death or prolonged hospital stay and is caused by health care management.[iii] |
| 'Grievance' | A personal complaint or difficulty about a work related issue that affects a staff member and that he/she considers to be discriminatory, unfair or unjustified.[iv] |

| | |
|---|---|
| 'Culture of learning' | The promotion, support and engagement of professional development and continuing education. |
| 'Failure of systems' | Consequence, often delayed, of technical design and organisational decisions. They relate to the design and construction of a system, the structure of an organisation, planning and scheduling, training and selection, budgeting and allocating resources. The adverse effects of these decisions may lie dormant for a very long time.[v] |
| 'Health Service' | The 17 metropolitan and rural Area Health Services, Corrections Health, the NSW Ambulance Service and the New Children's Hospital (the background paper explains the role of each of these bodies). |

## 1.3 Scope of the submission

The submission covers each of the terms of reference of the inquiry in the following way:

- 'Complaints handling' relates to the structures, guidelines and procedures that assist and support Health Services, staff and the public to identify, report and respond to all incidents.
- 'Culture of learning' relates to the promotion, support and engagement of professional development and continuing education initiatives within health services targeted at ensuring patient safety and minimising incidents.
- 'Willingness to share information about errors and failures of systems' relates to the capacity and protection provided to Health Services, staff and the public to engage in constructive dialogue regarding incidents.
- 'Assessment of whether the system encourages open and active discussion and improvement in clinical care' relates to the effectiveness of responses to incidents and the impact of solutions implemented.

This submission deals with issues within the responsibility of NSW Health.

As indicated in section 1.2, for the purposes of this submission the term 'complaint' will include expressions of dissatisfaction by staff. A grievance is when a staff member makes a particular type of complaint[vi].

*Agencies*

The NSW public health system is made up of a number of different agencies, namely, the NSW Department of Health, Area Health Services, Public Health Organisations, Statutory Health Corporations and Affiliated Health Organisations. This submission reports on and identifies the ways forward for all these agencies.

*Chronology*

Specific structures to enhance patient safety began in NSW in the late 1990s. This timing is comparable with other world leaders in health care and is due to the fact that internationally the true rates of failures in care were not fully recognised until the *Quality in Australian Health Care Study* (1995)[vii], followed by similar studies in the UK, the USA and New Zealand, revealed the rate of adverse events in each study area were similar, and as high as 10%. As such this submission will outline the achievements in complaints handling in NSW since the late 1990s and the challenges that lie ahead.

*Evidence and experience*

This submission draws on research and best practice from within NSW, other jurisdictions within Australia and overseas. In particular, the following publications and reports have been used:

- Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care (Canada)
- Health Care Complaints Commission Investigation into Macarthur Health Service
- The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. Learning from Bristol (United Kingdom)
- An organisation with a memory. Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer (United Kingdom).

*Conceptual scope*

Understanding the terms 'incident', 'complaint' and 'adverse event' and the relationship between each is needed to understand how complaints are handled in NSW Health.

An adverse event is a particular type of incident – one that *results in disability, death or prolonged hospital stay and is caused by health care management.* Many incidents are not adverse events. They could be 'near misses', have less severe health care outcomes or not be directly about the standard of health care (for example about a patient's bill or a staff member's salary). This is shown in Figure 1.

A complaint is an incident, adverse or otherwise, about which someone expresses dissatisfaction (figure 2). A key issue is that complaints can be about any type of incident. It should be noted that to be properly managed all incidents should be reported.

This submission has therefore interpreted the terms of reference relating to 'complaints handling' broadly to mean 'incident handling' in the Health Services.

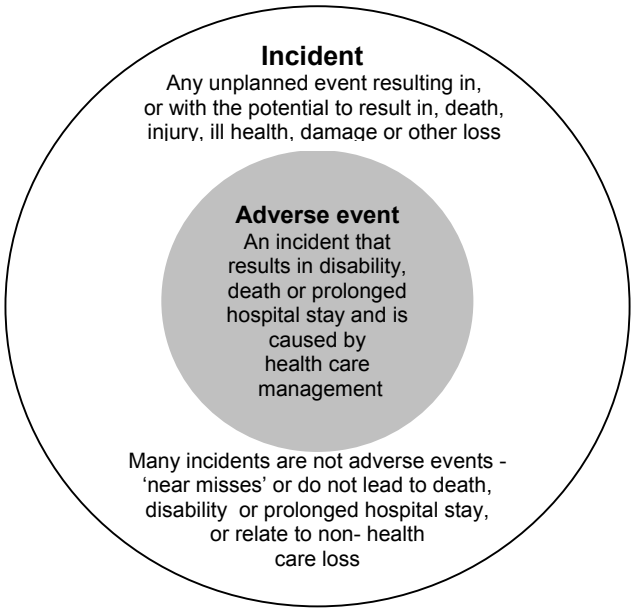


Figure 1: Adverse events are one type of incident.

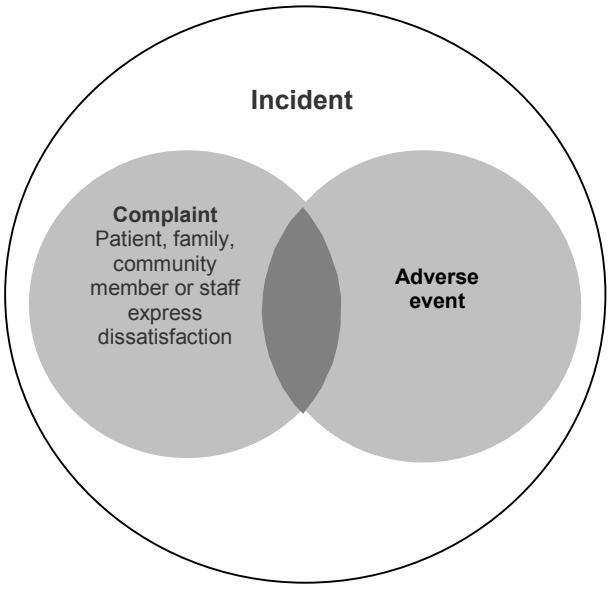


Figure 2: Complaints can be about incidents at a range of levels – adverse events and other incidents

# 2. NSW healthcare in context

## 2.1 NSW in the international arena

On the basis of accepted clinical measures, the quality of health care in NSW is similar to that in other modern, well-developed health systems. For example:

- Unplanned readmissions to hospital following elective surgery in NSW (a rate of 2.61%) are equivalent to other states (2.5%), greater than Europe (1.52%) and far better than the US (4.37%).
- Unplanned readmissions to the Intensive Care Unit in NSW (3.86%) are greater than the US (3.24%) and better than Europe (4.08%).
- Unplanned returns to the operating theatre in NSW (0.64%) are higher than other states (0.47%) but significantly better than the US (1.37%) and Europe (1.16%).

While some of these incidents do no harm and may not be widely reported or recognised, others will have very serious implications for patients, their families and staff and for public confidence in health care.

Health services both in Australia and overseas are working to continuously improve the way in which they manage complaints. NSW was the first jurisdiction, for example, to adopt a method developed by the Veterans Health Administration in the United States to identify the exact cause of health system errors and identify appropriate corrective action.

NSW is not alone in facing current concerns relating to complaints handling. The British Government, in responding to systemic problems revealed in 1998 following the deaths of a number of young children after heart surgery at Bristol Hospital, chose to significantly enhance their commitment to complaints handling and patient safety. Similarly the Veterans Health Administration decided on a substantial investment in complaints management and patient safety following revelations of a series of patient tragedies resulting from human errors and system failures. The Canadian Government has acknowledged it is behind Australia, the US and British, and last year released a national strategy to address these issues.

## 2.2 Scope and nature of adverse events

The rate at which failures in health care occur was the subject of several substantial research efforts internationally during the 1990s. The Harvard Medical Practice (1991)[viii] and Quality in Australian Health Care studies retrospectively reviewed large numbers of patient records across a number of hospitals.

The studies consistently showed that adverse events:

- Occur in about 10% of all admissions
- Are associated with avoidable serious harm in 2% percent of admissions
- Are associated with the avoidable death of a patient in 0.3% of admissions.

Importantly, the research also suggests that 50% of these events are avoidable.

## 2.3 Scope and nature of complaints

*Complaints made by patients*

Currently complaints made by patients, their relatives and the public are recorded separately to those made by staff.

During 2002/2003, NSW Health received 9,868 complaints from patients, relatives and the public. Across the state, the issues most often the subject of complaints were 'access' (32%), 'treatment' (24%) and 'communication' (22%). These issues showed up as the most common subject of complaints made in both rural and metropolitan areas as shown in Table 1.

| | 2001/2002 | | | 2002/2003 | | |
|---|---|---|---|---|---|---|
| | Statewide | Metro | Rural | Statewide | Metro | Rural |
| Issue | % | % | % | % | % | % |
| Total Access | 33.43 | 32.48 | 37.08 | 31.77 | 30.43 | 36.37 |
| Total Communication | 21.74 | 21.92 | 21.08 | 22.19 | 22.13 | 22.39 |
| Total Corporate Services | 21.74 | 21.92 | 21.08 | 9.70 | 9.33 | 10.92 |
| Total Cost | 2.49 | 2.72 | 1.63 | 2.49 | 2.68 | 1.81 |
| Total Grievances | 0.34 | 0.35 | 0.29 | 0.33 | 0.26 | 0.61 |
| Total Professional Conduct | 1.78 | 1.70 | 2.07 | 1.73 | 1.64 | 2.08 |
| Total Privacy/Discrimination | 4.36 | 4.41 | 4.16 | 3.68 | 3.62 | 3.82 |
| Total Treatment | 21.15 | 22.34 | 16.58 | 23.53 | 25.09 | 18.26 |
| Total Consent | 0.54 | 0.54 | 0.44 | 0.49 | 0.51 | 0.39 |
| Other | 6.12 | 6.32 | 5.36 | 4.09 | 4.31 | 3.35 |
| TOTAL | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 |

**Table 1 Complaints by issue, year, statewide and by rural and metropolitan services.**

*Complaints made by staff*

From May 2003 – January 2004, Health Services have reported 402 serious incidents to the Department of Health (see section 4.2 for the definition of a 'serious incident').

## 2.4 Causes: individual responsibility vs system-wide focus

Extensive research has taken place over many years in Australia and abroad to understand the causes of accidents and system failures in non-health care fields. These have shown that there is no single explanatory cause for such incidents. While such systematic research is sparse in health care, the evidence available suggests similar conclusions can be drawn about the causes of incidents in health care.[ix]

Human error is an element in many adverse events but it is only part of the explanation of why they occur. Inadequacies in the clinical workforce, where they exist, clearly need to be addressed through clinical supervision and support and continuing education and training.

However, research in Britain, USA and Australia has shown that many adverse events are not merely attributable to one individual who was on the spot at the time the event occurred. The same set of circumstances can provoke similar incidents, regardless of who is involved.[x] System issues are acknowledged in the US, the Britain, Canada and Australia as the main cause of failures in health care.

Adverse events are often the result of a chain of errors or omissions in the system of care leading up the critical event itself. They are often the result of a chain of errors or failures of systems that, unless identified and fixed, will lie latent until the circumstances occur again.[xi]

It is important to note that, even with the most motivated and expert personnel, human errors and system failures will occur.

# 3. Understanding complaints handling

## 3.1 Why is complaints handing important?

The recent events at Camden and Campbelltown hospitals have shown that when adverse events do occur, they can have devastating consequences for individual patients and their families, cause distress to the usually very committed health care staff involved and undermine public confidence in the NSW health system. Complaints handling is important as it provides an ongoing mechanism for health services to monitor and improve the safety and quality of care provided to patients. Effective systems for complaints handling also contribute to:

- Consumer satisfaction
- Avoidance of future similar incidents and better managed incidents when they do occur
- Informing the community about local health issues and solutions
- Informing health services about the needs and priorities of local communities
- Health service planning and evaluation.

## 3.2 International best practice

To handle a complaint according to best practice, two key phases must be addressed:

1. Understanding the complaint and developing sound solutions.
2. Making sure solutions are put into practice.[xii]

Figure 3 shows the key components in each phase. This is adapted from *An Organisation with a Memory (*United Kingdom) which was in turn adapted to health care from a model developed by BP Amoco.

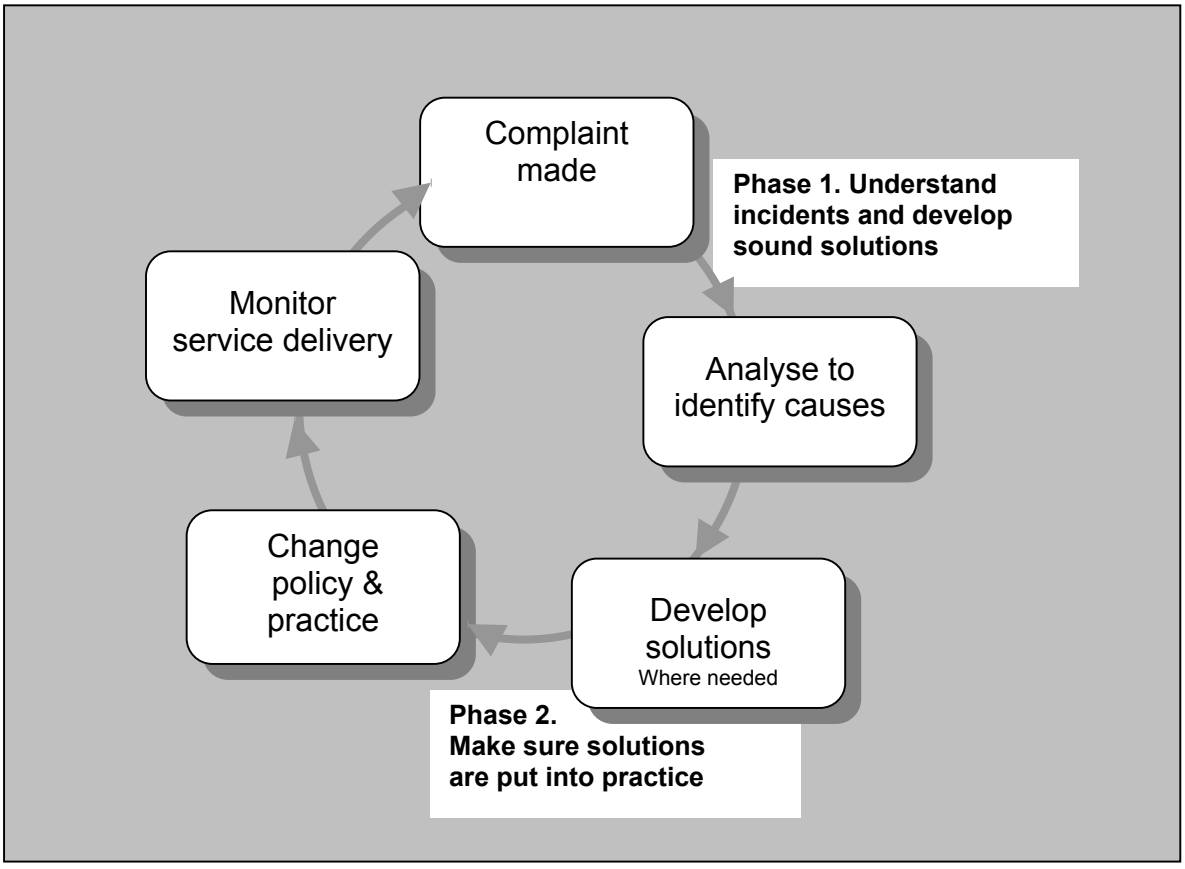


**Figure 3: Handling complaints for learning.**

Each component involves a range of communications between the complainant and the organisation, and internally between staff.

An effective system for handling complaints will be able to respond to a complaint at a range of levels – from a complaint that the hospital food was cold through to a complaint alleging a patient's death was due to causes other than their illness. An effective system should take a complaint through each of key components shown in Figure 3 in a way appropriate to the level of severity of the incident the complainant alleges occured.

NSW Health performs well in regards to the first phase of this international best practice model. It has performed less strongly in the second phase, in which policies and practices are changed in response to complaints and the delivery of these is monitored.

# 4. Handling complaints in NSW Health

This section outlines how NSW Health handles complaints made by patients, their families and the community, and those made by staff. This covers complaints about:

- Health services
- Individual clinicians (doctors, nurses, allied health professionals)
- Health authorities and independent providers.

More detailed information appears in the background paper.

An analysis of the strengths and challenges of these systems is provided in sections 5 – 7.

## 4.1 Complaints patients, families and the community makes to NSW Health

*Complaint made*

Patients, their families and members of the community need to know how to make a complaint. Since the mid 1990s most health services have had patient representatives/advocates to liaise with patients making complaints. Patients can make a complaint to a health service in a range of ways including by letter, in person or by telephone. Since late 2003, patients, families and the public can also make a complaint by calling a 1-800 community call line. All complainants should receive an acknowledgement of their complaint within five working days.

*Understanding incidents and developing sound solutions*

After receiving a complaint, the health service manager will review the issues raised with relevant staff and develop a response to the complainant. Each Health Service is responsible for managing complaints across hospitals and community based health services. NSW Health's complaints handling system is built on the premise that complaints should be handled at an institutional level appropriate to their severity. Many complaints can be handled effectively at a local level - in the hospital or the health service. The actions required depend on the nature and severity of the incident and whether the incident relates specifically to an individual clinician's performance or the systems of healthcare.

Where a manager assesses the complaint is about a serious or potentially serious incident, including complaints about a clinician, a comprehensive analysis should be undertaken (see section 4.2). For less serious incidents, a local review and analysis will be undertaken with relevant staff to assess this issues raised and identify action to be taken.

Since 1998, there have been clear timeframes within which all complaints should be managed and Health Services have had to report on complaint management to the Department of Health every three months[xiii]. Most complaints should be resolved within 35 days. If resolution is not achieved within 21 days, an interim response is made to the complainant with resolution of all complaints hopefully being achieved within 35 days.

*Making sure solutions are put into practice*

Table 2 shows the way in complaints have been resolved. The 'resolution mechanism' is the process by which the complaint is closed and no further interaction is anticipated to occur between the complainant and the organisation handling the complaint. Health services may report one or more resolution mechanisms for a given complaint.

| | 2001/2002 | | | 2002/2003 | | |
|---|---|---|---|---|---|---|
| | Statewide | Metro | Rural | Statewide | Metro | Rural |
| Resolution Mechanism | % | % | % | % | % | % |
| Explanation | 83.09 | 82.38 | 85.83 | 83.07 | 82.30 | 85.62 |
| Service Provided | 20.70 | 22.98 | 11.81 | 21.07 | 22.70 | 17.77 |
| Apology | 48.49 | 51.46 | 36.93 | 51.83 | 52.88 | 48.32 |
| Conciliation | 1.54 | 1.50 | 1.67 | 1.25 | 1.23 | 1.32 |
| Arbitration | 0.09 | 0.10 | 0.04 | 0.23 | 0.29 | 0.04 |
| Mediated Settlement | 0.34 | 0.33 | 0.35 | 0.29 | 0.27 | 0.36 |
| Compensation | 0.50 | 0.61 | 0.08 | 0.41 | 0.50 | 0.11 |
| Litigation | 0.11 | 0.10 | 0.12 | 0.12 | 0.12 | 0.14 |
| Unresolved | 2.76 | 2.79 | 2.66 | 3.47 | 3.44 | 3.57 |

**Table 2: Complaint Resolution Results**

State-wide, over the two collection years results were similar, with the majority of complaints (83%) resolved using an explanation. Apology was the second most common resolution mechanism, used in more than 48% of complaints across the State in both time periods. The third most common resolution mechanism used was 'Service Provided' (20.7% and 21% respectively). Both metropolitan and rural health services showed a similar pattern in both annual results.

The Department develops a report every six months using complaints data to allow Health Services to benchmark their performance and identify trends.

## 4.2 Complaints made by staff

Staff can make a complaint about a medical and non-medical incident – from near misses to adverse events. The following issues come into greater focus when a staff member makes a complaint:

- Confidentiality: staff being able to make protected disclosures.
- Culture of learning where staff are encouraged to share information about incidents.
- Managers respond effectively and appropriately in response to a complaint and in regards to the staff member making the complaint.
- Staff receive information about the action resulting from the complaint (or the reason if no action is deemed necessary).
- Systems for staff to be involved in continuous improvement to pre-empt 'complaints'.

Once Health Services receive a complaint from a staff member about an incident, they are required to assess the complaint according to its severity. Managers use a Severity

Assessment Code (SAC) that results in incidents being ranked on a scale of 1-4. SAC 1 is for serious incidents while SACs 2 - 4 are for less serious incidents (see box).

The SAC is based on a model developed by the Veterans Health Administration in the United States. The SAC is a risk matrix that is used to stratify both the consequence and likelihood of an incident. These include for example death caused by health care, wrong site surgery or incorrect blood transfusion.

At the same time as the SAC is being determined, staff are required to ask four key questions relating to an incident to initially identify the extent to which it may involve individual performance issues. The questions asked are - did the incident involve:

1. a criminal act
2. intentionally unsafe act
3. alcohol or drugs, or
4. deliberate patient or staff harm?[xiv]

How the complaint is handled next depends on its SAC score and the extent to which individual performance is identified as a potential issue.

*Understanding incidents and developing sound solutions: serious incidents*

Managers must undertake a detailed assessment of the causes of all incidents that are rated SAC 1. They must use a specific tool – called root cause analysis (RCA) developed by the Veterans Health Administration in the United States. The RCA helps staff identify the exact systemic cause of an incident and what corrective system-related action should be taken to ensure that it will not recur.

Health Services must also report all incidents that are given a SAC 1 to the NSW Department of Health.[xv] The Department is responsible for monitoring and managing these incidents and for developing strategies to minimise the likelihood of them occurring in the NSW public health system.

All deaths that occur in a hospital should be reviewed at the facility level. An additional external review is required of some deaths.

A complainant should be notified of the outcome of their complaint – if it is a SAC 1 incident - no more than 45 days after the complaint was made, pending action by other external bodies. If a complaint has not been resolved within 20 working days, a complainant should receive a progress report from the Area Health Service.

*Understanding incidents and developing sound solutions: less serious incidents*

For incidents rated SAC 2-4, health services conduct an internal analysis to identify action needed. Managers will use the RCA for some SAC 2 incidents. Health Services are required to regularly analyse the types of less serious incidents that are occurring to

## Severity Assessment Code

The Severity Assessment Code (SAC) below is a simple method that allows health services to stratify the risks associated with an incident. This ensures that appropriate management takes place.

| CONSEQUENCE / LIKEHOOD | Extreme | Major | Moderate | Minor | Insignificant |
|---|---|---|---|---|---|
| Frequent | 1 | 1 | 2 | 3 | 3 |
| Probable | 1 | 1 | 2 | 3 | 3 |
| Occasional | 1 | 2 | 2 | 3 | 4 |
| Uncommon | 1 | 2 | 3 | 4 | 4 |
| Remote | 2 | 3 | 3 | 4 | 4 |

A rating of 1 will always require investigation, a rating of 2 requires notification and investigation at the discretion of management, a rating of 3 or 4 is managed at the local level, unless the incident is likely to evoke external interest in which case it should be referred to management.

identify trends and systemic issues that may therefore need to be addressed. Typically, Health Services operate local facility Clinical Review Committees to routinely review patient outcomes (whether or not associated with an adverse event) and quality indicators such as unplanned returns to theatre, infection and other complication rates.

Complaints rated as less serious incidents should be resolved within 35 days of the complaint being made and the outcome communicated to the complainant.

Some complaints made by staff will require the use of appropriate grievance procedures. NSW Health developed the *Policy Framework and Best Practice Guidelines for the Development of Health Service Grievance Management Systems*[xvi] in 1999 to assist public health system Chief Executive Officers and human resource personnel to meet departmental and legislative requirements. Health Services have developed local policy in accordance with this. See Table 1 in the background paper for more information on complaints made by staff.

*Understanding incidents and developing sound solutions: incidents involving individual performance issues*

If managers have assessed that an incident may involve individual performance based on the four questions outlined or concerns about competency, the incident is analysed internally and action needed to manage performance identified. Serious incidents, such as those rated SAC 1 or 2, may also be referred to the relevant professional registration authority, the Health Care Complaints Commission or in the case of suspected serious maladministration or corrupt conduct to the Ombudsman or ICAC (if a complaint has not already been lodged with these bodies). Under the *Health Services Act 1997* the Director-General also has the authority to initiate reviews and inquiries.

*Making sure solutions are put into practice*

This system of rating and analysing incidents has been in place since 2003. Area Health Services are starting to introduce processes to check that the solutions to incidents have been implemented and their impact is as expected.

Figure 4 illustrates the complaints handling system. It shows the key steps in complaints handling from the complainant's perspective on the far left, NSW Health in the middle and external bodies on the right.

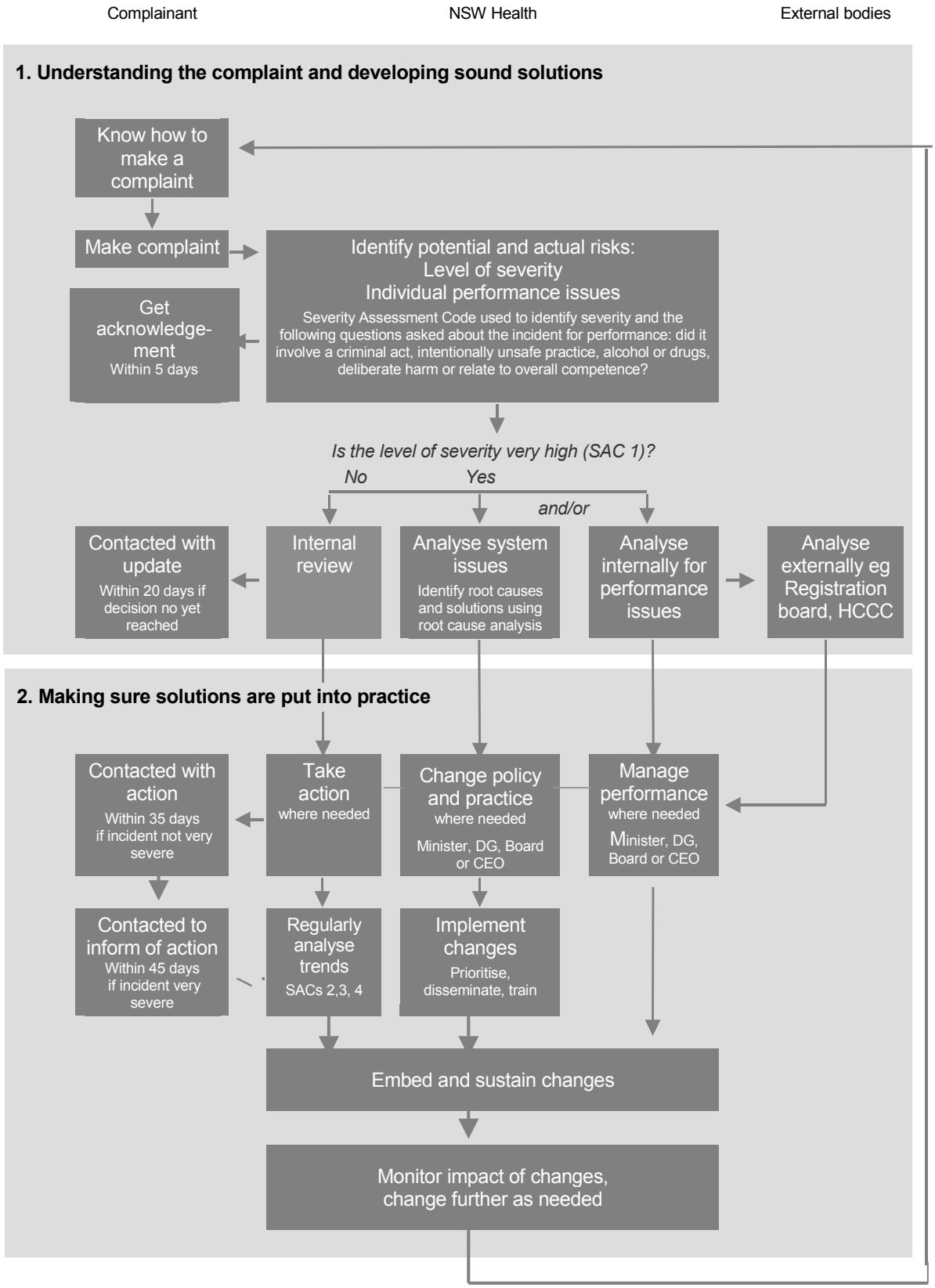


Figure 4: Complaints handling

### 4.3 NSW in context

The NSW system is consistent with the Australian Standard for complaints handling (AS4269-1995) which sets out the following as essential elements of an effective complaints handling process:

- Commitment
- Fairness
- Resources
- Visibility
- Access
- Assistance
- Responsiveness
- Charges
- Remedies
- Data Collection
- Systemic and recurring problems
- Accountability
- Reviews.[xvii]

The NSW system is also consistent with leading health care services in Australia and abroad. See Appendix C in background paper for a detailed analysis.

## 5. Culture of learning

**Strengths**

An organisation with a culture of learning is an organisation that promotes and supports professional development and continuing education initiatives. Without a culture of learning, complaints handling merely involves a one-off response to incidents perceived to be unrelated and of little value to the organisation. With a culture of learning, complaints handling is seen as cycle – as an opportunity to learn from and improve the quality of care provided to patients.

NSW Health has a strong culture of learning. It has drawn heavily on (and often led) best practice within Australia and abroad. In June 2001, for example, NSW set up a stand-alone institute - the Institute for Clinical Excellence (ICE) - to work closely with health professionals to reduce human error and disseminate information on best practice in health care. Experience in the United States and the United Kingdom had shown that setting up an independent body that was separate from line management was the most effective way to encourage doctors and nurses to improve the safety and the quality of their care. NSW Health has initiated, in collaboration with the ICE , professional development and continuing improvement programs. The programs use accepted best practice approaches for training, involve recognised leaders in quality programs internationally, and showcase new initiatives that are improving quality of clinical care.

**Challenges**

In the past staff and managers saw complaints handling as ending when an issue had been resolved with the complainant. The second phase required by international best practice – learning from complaints – was relatively absent. This has been changing since late 2002 when NSW Health introduced new complaints handling initiatives. NSW Health will continue to foster state wide cultural change.

**Priorities**

The British Department of Health identifies the following elements as necessary to develop a culture that can learn from and respond to incidents:

- Raise awareness of the costs of not taking risk seriously
- Focus on 'near misses' as well as actual incidents
- Ensure concerns can be reported without fear
- Avoid simplistic counting
- Develop effectively led teams as mechanisms for cultural change
- Use external input to stimulate learning
- Ensure effective communication and feedback to frontline staff
- Give a high-profile lead on the issue
- Recognise staff concerns.[xviii]

NSW Health has been introducing initiatives that address these elements and as a result a major cultural and behavioural shift across the health system is underway. It will continue to do so.

# 6. Willingness to share information about errors and failures of systems

This section analyses the first phase of handling complaints: understanding incidents and developing sound solutions. It explores the capacity and protection provided to Health Services, staff and the public to share information about incidents.

**Strengths**

In communicating with patients/relatives who make complaints, NSW Health generally meets its targets in relation to timeliness. In 2002/2003, 81% of complainants received an acknowledgment of their complaint within 5 working days (if the complaint had not been resolved within that time). Seventy nine per cent of complaints were resolved within 35 days.

NSW Health has made significant progress in recent years in engaging staff in constructive dialogue about incidents. The approaches NSW Health has adopted since late 2002 use recognised international best practice in complaints handling. These systems increase the capacity of Health Services, staff and the public to engage in constructive dialogue about incidents as they ensure all incidents are reported, investigated and sound solutions implemented. The ability to rate incidents according to their severity (SAC) has considerably increased the Health Services' ability to manage incidents appropriately. The RCA is proving a powerful tool for identifying the root causes and factors that contribute to SAC 1 incidents without which meaningful and workable solutions could not be identified. Since December 2002, NSW Health has trained 2000 doctors, nurses and managers in RCA. Doctors and nurses have responded positively to both SAC and RCA.

## Challenges

International experience has revealed significant underreporting of incidents. The rates of reporting of adverse incidents, for example, are substantially lower than the 10% expected based on the retrospective medical record studies. A similar situation is likely to exist in NSW.

While the introduction of approaches such as SAC and RCA provide a strong foundation for sharing information about complaints, they are in their early stages and have not necessarily been adopted at the same rate around the state, particularly as compliance is not currently checked. Integrating the way in which patient complaints and staff-initiated complaints are managed would also help address this issue.

Change is also needed in several vital areas of communication. In relation to complaints made by patients, many of those arising from Campbelltown and Camden were due to poor communication from doctors to families about the patients' condition and treatment. Also, some services such as intensive care units have well developed processes for openly disclosing an incident to a patient. Other services are yet to regularly use open disclosure. Furthermore, change is needed to ensure reports are sent to patients and their families within 20 working days if a complaint is still unresolved at the time. In 2002/03, 32% of complainants statewide received such a progress report.

In terms of complaints made by staff, clinicians and administrators remain concerned that those who report incidents may be subject to harassment or persecution, either directly from the subject of the complaint, or through institutional processes, as the Health Care Complaints Commission Investigation into Camden and Campbelltown Hospital found occurred at Macarthur Health Service.

## Priorities

NSW Health will continue to:

- Strengthen the recently introduced structures for identifying and analysing incidents.
- Improve communication between NSW Health staff and patients to minimise complaints occurring and improving communications with patients who make a complaint, for example open disclosure consistently applied across the state.
- Build a more open culture where staff are able to discuss incidents without fear of reprisal.
- Strengthen mechanisms to identify and address performance issues when they are found to be a cause of incidents.

# 7. Assessment of whether the system encourages open and active discussion and improvements in clinical care

It is vital that NSW Health makes sure that once solutions are developed, they are put into practice. Commentators in the United Kingdom observe that:

> 'If an organisation focuses intensively on a particular problem for a short period of time but forgets about it when new priorities emerge or key personnel move on, effective learning has not taken place….learning is not a one-off event, it is a continuous process…
>
> 'Continuous monitoring of changes and improvement in practice is an essential part of ongoing learning and improvement.
>
> 'All the evidence suggests that …it is at the stages of implementation and embedding that the learning loop often seems to fracture.[xix]'

This section examines systems in place to implement and monitor changes and improvements in practice.

**Strengths**

NSW Health developed The Clinician's Toolkit[xx] in 2001 as an 'easy guide' for clinicians and managers that outlined NSW Health's expectations for individuals in improving the quality of care provided to patients. The Toolkit is applicable to all clinicians and managers, whether they are employed by the public or private system, or self-employed. It requires clinicians and managers to take the information gained through analysing incidents and human factors in the workplace and act on it using a sound scientific method to improve care[xxi].

The SAC and RCA provide a strong information base for checking the implementation and impact of changes . The use of external input via peers in the RCA helps facilitate a culture of learning (see section 5). SAC and RCA mean statewide changes in policies can be rapid, effective and focused on improvements to those practices that pose the greatest risks.

A consistent method of analysing incidents and recording changes to practices allows Health Services to more effectively monitor whether the changes had the intended impact. The approaches currently underway also allow more information to be generated and given to the public on incidents and the effectiveness of action taken to address them. This was a recommendation of the Productivity Commission report on Performance Reporting.

**Challenges**

The HCCC has called for clear lines of accountability for complaints handling. NSW Health is considering linking performance agreements for Area Health Services Boards and managers closely with incident management.

For open and active discussion of incidents, a cultural shift is needed - from the simplistic counting of data - towards a more sophisticated interpretation of data (see also section 5). This is vital as the number of **reported** incidents would significantly rise, not necessarily due to more incidents per se but to the fact that more of the incidents that occur are being reported. For example, the Veterans Health Administration had a 70-fold increase in

reported failures of care in the first three years following the introduction of a similar system. Education about 'near misses' and what an 'incident' actually is, will further increase the reporting rate. NSW Health therefore would evaluate the number of **actual** incidents as well as the number reported. A method similar to that used in the retrospective studies could be used. The rates of actual incidents would be expected to fall.

**Priorities**

NSW Health will continue to:

- Assess the extent to which solutions to complaints are implemented and effective.
- Strengthen lines of accountability for incidents and their appropriate management.
- Publish information for the public about incidents and support its appropriate interpretation.

# 8. Conclusion

Health services both in Australia and overseas are working to continuously improve the way in which they manage complaints.

NSW Health recognises the importance of an integrated and responsive complaints handling system, which acknowledges the concerns of health system staff and the community they serve, and takes what can be learnt from them to instigate systemic improvements in clinical care.

It has made significant progress in recent years in handling complaints, much of which has occurred subsequent to events at Campbelltown and Camden hospitals. NSW was the first jurisdiction, for example, to adopt a method developed by the Veterans Health Administration in the United States to identify the exact causes of health system errors and identify appropriate corrective action. These structures are in their infancy but are being well received by frontline doctors and nurses. They are designed to effectively handle complaints at a range of levels.

NSW Health is also resolute that some benefit can come out of the tragic incidents that took place at Campbelltown and Camden hospitals. NSW Health's culture of learning, and the success of the complaints handling systems in recent years, demonstrates the commitment of staff to using best practice in handling complaints and the ability of health services to improve how they handle complaints in challenging circumstances.

The challenge that faces NSW Health is to deliver on the recent achievements but with increased attention on: consistent delivery of the new structures statewide; communicating effectively with patients and supporting and protecting staff who wish to make complaints; better managing individual clinicians where the performance is found to be an issue and having clear lines of accountability in Health Services for complaints handling and ensuring the public has a sound understanding of the effectiveness of complaints handling in NSW.

Recommendations made by the inquiries currently in train will guide further decisions on improving quality of care, and to ensure prompt and effective responses to concerns of patients, relatives and health professionals.

[i] NSW Health Circular 2002/19 Effective incident response: a framework for prevention and management in the health workplace. February 2002

[ii] NSW Health, Circular 2002/19 Ibid.

[iii] NSW Health, *The Clinician's Toolkit for improving patient care*. November 2001.

[iv] NSW Health , Circular 1999/42 NSW Department of Health Grievance Resolution Procedures.

[v] Reason J In: Bogner MS, ed (1994) *Human Error in Medicine*. Hillsdale, NJ. Lawrence Erlbaum Associates.

[vi] A grievance, as outlined is defined as a personal complaint made by a member of staff about a work related issue that affects a staff member and that he/she considers to be discriminatory, unfair or unjustified. General expressions of dissatisfaction about 'near misses', putative malprocesses that actually resulted in patient health status loss, or an actual or potential injury to a staff member or visitor, will be defined as making a complaint, but not grievances.

[vii] Wilson RM, Runicman WB, Gibberd RW et al, *The Quality in Australian Health Care Study*. MJA 1995 Nov 6;163(9):458-471.

[viii] Brennan, TA; Leape, LL; Laird, MN et al(1991) "*Incidence of adverse events and negligence in hospitalised patients: Results of the Harvard Medical Practice Study I* . New England Journal of Medicine 324:p370-376

[ix] Department of Health, London (2000) *An Organisation with a memory. Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer,* The Stationary Office, London.

[x] Department of Health, London (2000) Ibid.

[xi] Reason J (2000) *Human error: models and management*. *British Medical Journal* 320, 768-770.

[xii] Department of Health, London (2000) Op. Cit. Pages 28-32.

[xiii] NSW Health, *Better Practice Guidelines for Frontline Complaints Handling*, February 1998.

[xiv] Based on the Veterans Health Administration model, see: Bagian J, Lee C et al. (2001) 'Developing and Deploying a Patient Safety Program in a Large Health Care Delivery System: Your can't fix what you don't know about'. *The Joint Commission Journal on Quality Improvement*; 27: p522-532.

[xv] NSW Health, Circular 2003/88 *Reportable Incident Briefs to the NSW Department of Health*, 8 December 2003.

[xvi] NSW Health, Circular 1999/45 *Policy Framework and Best Practice Guidelines for the Development of Health Service Grievance Management Systems*

[xvii] Standards Australia (1995) *Australian Standard Complaints Handling.* Standards Australia, NSW, pps6-10.

[xviii]Department of Health, London (2000) Op. Cit. p 37-38

[xix] Department of Health, London (2000) Ibid. p 29-30.

[xx] NSW Health, *The Clinician's Toolkit for Improving Patient Care* Op. Cit.

[xxi] NSW Health, *Easy Guide to Clinical Practice Improvement: A Guide for Healthcare Professionals*, October 2002.