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Patient Complaints about Healthcare in Ambulatory Care Clinics at King Abdulaziz Medical City, Riyadh, Saudi Arabia

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Abstract

Aim: Patient complaints are identified as a valuable resource for improving as well as monitoring the patient satisfaction and safety. This study aims to provide empirical data on the nature and severity of patient complaints reported in ambulatory care clinics at King Abdulaziz Medical City, National Guard Health Affairs, Riyadh, Saudi Arabia.

Method: A retrospective descriptive study was undertaken using the complaint database from 1st January 2015 through 30th June 2016. A total of 627 patient complaints were filed and all complains were included using total patient population sampling.

Results: The findings of the study suggested that most of the complaints concerned patients aged 30-39 years (22%). Complaints received during the year 2015 were higher than that received in 2016 (26.5%). Overall, 75.6% of the complaints received were verbal, 74% complains were due to appointment delays, 78.5% were minor in level, and 97.1% were non-medical complains.

Conclusion: Complaints can potentially be useful tool for assuring quality, as it mainly identify flaws in the system. Development of effective strategies, communication skill improvements, sufficient medical staff availability, paying attention to the needs of the patient as well as expectations among most significant things may modify individual behaviors, thus, reducing the complaints from public health facilities.

Keywords: Complaint, Satisfaction, Healthcare quality improvement, Patient satisfaction

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1. INTRODUCTION

In spite of 1.2 billion ambulatory visits in 2005, and from the outlook of healthcare quality as well as safety, the ambulatory settings has been less subject to inspection and research as compared to high risk inpatient locales such as emergency department (ED), perinatal care, perioperative care, and surgery [1]. The ambulatory environment is often predisposed to errors as well as issues that comprise of overdue and missed diagnosis, delays of preventive services and proper treatments, adverse drug events, medication errors, ineffective information and communication flows [2]. As soon as a clarity is achieved in terms of the strategies, evidence-based teamwork tools, nature of outpatient errors, principles, and behaviors can be implemented as countermeasures to elements of the error chain.

The complaints of the patients offers a valued source of insights into safety related concerns across healthcare organization [3]. Patients are usually sensitive to recognizing a range of problems during the delivery of healthcare [4]. Some of the complaints cannot be recognized by traditional healthcare system monitoring (for example, retrospective case reviews, and incident reporting systems) [5]. Hence,evaluation of patientscomplaints can offer important information to the healthcare organizations on to the ways of improving safety of the patients [6]. Moreover, data analysis on negative experiences of the patient tends to strengthen the capability of the organizations of healthcare to identify the logical concerns during care. It has also been reported in one of the Francis report in the UK on 1200 avoidable deaths that over 3 years at "Mid-Staffordshire NHS Foundation hospital". This study also reported that over the tenure of this incident, written complaints from patients have recognized the concerns of poor or neglected care at the trust [7]. Nevertheless, complaint handling deficiencies meant critical warning signs that were missed and so several challenges in utilizing the complaint data from patient in order to improve the safety of the patients were highlighted [8].

Generally, healthcare organization often receive a high volume of complaints (for example, more than 100,000 of annual complaints on the hospital care in NHS) and these complaints therefore emphasizes on several issues (from prescribing errors, waiting times and cleanliness to quality of care, or car parking), have malpractice or legal implications), address different types of harm (for instance emotional or physical), as well as also have underlying aims (such as preventing future concerns, creating changes and resolving dissatisfaction) [9-11].These

standardization levels of techniques utilized for analyzing the patients complaints are often not clear and there may be an advantage in forming a reliable and standardized taxonomy to interpret and analyze (with regards to the safety of the patients) complaint data. To acquire this, this study aims to provide empirical data on the nature and severity of patient complaints reported in ambulatory care clinics at King Abdulaziz Medical City, Riyadh, Saudi Arabia.

2. METHODS

2.1 Research design

A retrospective cross sectional descriptive study design was used to examine filed complaints and to assess the levels of patient's complaints while attending ambulatory care clinics in King Abdulaziz Medical City, National Guard Health Affairs, Riyadh, Saudi Arabia.

2.2 Study population

The hospital has a dedicated complaint department i.e. "Patients relations affairs in King Abdulaziz medical city in Riyadh city" that collates and receives complaints from patients and their families. All complaints recorded with regards to the healthcare services and the service area involved were included in this study.

2.3 Sampling

All complaints received from 1st January 2015 through 30th June 2016 were included in the study. These patients were admitted to ambulatory care clinics of King Abdulaziz medical city, Riyadh, Saudi Arabia. Overall, 627 patient complaints were included using total patient population sampling.

2.4 Research Instruments

Retrospective records review were undertaken including the gender, age, type of complaint, tenure in which the complaints were received, source of complaints, methods, level of complaints, types of delays, and nature of complaints. No peculiar information of patient were mentioned in the records. The instrument included the complaint type and complaint category. The review of the relevant literature was made to ensure validity. The complaint form enclosed

socio-demographic information (gender, age), date of complain, types of complains, department and sources of complaints (patients or relatives).

2.5 Data collection/ Inclusion and Exclusion

The complaints of patients were included in the study only if the patient is admitted in the ambulatory care unit and was in a position to respond either unconsciously or semi-consciously. The patient relation affairs was approached to gather data concerning all complaints arriving to the department including 627 complaints during the period of 1st January 2015- 30th June 2016. These complaints were received from all the departments of ambulatory care clinics.

2.6 Data Analysis

The complaints were entered according to the ideal format and were analyzed using excel and SPSS version 20 program. Analyses of findings were primarily descriptive and variables were put in tabular formats with frequency as well as percentages.

3. RESULTS

Following investigation of the 1.5 years period data was received from patient's relations affairs of King Abdulaziz medical city. The demographic characteristics of the patients aredemonstrated in Table 1.

The study included 627 complaints from ambulatory clinic of King Abdulaziz medical city, Riyadh, Saudi Arabia, mainly from patients (67.9%), followed by family (28.2%), relatives (2.7 %), sitter (0.8 %), staff (0.2%), or legal guardian (0.2%). The most frequent category of the complainants were patients. Female patients were reported to make more complaints (63%) that is more women than men lodged complaints concerning themselves (37%). The age of the participants ranged between 30 and 80 years. Most complaints concerned patients aged 30-39 years (22%). Patients under the age of 12 made more complaints (10.7%) than individuals over the age of 80 (3%). Most of complaints (73.5%) were received during the year 2015, while only 26.5% of complaints were received in 2016.

Most complained verbally (75.6%) and the remaining complaints were written either by letters/emails (22.3 %) or received by phone (2.1%). The reasons for complaints were classified into six groups: (1) complaints with respect to delays (74%); (2) Staff related complaints

(15.3%); (3) Medical complaints (5.4 %); (4) Patient related complaints (3.8 %); (5) Environment related complaints (1.3 %); (6) Attitude and Quality related complaints (0.2%).

Analysis of complaints showed most common type of delays and postponement in providing services. Around 359 cases (57.3%) included appointment delays, 5.3% of the complaints were associated to accessibility of staff in which most of them were associated to the availability of MD physicians. Only 0.6% complaints concerned with the Allied Health professional accessibility. Forty eight (7.7%) of all complaints were about limited assistance provided by the staff, which ranked this concern as the second objective of dissatisfaction. Patient expressed dissatisfaction and annoyance about the miscommunication by staff (5.3%) and not providing information (1.6%). Findings also demonstrated that other significant parts of the patient's complaints were related to environment including hygiene and housekeeping (0.6%); ethical consideration such as misused card (0.6 %), disclosed confidentiality (0.5%), and breaking patient's privacy and professional code of conduct (0.2%).

Each complaint was assigned a severity category (Minor, Moderate, Major, and Catastrophic). Overall, 78.5% of complains were minor in level, 19.9% of the complaints were moderate while only 0.2% of the complaints were catastrophic. Around 97.1% included non-medical complaints for example, financial, criminal, and insurance, while 2.9% enclosed all medical related complaints.

Table 1: Demographic characteristics of the complainants and distribution of nature and severity of complaints

	Frequency	Percentage
Age (years)	**627**	**100**
30 - 39 y	138	22.0
20 - 29 y	103	16.4
40 - 49 y	88	14.0
50 - 59 y	79	12.6
< 12 y	67	10.7
60 - 69 y	47	7.5
70 - 79 y	44	7.0
12 - 19 y	42	6.7
80 y and above	19	3.0
Gender	**627**	**100**
Female	395	63.0
Males	232	37.0
Duration when complain received		
2015	461	73.5
2016	166	26.5
Methods of complaints received		
Verbal	474	75.6
Written	140	22.3
Hotline	13	2.1

Sources of complaints		
Patient	426	67.9
Family	177	28.2
Relative	17	2.7
Sitter	5	0.8
Staff	1	0.2
Legal Guardian	1	0.2
Types of Complaints		
Delayed	464	74.0
Staff Related	96	15.3
Medical	34	5.4
Patient Related	24	3.8
Environment Related	8	1.3
Attitude and Quality	1	0.2
Reasons for complaints: Types of delays		
Appointment	359	57.3
Not Providing Help	48	7.7
ROI	41	6.5
MD Physician	33	5.3
Miscommunication	33	5.3
Medical Management	14	2.2
Admission	13	2.1
Verbal Abused	13	2.1
Not Providing Information	10	1.6
Check IN	7	1.1
Chart	5	0.8
Discharge	5	0.8
Medication	5	0.8
Pharmacy	5	0.8
Allied Health Professional	4	0.6
Uncooperative	4	0.6
Misused Card	4	0.6
Hygiene / Housekeeping	4	0.6
Disclosed Confidentiality	3	0.5
Registration	3	0.5
Clinic Settings	3	0.5
Nursing	2	0.3
Physical Abused	2	0.3
Code Gray	2	0.3
Eligibility	1	0.2
Incitation	1	0.2
Patient Escort	1	0.2
Security	1	0.2
Breaking Patients Privacy and Professional Code of Conduct	1	0.2
Complaints level		
Minor	492	78.5
Moderate	125	19.9
Major	9	1.4
Catastrophic	1	0.2
Nature of complain		
Non-Medical	609	97.1
Medical	18	2.9

4. DISCUSSION

The research was carried out to investigate the nature and severity of complaints reported in Ambulatory care clinics at King Abdulaziz Medical City, Riyadh, Saudi Arabia. Overall, 627 patient's complaints were collected from patients' relations affairs during the period from 1st

January 2015 till 30th June 2016. Schaad [12] acknowledged 372 diverse complaints types together with 28 major analytical themes. Five assembled themes arose from this investigation. The results of the study found that quality of the interpersonal correlation with health-care professionals were the primary complaint topic. The complaint methods differsextensively, based on the hospital policy, cultural, demographic, social, and other factors. It is imperative to ascertain that management system for complaint is developed and established in a way that everyone is capable of submitting his/her complaints in the most convenient manner.

Likewise, verbal complaints (75.6%) were reported to be most common type in our study. The results were consistent with the results of another study performed in Tehran hospitals. This study demonstrated that 88.7% of the complaints were verbal while, 11.3% were in written [13]. The complaints were minor, however the complaint sides were not able to resolve an argument because of lack of communication skills. Our study reported uncooperative staff (0.6%), verbal abuse (2.1%), miscommunication by staff (5.3%) and not providing information (1.6%). The findings are comparable with other study which demonstrated that refining communication skills (apology and explanation in place) of staff meaningfully helps to reduce the number of complaints [14]. Additional complaintscan be prevented by means of appropriate behavior and apology during initial dispute stages [15- 16]. On the other hand, Manochehri stated that less than 90% of verbal complaints can be solved by offering suitable explanations in which, 2.1% and 1.3% were solved via verbal apology besides offering compensation respectively [17].

During the year 2015, complaints received were higher than the complaints received in the year 2016. The results of our study contradicts with the findings of previous studies showing that complaints for medical issues increased from 1998-2004 mainly in French university hospitals [18]. Majority of the complaints received were non-medical (97.1%). Our results therefore contradicts with the results reported by other studies in literature revealing that in most cases, complaints mainly involved issues regarding clinical competence [19].

Our findings revealed that complaints were mostly made by women. These results are consistent with similar studies in other countries. The primary reason why women tend to make more complains than men is not known, as very limited studies have been conducted on this topic [20, 21]. In some of the research studies, women were known to score less on patient rights as compared to men [22], whereas in other studies they scored higher [23]. One of the possible

explanation may be that females have suffered through a work division based on the societal gender role while, primarily carrying the care burden.

Mann [24] revealed that 453 complaints were reported with respect to waiting time (15%), staff attitude, medical care and clinical care (31%), delays in healthcare process (30%), communication issues (19%), poor discharge planning (6%) and institutional environment (8%). One of the major causes of dissatisfaction included healthcare providers who either gave insufficient information or did not tell the truth [25]. The primary reason reported for dissatisfaction in other studies included inadequate treatment, billing or misdiagnosis. There were 0.69 complaints per 1,000 patient visits in the non-urgent medical portion of the ED [26]. Jangland [27], registered at a "local patient advisory committee between 2002, and 2004 were included. Three categories were identified "Not being met in a professional manner" and "Not receiving information or being given the option to participate".

The study had several limitations. First, the study was conducted in one hospital of Riyadh which made the results unrepresentative of the general population. No previous studies have been conducted in Saudi Arabia with respect to the reporting of complaints. The evaluation and analysis of complains were carried out by the researcher;therefore, there may be lack of experience in identifying and analyzing all the types of complains. Time constraints were also acknowledged as a limitations to the work.

5. CONCLUSION

A range of relationship, management as well as clinical concerns underlie the complaints of the patient. The systematic data collation on the complaints of the patient probably offers an aspect through which the healthcare standards can be visualized and interventions based on system can be developed. The complaints can possibly be a helpful tool for quality assurance and can identify flaws in the system. Development of operative strategies, abundant medical staff availability, and communication skill improvement along with paying attention to the expectations and needs of the patientsmay adapt an individual's behavior along with reducing complaints from public health facilities. Communication factors tends to play a crucial role in the consequence and occurrence of patients' satisfaction and adverse events.

5.1 Recommendation

The study therefore recommends that the relations of the patients must be supported by senior leadership as well as should coordinate with family and patient for acquiring protocols, visitors on current policies, educating families/ patients, and getting feedback so as to avoid misunderstanding. In future, the improvements in the methodology is needed to codify complaints that may guide in overcoming such issues. Further studies should identify the major contributory aspects to the current and future quality of healthcare.

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