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## Enhancing patient involvement in quality improvement: How complaint managers see their roles and limitations

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### Cover Page Footnote

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## Enhancing patient involvement in quality improvement: How complaint managers see their roles and limitations

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### Abstract

Patient involvement is a priority for healthcare organizations seeking to improve the quality of care and services. The contribution that complaint handling can make towards quality improvement has remained underexplored, while healthcare organizations are implementing strategies to effectively involve patients in quality improvement. We conducted a qualitative study to understand how complaint managers see their roles and limitations in enhancing patient involvement in quality improvement. A convenience sample of eleven complaint managers was selected from nine Canadian healthcare organizations with various annual volumes of complaints and situated in different settings (urban, rural, and semi-urban). The data were analyzed using a hybrid deductive-inductive approach with QDA Miner. The complaint managers saw themselves as having multiple roles that enhanced patient involvement in quality improvement: ensuring mediations with patients and clinical teams, monitoring improvements following a complaint, and informing the quality improvement and operations teams about the patients' experiences. The complaint managers also reported limitations in their roles, such as the need to respect confidentiality that excluded patients from decisions about improvements and their hierarchical independence in the organization that kept them away from continuous quality improvement activities. Interestingly, the participants reported using new, promising practices that helped integrate, both retrospectively and proactively, the patients' perspectives on quality improvement. Complaint handling can be effective, though it is a seldom-used gateway for integrating the patient's voice in quality improvement. Several challenges need to be addressed to make complaint handling a more substantial element in the strategies for involving patients in healthcare organizations.

### Keywords

Patient complaints, patient experience, complaint managers, patient involvement, quality improvement, qualitative methods

### Introduction

Internationally, patient involvement (PI) has become a priority for healthcare organizations (HCOs) seeking to improve the quality of care and services.<sup>1-3</sup> In Canada, accreditation bodies and governments have defined new guidelines, standards, and policies that make PI a core dimension of healthcare delivery. The involvement of patients in quality improvement (QI) can take different forms in HCOs, from retrospective to proactive. The latter includes the integration of patient advisors in quality committees<sup>4,5</sup> or co-designing with patients to re-design services or care pathways,<sup>6</sup> while retrospective involvement implies the analysis of feedback from patients, as in patient experience surveys<sup>7</sup> and patient complaints.<sup>8</sup> Since 2015, HCOs have introduced proactive forms of PI such as partnership or co-design approaches with patients, an important group of stakeholders, who were missing in the QI process. HCOs also reinforced patient experience surveys to the detriment of satisfaction

surveys to gain a better understanding of specific aspects of the patient experience with care and services.<sup>9</sup> Patient complaints are valuable resources for monitoring and improving quality in HCOs.<sup>8,10,11</sup> Patient complaints and dissatisfactions can reveal unmet expectations of patients.<sup>10,11</sup> Moreover, complaint handling is a management process for identifying and correcting the various causes of patient dissatisfaction.<sup>8,12</sup> The information gathered from the patient's perspective can be valuable for enhancing PI in QI.<sup>2</sup> In many countries, complaint handling is a formal, independent and confidential management process in HCOs that can help integrate patient perspectives in QI. In the province of Quebec (Canada), HCOs have a legal obligation to appoint local service quality and complaint commissioners in charge of handling complaints. These complaint managers are independently and exclusively mandated to manage complaints and dissatisfactions in their HCO.

Many studies have analyzed the implementation of proactive forms of PI and the use of retrospective patient-experience data for quality improvement purposes.

Nevertheless, the role of complaint handling has remained underexplored in the context of implementing strategies to enhance PI in the QI process. Complaint managers, with their in-depth knowledge and understanding of patient experiences could be key actors for implementing PI models in HCOs. In this context, a better understanding is needed of how complaint managers see their roles and limitations in enhancing PI in QI.

## Methods

### *Study design and recruitment of participants*

A qualitative approach was used to investigate the perceptions of complaint managers with regards to their roles and limitations in enhancing PI in QI. A convenience sample of complaint managers was interviewed between March 2016 and February 2017. To ensure the relevance of the data, the recruited complaint managers had to fit the following criteria: 1) currently in a position within an HCO in Quebec; 2) with at least two years of experience as a complaint manager, and 3) available for a 60-90-minute face-to-face interview. Furthermore, to ensure a diversity of perceptions, potential participants were identified in HCOs in a variety of settings (urban, semi-urban, and rural), dealing with different annual volumes of complaints.

### *Data collection*

All identified complaint managers were contacted by email to inform them about the project and to confirm their interest to participate. Consent forms were signed by participants and returned to the research team before interviews were conducted.

Interview questions (Table 1) were organized around two main topics: strengths of complaint managers' roles and the limitations in their roles to enhance PI in QI. To ensure confidentiality of the data and participants, recorded interviews were transcribed, and participants were given numbers. This study was approved by the

UofM's Health Sciences Research Ethics Committee (certificate #14-127-CERES-D).

We used the Standards for Reporting Qualitative Research (SRQR) to report our research results.<sup>13</sup>

### *Data analysis*

The data were analyzed using a hybrid deductive-inductive approach<sup>14</sup> with QDA Miner. The codification and categorization of the data were based on an a priori template of codes<sup>15</sup> that was developed from the main themes in the interview guide. The identification of new codes and categories followed the data-driven analysis.<sup>16</sup> Finally, our findings were formulated and verified. The first three interviews were coded independently by two reviewers (NC, MPP). Divergent codification and the formulation of results were discussed until the two reviewers reached a consensus.

### *Patient and public involvement*

Our findings have been presented in a community of practice on patient experience and patient partnership that included patient advisors, patient representatives, and managers (i.e., quality managers, complaint managers) in 17 Quebec HCOs.

## Results

A total of 11 face-to-face interviews were carried out with complaint managers in nine HCOs in the province of Quebec. Four HCOs were situated in urban areas, three were in semi-urban settings, and two were in rural areas. In addition, three HCOs had an annual volume of patient complaints and notices of dissatisfactions below 500, four had volumes between 500 and 1,000, and two HCOs had volumes above 1,000. Among the HCOs receiving more than 1,000 complaints and dissatisfactions, two complaint managers were interviewed: the chief commissioner and an assistant commissioner. To protect the privacy of participants, the quotations refer to anonymized HCOs.

**Table 1: Interview questions**

- 1) Can you describe your function in the organization?
- 2) How many complaints did you handle last year? What types of complaints or dissatisfactions did you handle last year? Compared to previous years?
- 3) Can you describe your function regarding complaint handling? What actions can you take to handle complaints or dissatisfactions?
- 4) As a complaint manager, do you think that you help involve patients in quality improvement? How do you contribute to that and what are your roles in this area?
- 5) With whom (department, program, type of managers, healthcare units, providers, etc.) do you collaborate regularly?
- 6) To which extent do you think you contribute to involve the patient's voice in quality improvement? What are the limitations in your roles and what challenges are you facing in this regard?

The results of the interviews are gathered around four main roles that complaint managers reported as contributing to the enhancement of PI in QI, along with the perceived limitations and challenges associated with these roles. New emerging practices reported by several complaint managers are also presented.

### ***Roles of complaint managers: Strengths and limitations to enhance PI in QI***

All of the complaint managers saw themselves as having a key role in the enhancement of PI for QI in their HCO. The complaint managers considered that patient complaints or dissatisfactions, and how they were handled provide opportunities for improving the care and services to the patients' experience and expectations.

*I find that dissatisfaction is a voice and an opportunity that helps to put the patient at the heart of the concerns. By doing that, we question providers and managers about their practice, and call to adapt care and services to users' expectations (I.2).*

#### ***Role 1: Investigating the appropriateness of patient complaints***

In cases of patient complaints, complaint managers have the power to investigate and verify the facts as told or written by patients. The investigatory work is necessary to determine whether or not some action is required to avoid similar problems from happening again.

All complaint managers mentioned that the investigation of complaints relies on active listening to the patient's stories. Active listening of the patient experience is the first step in the process of complaint handling. Complaint managers see complaints as the result of unsatisfied needs or expectations that have not yet been expressed. According to one complaint manager, active listening is a prerequisite for investigating the appropriateness of the complaint:

*People want to be listened to, and complaints are often a way for patients to express themselves because they did not have time to speak with their provider or they did not dare. This element of communication is part of the complaint (I.4).*

Several complaint managers (n=6) noted that for complaints related to relationships, it can sometimes be difficult to determine the appropriateness of the complaint since standards related to care approaches leave room for interpretation.

*My role is to handle the dissatisfaction of the user and to establish if the organization or the health team needs to improve. There are complaints for which it is quite simple because a trajectory of services or a care practice is well documented, but for complaints related to human relations, it's much more difficult (I.5).*

Some of the complaint managers (n=4) reported specific limitations and challenges in their role in the context of mental health. When a complaint is made by a patient with a mental health condition, the investigation becomes more complex, since the complaint can be an expression of anxiety associated with the illness rather than related to disfunction in care or services. Thus, complaint managers need to have a greater understanding of the person with a mental health condition and the mental health care environment.

*My knowledge of the suffering of people with mental illness leads me to another reflection on complaint handling because the complaint can be just a symptom of paranoia or it can be a truly well-founded complaint, so we have to make the distinction. We have to adapt, to base our judgment, depending on the person and the complaint made (I.8).*

#### ***Role 2: Mediations between patients and clinical teams***

During the interviews, all of the complaint managers indicated their role in mediating between patients and their clinical teams when they assisted patients with regards to dissatisfactions or formal complaints involving interpersonal relationships. Their mediation role consisted of facilitating communications between the patient and the clinical team by encouraging and supporting patients to discuss their discontent with their providers regarding an event they experienced. The complaint managers mentioned that when mediations are concerned with relationship dissatisfactions, the providers' attitudes or behaviors typically change to better fit the patient's expectations.

The complaint managers mentioned that mediation is crucial to help and restore patient trust in the team, find solutions that will improve the situation, and in some circumstances avoid formal complaints from patients. All complaint managers mentioned that in some circumstances, they use mediation to handle complaints and to conciliate patients about a problematic situation.

*When it's a complicated situation, I ask users if they want to meet the team, and I accompany them. I encourage them to share with the team what is their perception of the situation. The gateway is the complaint, and there is a gap between users' expectations and the practice of the team. Mediation makes it possible to bring these two worlds together (I.5).*

Nevertheless, the complaint managers reported that mediation may not always be appropriate, especially for reasons of confidentiality in complaints or dissatisfactions.

#### ***Role 3: Monitoring improvements following patient complaints***

Complaint managers also monitor the implementation of improvement measures following a complaint. Although

operations managers are accountable to complaint managers for improvements, they are free to choose the methods for improving a situation. In some cases, the complaint managers must give a formal recommendation, supported by the board of directors, when a manager fails to implement a corrective measure or when accidents or incidents occur. Given the confidential nature of complaints, patients are generally not involved in the decisions for making improvements.

Interestingly, the complaint managers reported new emerging practices that can help integrate the patient perspective in the QI process following a complaint. In several HCOs, the complaint managers (n=6) mentioned that the committee of vigilance and quality ask them to systematically monitor the sustainability of corrective measures over time, by carrying out audits to assess the patient experience in the relevant clinical units. The audits contribute to ensuring that the measures implemented in response to a complaint meet the needs and expectations of users and that their experience of care and services is good.

*The committee of vigilance and quality asked me to see if the recommendation I made and the changes that have been made are sustainable over time. So, I have to do audits in those areas where there have been changes. So, we have developed guidelines, a minimum of one per year to check if the recommendation is still in place and if it continues. The other thing I have been asked to do is to do tracer cases, to go and see in the units, to talk to people about their experience of care, to see if the changes that have been made fit their expectations and needs (I.8).*

Several complaint managers (n=5) also recommended incorporating unsatisfied patients who filed a complaint or expressed a dissatisfaction in the QI committees or in activities where the complaints or dissatisfactions recur. This practice is typically used when the norms or standards of care and services are respected but dissatisfactions continue to arise.

*Now I recommend the presence of a patient partner for projects aiming at reorganizing services or installations. For example, we had a problem with access to one of our buildings for people in wheelchairs. The answers I was getting from technical services was that access was conforming to the standards, yet patients in wheelchairs were saying that access was not optimal at all in wheelchairs. I continued to receive complaints for years. So I asked for a patient partner to be involved from the very beginning of the facility improvement project. The patient partner involved in this project worked on the plans with the technical services team (I.11).*

#### **Role 4: Reporting on patient experiences and dissatisfaction**

Beyond informing about patients' rights, all the complaint managers reported having a daily role in raising awareness in managers and healthcare providers about the

experiences and dissatisfaction of patients. They accomplish this role when they handle complaints but also when they are consulted by managers or invited to attend organizational committees to discuss patient experiences regarding care and services.

The complaint managers reported being increasingly consulted by managers and healthcare providers about patients' expectations and experiences. Several (n=8) found that the number of consultations has increased in recent years, representing 15 to 20% of their daily work. The complaint managers said that consultations can help to prevent and avoid dissatisfaction or complaints from patients.

*We do respond to consultations; it's mostly managers or providers who consult us. Managers question us about "Is it okay if we do that, in that way, do we respect users' rights? What are their experience and expectations? Often managers consult us preventively. This helps prevent prejudicial actions, so it allows us to be pro-active, so I always contribute to these things (I.7).*

Complaint managers can also discuss patients' experiences when they are invited to attend a clinical or management committee for improving care and services. The complaint managers reported that their continuous attendance in different quality improvement committees is not possible because of their hierarchical independence from the other departments within the HCO. The independence of their function prevents them from continuously sharing patients' experiences and dissatisfactions that are key information for continuously improve care and services.

*Well, I can't sit on a committee, the law won't let me. Because I cannot sit on a committee that is going to make a decision and one day I will have a complaint about that decision and I will be in conflict, but the law says that I can go there on an ad hoc basis, I can be asked for my opinion occasionally, and then I'm gone. When I'm invited, I share my opinion on the dissatisfactions expressed by patients or families and the avenues for improvement. We share very difficult situations experienced by patients and families, but only when we are invited to do so (I.3).*

Several complaint managers (n=7) reported that one challenge is to better promote their role to managers and healthcare providers so that they can be recognized and invited more often on an ad hoc basis as experts on patient experiences and QI.

Six of the complaint managers mentioned that they are increasingly solicited by the quality departments responsible for deploying PI in QI. They have been asked to identify complainants who could have relevant experience to be shared, and to participate in activities aimed at reorganizing care processes and the organization of services. The complaint managers reported that their function does not allow them to respond to this type of



request systematically, to respect the confidentiality of the complainants and their independence in the organization.

*Yes, I am regularly approached by the quality managers in charge of the partnership approach that we have in our organization. Sometimes I'm asked to find patient advisors, who have made a complaint or expressed dissatisfactions and who have a useful experience to share, but I can't do that systematically, it's not part of my role. Also, there is the whole issue of the confidential nature of the complaint (I.6).*

## Discussion

### **Strengths and limitations of the study**

While involving patients is increasingly recognized as an essential strategy for QI, our study sheds light on how complaint managers see their roles and the limitations of their roles in the effective integration of PI in QI. Previous studies have focused on assessing the nature of patient complaints,<sup>17</sup> and the characteristics of effective complaints management for improving the quality of care and services in HCOs.<sup>18</sup>

The main limits of this exploratory study are the small number of interviews and the fact that it covered the perceptions of complaint managers in HCOs situated in a province of Canada (Quebec). Because of the specific context of the study, we cannot assume the transferability of our findings across other jurisdictions. Nevertheless, we tried to ensure that a diversity of perceptions was included by recruiting complaint managers with different years of experience, and who worked in nine different HCOs with various characteristics. Moreover, we attained data saturation since no additional main ideas were developed in the last two interviews. Finally, the findings are only based on the complaint managers' perceptions of their roles since the study was a first attempt to understand the contribution of complaint handling in the area of PI in QI. Future research should be conducted to identify the perspectives of quality managers, healthcare providers, and patients on the contribution of complaint handling for enhancing PI in QI.

### **Strengths and limitations of complaint managers' roles to enhance PI in QI**

The multiple roles of complaint managers both help and limit the full inclusion of the patients' perspectives in QI. As suggested by the literature, complaint handling can reveal problems in patient care that may not be captured by other QI systems,<sup>8,19,20</sup> at the same time representing a missed opportunity to learn from the patients' experiences and dissatisfactions.<sup>21</sup>

One of the primary roles of a complaint manager is to determine the appropriateness of a complaint and realize whether or not a patient's expectation can be satisfied. Active listening to the stories of patients helps in

understanding a patient's perception of an unsatisfactory situation. Recent literature on complaint handling supports the idea that listening to the stories of patients is a key element for effective complaint management.<sup>22,23</sup>

Nevertheless, complaint managers reported a challenge in differentiating between realistic and unrealistic expectations, especially in regard to patient-provider relationship issues and issues in the context of mental health. This challenge points to the need for clear guidelines on relational aspects of care (communication, respect, and involvement in care decisions) and an education and awareness campaign among managers, providers, and patients.<sup>24,25</sup>

In the case of relationship issues, complaint managers occasionally offer mediations between patients and clinical teams to encourage patients to express their expectations and fix a given situation. The literature indicates that mediation can help restore patient trust in the clinical team<sup>12</sup> and find solutions that will mitigate or resolve the situation, especially with regards to relationship issues.<sup>26</sup> Most of the time, however, the formal process of complaint handling does not necessarily leave room for patients to find solutions for improving the situation. This is partly due to the confidential nature of the complaints, which protects patients and at the same time excludes them from the decision-making process. To find solutions and improvements, operations managers are accountable to complaint managers who share the patient stories. The formal handling process often seeks to address the immediate dissatisfaction of patients in a timely manner, what Liu et al. refer to as "putting out fires."<sup>27</sup> This does not result in a full and sustainable integration of the patient's perspective in the QI effort.

Beyond the formal handling of complaints, complaint managers have an increasing role in informing and raising awareness about patients' experiences and expectations, through consultation requests they receive from managers and healthcare providers or from their attendance in QI committees. Studies suggest that raising the awareness about expectations of patients is crucial to implementing effective patient-centered care and services.<sup>28</sup>

Nevertheless, only scant evidence in the literature supports the daily role played by complaint managers in reporting and raising awareness on patients' experiences and expectations or indicates the limitations and challenges in this specific role. The independence of their function and lack of awareness among operational leaders about their advisory role prevent their systematic or continuous engagement in activities that might fully integrate the patient experience in QI.

### ***New practices of complaint managers for enhancing PI in QI***

Interestingly, our results show that new practices in the handling process have been recently used by complaint managers when implementing patient-partnership models in HCOs. Moving beyond the role of *putting out fires*, complaint managers increasingly conduct audits to retrospectively assess the patients' experience in clinical units where recurring complaints have occurred. Several of the complaint managers recommended integrating patients who filed a complaint or expressed dissatisfaction into QI committees or activities, so as to proactively engage dissatisfied patients in QI. The emerging practices in complaint handling contribute to the retrospective and proactive integration of patients' perspective into QI. The new practices have not been identified in other studies on complaint handling, and are particularly important in the context of implementing PI models and strategies in Canadian HCOs and abroad.<sup>1-3</sup>

Our results show that complaints and dissatisfaction handling give opportunities for complaint managers to integrate the patient's voice in QI. At the same time, their function within HCOs and the formal process of complaint handling also prevent patients from being systematically included in QI decisions. This study is the first of its kind to explore how complaint managers see their roles and limitations in the enhancement of PI in QI. In the context of implementing PI strategies in HCOs, the findings show the emergence of promising practices among complaint managers to help integrate patient perspectives in QI decisions.

### ***Complaint handling: An effective but rarely used gateway for enhancing PI in QI – Future challenges for complaint managers and HCOs***

Several approaches to PI in QI are regularly promoted in HCOs, including patient experience data analysis, experience-based co-designing,<sup>29,30</sup> or partnership with patient advisors.<sup>5,31,32</sup> Complaint handling is another useful but underpromoted and underused gateway to integrate the patient's voice, retrospectively or proactively in QI efforts.

Some challenges need to be addressed before complaint handling can become a key element in PI strategies in HCOs. As Liu et al. and de Vos et al. highlighted, patient complaints are often handled in isolation but they could be integrated into the HCO-wide QI system as sustainable improvements that address problems in the patient's experience.<sup>21,27</sup> While complaint handling is hierarchically separate from other QI functions in the HCOs, closer cooperation should be encouraged between the quality departments that are responsible for implementing and evaluating PI and QI initiatives, and the complaint managers who have extensive knowledge of patients' experiences.<sup>33</sup> Quality departments and managers in charge

of implementing PI initiatives have a role to play in promoting PI to the complaint managers who could encourage the clinical teams to proactively involve dissatisfied patients in QI projects or committees. The integration of dissatisfied patients could be promoted more systemically to proactively involve patients in QI. In any case, the confidential nature of complaints requires complaint managers to introduce specific measures to ensure that patients are willing to reveal their identity and participate in QI activities.

In addition, quality managers should invite complaint managers more often to attend QI committees to discuss patient stories or help them identify patients with negative experiences who could be directly involved in QI activities. To that end, the HCOs could make ongoing efforts to promote the multiple roles of complaint managers in integrating the patient's voice in QI.

### **Data availability**

The data (quotations) generated during the current study are available from the corresponding author on request. Some data (selected quotations) have been shown in the results section.

### **Competing interests**

None declared.

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