ORIGINAL ARTICLE

Healthcare provider complaints to the emergency department: a preliminary report on a new quality improvement instrument

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Objectives: Patient complaints to the emergency department (ED) have been well studied as indicators of quality. However, no study of complaints from healthcare providers (physicians, nurses and hospital administrators) has been published. Given their experience and expertise, healthcare providers are uniquely positioned to provide informed opinions about patient care. We present 1 year's results from a system initiated to capture healthcare providers' complaints, respond systematically, and integrate them into our quality program.

Methods: Complaints by healthcare providers to the ED for calendar year 2002 generated a "Care Concern" addressed by the involved emergency physician within 7 days. These were reviewed by two quality managers who assigned one of eight categories to the primary complaint and evaluated the need for formal peer review.

Results: Of 185 complaints, 53 (29%) were from healthcare providers. Of these, 31 (58%) related to medical care: 8 (15%) to diagnostic work-up, 9 (16%) to ED management, and 14 (26%) to consultations. Eleven (21%) related to miscommunication: 7 (13%) to disposition and 4 (8%) concerned infraction of hospital policy. Ten (19%) led to further formal review with two resulting in changes in ED policy.

Conclusion: Healthcare workers' complaints highlight an aspect of customer care that is sometimes overlooked—that which we provide to other services. The complaints relate primarily to patient care issues, frequently raising concerns requiring intervention. This underused source of information presents a potential wealth of opportunity for quality improvement and customer service in the ED.

While the use of patient complaints in assessing patient satisfaction and quality of care has received much attention,^{1–8} relatively little is published regarding another valuable source of feedback to the emergency department (ED)—that is, complaints received from physicians, nurses, and hospital administrators.

This underused source of patient care information presents a potential wealth of opportunity for quality improvement and customer service. Given their training, experience and expertise, healthcare providers (HCPs) are uniquely positioned to provide detailed follow up, to present pointed inquiry, and to give informed opinions about care in the ED. In addition to assessing the quality of patient care, HCPs' complaints highlight an aspect of customer care that is sometimes overlooked—namely, that which we provide to other services within the hospital.

We present a review of HCPs' complaints to our ED, tracked as part of a quality improvement initiative to respond expeditiously and systematically to care inquiries from within our hospital system. We report on the types of complaints received and describe a method for responding to and integrating complaints into our quality management program.

METHODS

Setting

The study was undertaken in a metropolitan academic tertiary care ED with annual patient volume of 53 000 visits, staffed by resident physicians and supervised by attending emergency physicians.

Study design

This retrospective descriptive study of received HCP complaints was performed after initiation of a "Care Concern"

process in the ED to handle HCP complaints and to use these in identifying problems in ED care. We present data for calendar year 2002. Percentages are rounded to the nearest number. Institutional review board approval was obtained for this study.

Data collection

All HCP complaints received by the quality director or by ED leadership were forwarded, according to standard operating procedure, to the quality director who recorded them in a database. This initiated a "Care Concern" form to be sent with an attached copy of the ED chart to the emergency physician involved for his/her response to the HCP within 7 days of receipt. This form was used to gather data regarding the complaint and its resolution, including patient name, medical record number, date of service, emergency physician involved, complainant, nature of the concern, service involved, type of contact made, and patient disposition.

Selection of cases for further formal review was determined by collective implicit review of cases by the quality director and departmental vice chairman involved with quality improvement. This consisted primarily of the standard in use for routine monthly departmental peer review of deaths and return admissions assigned to individual emergency physicians on a rotating basis. Specifically, this asks the reviewer to determine whether an issue is present which might represent a deviation from the accepted standards of clinical care. Further peer review was performed by presentation at a morbidity and mortality conference or by root cause analysis at the hospital risk management/quality assurance committee level, as appropriate. Physicians

Abbreviations: ED, emergency department; HCP, healthcare provider

responding to complaints that were not formally reviewed but warranting staff re-education or clarification of policy received input from the chairman or vice chairman as determined by initial review. Actions taken to remedy problems identified by HCP complaints undergoing formal review arose from discussions at a morbidity and mortality conference or at root cause analysis and were vetted by ED leadership and group consensus at a faculty meeting.

One of eight categories chosen for parsimony and differentiation among complaint types was assigned by the authors to the "concern raised". Secondary and tertiary categories were assigned when appropriate but were not included for data analysis here. Complaints involving multiple patients were considered separately. The categories included: infraction of hospital policy/procedure; miscommunication; inadequate diagnostic work-up; inadequate ED management/therapeutics; delay in or failure to obtain consultation; and wrong admitting service, inappropriate transfer, and inappropriate discharge. For simplicity and ease of presentation the last three categories relating to patient disposition were subsequently collapsed under "Disposition," such that six categories are presented.

Complaints were generally registered by e-mail but all emergency physicians are also available in our network by pager, telephone and mail. Issues resolved at the time of the event were not included for analysis.

RESULTS

Fifty three complaints were received from HCPs, representing one HCP complaint per 1000 visits (0.001%) or, with a 30% admission rate, 3/1000 admissions. Individual emergency physicians were identified in 92.5% of complaints registered, with 18/23 emergency physicians identified in at least one

complaint (range 0–5 complaints, unadjusted for hours worked). Thirty unique HCPs generated the complaints received (range 0–6 from any individual).

Ten complaints (19%) concerned patients discharged from the ED, two (3.7%) involved patients discharged and readmitted, and four (7.5%) involved patients transferred to an affiliated facility. The remaining 37 (70%) involved patients admitted to the hospital. Thirty seven (70%) care concerns were initiated by attending physicians, nine (17%) by residents, three (6%) by nursing staff, and four (8%) by other administrative personnel. Those generated by physicians originated with the following services: internal medicine 30/46 (65%), surgery 10/46 (22%), renal dialysis 2/46 (4%), anesthesiology 2/46 (4%), and cardiology 2/46 (4%), following the distribution pattern of admissions.

Among the concerns raised by HCPs, 31 (58%) related to medical care in the ED (eight (15%) to diagnostic work-up, nine (17%) to treatment rendered, and 14 (26%) to delay in or lack of consultation). Eleven complaints (21%) primarily involved miscommunication—notably, problems with or lack of medical doctor notification. Seven complaints (13%) related to disposition (four (8%) to inappropriate admitting service, two (4%) for inappropriate discharge, and one (2%) for inappropriate transfer). Four (8%) care concerns regarded infraction of a hospital policy (table 1).

Overall, 10 care concerns (19%) were determined to warrant formal peer review, with eight cases leading to re-education of the emergency physician and clarification of policy and two resulting in the following changes in patient care policy and practice: (1) promulgation of a policy requiring all electrocardiograms to be brought to the attending physician or senior resident for immediate review; and (2) establishing computerized prompting to order

Table 1 Complaint types and action taken

Complaint type and frequency	Referred for further review	Action taken
Infraction of hospital policy/procedure		
Anesthesiology/airway (n = 1)		Communication with HCP. Staff re-education/clarification and reinforcement of policy
Administration of medications (n = 1)		Communication with HCP. Staff re-education/clarification and reinforcement of policy
Blood borne pathogen exposure (n = 2)		Communication with HCP. Staff re-education/clarification and reinforcement of policy
Disposition		
Wrong admitting service (n = 4)	2	Communication with HCP. No further action
Inappropriate discharge or transfer (n = 3)		Staff re-education/clarification and reinforcement of policy New policy requiring immediate review of electrocardiographs by attending or senior resident
Miscommunication		
No call to PCP/referring MD (n = 11)		Communication with HCP. Staff re-education/clarification and reinforcement of policy
Medical care		
Diagnostic work-up		
Requested testing not performed (n = 3)		Communication with HCP. No further action
Incomplete workup (n = 5)		Communication with HCP. No further action
ED management/therapeutics		
Medication choice/medication not given (n = 3)	1	New intervention prompting ordering of chronic medications in ED OBS
Inadequate stabilization prior to admission (n = 3)	3	Communication with HCP. Staff re-education/clarification and reinforcement of policy
Other (n = 3)		Communication with HCP. No further action
Consultation		
Delay in consultation/failure to consult (n = 14)	4	Communication with HCP. Staff re-education/clarification and reinforcement of policy

HCP, healthcare provider; PCP, primary care provider; OBS, ED observation unit.

chronic medications for patients admitted to the ED observation unit. A number of care concerns involved the care of critically ill patients but none involved a patient death.

DISCUSSION

This study represents the first series of HCP complaints to the ED reported in the medical literature. Patient complaints are frequently used as determinants of quality and in targeting areas for improvement. Our findings suggest that HCPs' complaints can provide a further resource in this regard. HCP complaints should be considered for addition to routine screening criteria in identifying areas for ED quality improvement efforts.

Although not a measured end point, we found care concerns from HCPs to be a valuable addition in identifying patient care problems for presentation at our morbidity and mortality review, and we used this information to target process improvements in the ED.

HCPs' complaints relating to medical care (diagnostic evaluation, treatment rendered, consultation) comprised 58% of care concerns. Complaints relating to disposition, involving miscommunication, or infraction of hospital policies could also be argued as medical care issues, increasing this number further. This contrasts with the findings in the patient complaint literature, where factors such as waiting times or service issues feature more prominently.

Considering the range of departments, services and administrators with whom emergency physicians routinely interact, a high frequency of complaints from HCPs was expected. However, the frequency of HCP complaints fell within the mid to high range reported for patient complaints.⁵⁻⁶ While up to 93% of patient complaints come from discharged patients,⁶ we found that over 80% of HCPs' complaints involved patients who were ultimately admitted or transferred. In light of this, the metric "complaints per admission" may be more appropriate for HCP concerns than "complaints per 1000 patients" often used in the literature on patient complaints. Our findings contrast with those in the literature on patient complaints where the frequency of complaints appears to be inversely proportional to acuity.⁶⁻⁹

Timely resolution of complaints and primary responsibility for communication by a designated individual are thought to be important for effective management of patient complaints.⁹⁻¹⁰ While this approach offers centralized responsibility and a uniform style to addressing issues, we felt that direct contact between parties was more successful and appropriate for handling HCPs' complaints. This ensures efficient communication and avoids third party chart review and guesswork in determining clinical decision making and the accuracy of circumstances.

The majority of complaints received were addressed, when appropriate, with reinforcement of existing policy and/or education and feedback to the involved provider. Two HCP complaints led to new ED policies. A discussion of the exact reasons for the intervention used and the level of success achieved are beyond the main focus and scope of our review. However, the rationale underlying responses to complaints is likely to be multifactorial and to include the perceived importance of the given complaint, the relative ease or complexity of an intervention and the tradeoffs therein, identification of concerning trends, and existence of an otherwise effective policy, as well as other factors. Further studies analyzing responses to identified areas of concern and the corresponding results achieved would be of interest in

informing decisions regarding future interventions for performance improvement.

Limitations and future directions

Our study has a number of limitations. This preliminary study includes 1 year's data and we expect our findings to improve in reliability as more data are collected and analyzed. While it is our routine practice to respond to all HCP complaints using the care concern system, it is possible that we did not achieve 100% capture and that complaints may have been addressed outside the system described. It is unclear to what extent our results are generalizable. It is conceivable that there is a fair amount of variability in both the frequency and type of complaints experienced in institutions of different types and sizes. Categorization of complaints and determination of need for formal peer review by intrinsic review are subject to the inherent limitations of this design. Ideally, categories are mutually exclusive, provide for a range of discrete complaints, and issues fall neatly into one category or another. In practice these distinctions are sometimes problematic, and complete elimination of subjectivity and variability in categorization is impossible. Furthermore, while the use of exhaustive extrinsic criteria for determination of need for formal peer review is impractical and significant disagreement in our assessment was not our experience, this is a limitation that may also be open to bias.

It has been noted that efforts in this area emphasize identifying determinants of patient satisfaction, not *dissatisfaction*, and that studies of patient complaints use a passive rather than active strategy.³ Future directions for improving quality using HCPs' complaints might conversely include assessment of HCP satisfaction with care and solicit input from staff other than "care concerns". We plan to use our findings to develop a systematic approach to interventions aimed at pre-empting the occurrence of common problems in care, to track satisfaction with responses, and to confirm timely loop closure of care concerns going forward.

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