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IRIS PITARKA-CARCANI, GEORGE SZMUKLER AND CLAIRE HENDERSON

Complaints about care in a mental health trust

AIMS AND METHOD

A retrospective review of a random sample of written complaints made by, or on behalf of, users of psychiatric services to determine: (a) the number and nature of written complaints against clinical aspects of services in a mental health trust over a 1-year period; and (b) what information complaints provide about deficiencies in the quality of care.

RESULTS

Out of 325 recorded complaints in 1997, 192 concerned clinical aspects of services; 89% of complainants complained once. There was a roughly equal split between complaints about technical *v.* interpersonal aspects of care. Complaints were far higher from in-patient than from out-patient settings. Evidence that the complaints related to psychotic symptoms was rare. All complaints were resolved locally, but 28 responses by the team were judged unsatisfactory. In 39 cases further action was taken as a result of the complaint, but no disciplinary action was taken against medical staff.

CLINICAL IMPLICATIONS

Poor communication is likely to be at the root of many complaints. Room for improvement was found with respect to responses to complaints.

A review of complaints and their resolution allows assessment of both the quality of medical care and patient satisfaction with it (Thompson & Rodrick, 1982; Schwartz & Overton, 1987; Burstein & Fleisher, 1991; Chande *et al*, 1991). Most studies that have examined complaints about medical services (Schwartz & Overton, 1987; Burstein & Fleisher, 1991; Chande *et al*, 1991; Curka *et al*, 1995) have found a strong relationship between poor doctor–patient communication and patient dissatisfaction, but few have analysed complaints about psychiatric care. A review of the American National Association of Insurance Commissioners Claims (Slawson & Guggenheim, 1984) showed that only 0.3% of the 71 788 malpractice claims filed by American physicians between 1974 and 1978 were against psychiatrists. Diagnostic errors, suicide and self-injury were the main subjects, while use of electroconvulsive therapy and psychotropic drugs accounted for 5% and 16%, respectively. Ingram and Roy (1995) studied complaints against psychiatrists in Winchester and Basingstoke over the 5 years preceding publication of the Wilson Committee's recommendations (Department of Health, 1994). Most complaints were made by relatives and concerned the perceived failure of psychiatrists to explain treatment or diagnosis adequately, or disputes over in-patient treatment plans. Again, the findings were interpreted as indicating a need to improve professional communication with patient and relatives.

Methods

Services studied

The South London and Maudsley NHS Trust's clinical services are organised into two major divisions, community and specialist services. The community services provide care through 18 mental health teams, at acute in-patient units and in the community. The specialist services provide in-patient and out-patient specialist treatment for problems that are rarer or more difficult to manage, such as neuropsychiatric and eating disorders.

Complaints procedure

The complaints procedure was introduced in 1996 with mechanisms and explicit standards based on the Wilson Committee's guidelines. The maintenance of the standards is monitored through quarterly reports prepared by the customer relations officer (CRO). Written or verbal complaints are made to the CRO. The method of conciliation is usually a letter to the complainant, but it may involve a meeting between the patient and staff concerned. A final written response is then overseen by the trust's chief executive. If local resolution fails, the complainant is offered referral of the complaint to a non-executive convenor, who attempts further local resolution. If this fails, the convenor may instigate an

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independent review panel (IRP). If a panel is not established, the complainant has the right to contact the ombudsman.

Data extraction

One hundred complainants were randomly selected from a total of 192 for 1997, using the records of the customer relations office. We limited the scope of the study to complaints that involved clinical matters, although in some cases they also included non-medical issues (administration, maintenance, etc.). We extracted the following information from the confidential complaint file:

- gender;
- legal status (when possible);
- NHS status (in-patient or out-patient);
- number of complaints made in the same year (1997);
- time between the index incident and the complaint(s);
- nature of the complaint(s);
- person/people against whom the complaint was made;
- response time;
- means of resolution;
- whether responses to complaints were *a priori* plausible (if they addressed in full the complaint and offered plausible explanation) or implausible; this distinction was made independently of the complainant's satisfaction with the resolution;
- whether further action was required or taken by the trust as result of the complaint.

We attempted to identify whether the complaint might have resulted directly from a patient's disturbed mental state, especially if suffering from psychosis, as indicated by the content of the complaint and/or the response to it.

Results

Out of a total of 325 complaints to the trust during 1997, 192 were against clinical aspects of services. The total represents a 15% fall from the number of complaints made in 1996, the first year of the new system.

Patients

Of the 100 complaints studied, 58 concerned male patients. Twelve patients (all male) had been detained under the Mental Health Act (MHA) 1983 at the time of the incident, which gave cause for the complaints. Fifty-seven complaints were made about in-patient treatment.

Who complained

Just over half of the complaints (54) were initiated by patients themselves and over one-quarter (29) were made by relatives. Other complainants included representatives of an advocacy or users' group (6) and other agencies unrelated to the trust (5), such as the patient's solicitor or neighbours.

Service source of complaint

Table 1 shows the number of complaints against each service and the estimated rates of complaints by patient and by episode of in-patient care. Complaints were far higher from in-patient than from out-patient settings (difference=2.6%, 95% CI 2.2–2.9; $P<0.0001$).

Table 2 shows that one-third of complaints were made against a team, as opposed to an individual professional. Most complaints against consultants concerned out-patient care, whereas in-patients' complaints more frequently concerned nurses (15).

Number of complaints per complainant

The majority (89) made only one complaint, although the possibility of incomplete cross-referencing of complaints means this may be an overestimate. Seven patients made a second complaint that year; four made three or more. These last were initiated by patients whose documents suggest possible long-standing difficulties in their relationships with staff.

Nature of complaints

Complaints were defined as single, concerning one professional or aspect of care, or multiple, involving more than one professional or aspect of care. Most (60) were

Table 1. Complaints against psychiatric services

	In-patient			Out-patients	
Service	No. of complaints	% of patients who made a complaint	% of episodes about which a complaint was made	No. of complaints	% of patients who made a complaint
Community	30	3.27	2.27	32	0.68
Forensic	1	3.1	3	0	0
Addictions	1	0.21	0.18	0	0
Child and adolescent	4	12.8	11.5	3	0.22
Old age	2	1.6	1.1	1	0.33
Other specialist	15	5.7	4.7	11	0.64
Total	53	2.8[1]	2.1	47	0.54[1]

1. 95% CI for difference 2.2–2.9; $P<0.0001$.

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Table 2. Complaints about professionals

Profession	In-patient	Out-patient	Total
Mental health team	18	14	32
Consultant	7	17	24
Senior house officer	3	3	6
Specialist registrar	0	3	3
Nurse	11	4	15
Psychologist	0	1	1
More than one specified professional	12	3	15
Other professionals	2	2	4
Total	53	47	100

Table 3. Nature of the complaints

Nature	Number
General care	55
'Not enough'	27
'Wrong'	28
Physical restraint	8
Discharge procedure	3
Seclusion	3
Detention	7
Others	7
Diagnosis	7
Misdiagnosis	4
Disregard of religious beliefs	1
Others	2
Nurses	40
Rudeness	11
Insensitive/uncaring	14
Unprofessional behaviour	8
Wrong attitude	3
Racial offence	2
Others	2
Pharmacological treatment	23
Ineffective	5
Excessive (parenteral)	4
Enforced (parenteral)	4
Side-effects	2
Errors in administration	1
Others	7
Communication and information	25
Breach of confidentiality	3
Others (diagnosis, treatment, etc.)	22
Psychiatrists	20
Insensitive/disrespectful	10
Intrusive/inappropriate approach	2
Delay in reports, referrals	3
Others	5
Others	8

multiple. The categories of complaints are described in Table 3. Examples of inadequate care mainly concerned community care, regarding generally inadequate aftercare or lack of access to the consultant. Lack of involvement of the patient or carers in planning treatment was a cause of complaint in five cases, three of which concerned detained patients with learning disabilities. Misinformation on a patient's leave of the ward was the basis of six complaints. Formal complaints were made three times after informal ones were felt to have gone unacknowledged. There was no gender difference in terms of the frequency, nature and subject of the complaints. In summary, these data represent roughly equal numbers of complaints about technical *v.* interpersonal aspects of care.

Timing of the complaint

We were unable to determine the timing of 27 complaints from the documentation. Twenty-five were initiated less than 1 week after the event giving rise to the complaint; 12 after less than 1 month; five after 2–6 months; four complaints were initiated after 20 months.

Complaints and patient mental state

Evidence was sought for the content of the complaint and the response that psychotic symptoms were the basis for complaints. Fifty-six were made by patients who were possibly psychotic at the time of complaint or by relatives or representatives on behalf of such patients. However, in only four cases was there clear evidence that the nature of the complaints related to psychotic symptoms (for example, the doctor or nurse was incorporated in the patient's delusional beliefs of a grandiose and/or paranoid nature). The remainder of the complaints were clearly unrelated to delusional beliefs. Two complaints against detention under the MHA derived from lack of insight into a psychosis.

The remainder concerned patients who suffered from various psychiatric disorders, but whose mental state was not psychotic at the time of the complaint. Of these, in 13 patients there was evidence of long-term difficulties in relations with medical staff. There was a tendency for this particular group to complain about the professionals' attitudes as well as about perceived insufficient care. However, overall 'mental state' was not associated with any particular type of complaint. We were unable to determine the patient's mental state in 10 cases.

Resolution

All complaints had been acknowledged with an apology within a month. Most of them (88) were dealt with by a written response from the chief executive or the consultant psychiatrist concerned. In seven cases a meeting was the initial means of resolution. Only eight required a further meeting with the manager, consultant or other professionals involved in the alleged incident. Seven had appealed for an IRP following dissatisfaction with the attempt at local resolution. Two years later, none of these appeals had gone on to the IRP, as local resolution had been achieved.

Response plausibility

In 70 cases the responses addressed all issues by the complainant, indicated that a successful investigation had been carried out offered some solution to the problem. For the remainder, 28 did not fully address the content of

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the complaint or give a plausible explanation of the alleged incident (for example, three responses justified the professional's rude or insensitive manner by citing overwhelming workload). In five cases there had been difficulties in investigating the complaint owing to lack of detailed documentation of the incident, the professionals having left the trust or a discrepancy between accounts of a one-to-one situation between patient and nurse. For two complaints response letters were missing from the files.

Action upon complaints

When appropriate, further action was taken in response to complaints (39). These included: referral for a second opinion (2); transfer to another consultant (4); review of staff training on communication skills (4); review of seclusion (2); discharge (1) and detention (2); and drug withdrawal regimen according to codes of practice. Complaints led to the introduction of information booklets for users and relatives and implementation of auditing measures with an emphasis on communication skills. No complaint led to litigation.

Discussion

To our knowledge this is the first analysis of complaints against mental health professionals across the services of a particular NHS trust. It may be that complaints by psychiatric patients are often assumed to reflect mental state rather than an actual cause for complaint. This study provides strong evidence to challenge this assumption because for only four complaints (4%) was there evidence that the complaint resulted directly from psychotic symptoms. We are also able to reject the assumption that most complaints are made by a handful of patients who complain repeatedly because the vast majority of patients complained only once over the year. However, a small group had complained more than once during this period.

Complaints are made far more frequently about in-patient than out-patient care. Given the high rates of MHA use in London this might be thought to relate to compulsory detention in hospital; yet, of 12 patients detained under MHA who complained, only 5 complained against their detention. One possible explanation is that dissatisfaction is channelled through the appeals procedure. Seclusion, physical restraint and compulsory medication, all practised only on in-patient wards, accounted for some of the excess.

Patients on acute psychiatric wards (Sainsbury Centre for Mental Health, 1998) surveyed recently echoed the types of complaint made against in-patient care at this trust. Nearly half said they had received insufficient information on their illness and possible treatments and that social needs were not addressed and discharge planning was inadequate. Other common problems were boredom and concerns about privacy, cleanliness, personal safety and safety of possessions. The Sainsbury Centre study suggests that in-patient care is generally very unpopular, regardless of MHA status; it seems this trust is no exception.

Although three categories of complaint appear to address technical issues of care (general care, pharmacological treatment and diagnosis), in most cases there was a failure to communicate clearly and deliver adequate information to patients/their relatives. This is consistent with other findings from studies conducted in accident and emergency departments and general medical services, and reflects the need for care in making distinctions between technical and interpersonal aspects of care (Gronroos, 1979, 1983; Donabedian, 1988).

Most complaints were successfully handled according the Wilson Committee's guidelines. However, our findings suggest that 28% of responses could have been improved. They also confirm the important role of the convenor in facilitating local resolution of complaints despite previous failed attempts.

The current NHS complaints system provides a way to improve accountability on the part of mental health professionals and the teams in which they work. This study shows how learning from complaints and instituting change can contribute to the practice of clinical governance. However, their investigation and resolution can be time-consuming for trust administrators and medical directors (Swor, 1992) and unpleasant for the professionals involved (Jain & Ogden, 1999). Thus, one of the ultimate aims should be to reduce the rate of complaints while retaining an accessible complaints system that meets standards based on guidelines set by the Wilson Committee. To this end, it is important to make staff aware that the majority of complaints arise owing to poor communication and insensitive attitudes. To some extent this is a training issue. However, it may also reflect the current staffing problems on in-patient wards, where the high proportion of agency staff barely know their patients and may have a less than optimal level of incentive to communicate well with patients. Despite these problems, the 15% fall in complaints between 1996 and 1997 suggests a process of change based on what complaints can teach us, for example through the trust's complaints workshops. Although some changes have been made, for example in-patients are encouraged to take their complaint to the team before formalising it, it is unlikely that these account for all of the reduction.

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Iris Pitarka-Carcani Senior House Officer in Psychiatry, **George Szmukler** Consultant Psychiatrist and Joint Medical Director, South London and Maudsley NHS Trust, Denmark Hill, London SE5 8AZ, ***Claire Henderson** MRC Training Fellow in Health Services Research and Honorary Specialist Registrar in Psychiatry, Section of Community Psychiatry, Health Services Research Department, Institute of Psychiatry, De Crespigny Park, London SE5 8AF; tel.: 020 7919 2692, fax: 020 7277 1462, e-mail: C.Henderson@iop.kcl.ac.uk

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SATI SEMBHI AND GILL LIVINGSTON

What trainees and trainers think about supervision

AIMS AND METHOD

A confidential questionnaire was mailed to all trainers and trainees on the UCL/North London rotation (n=127), asking about the content and ways of improving supervision.

RESULTS

Seventy-six per cent of trainees received regular, timetabled supervision. Ninety-four per cent of trainees felt it was a good idea, but identified improvements, including more planning, setting an agenda and flexibility. There were differences between reports from trainers and trainees regarding the content of supervision. Respondents' comments are included.

CLINICAL IMPLICATIONS

Although supervision is popular and widely practised, this survey suggests that it is still not universally practised despite College stipulations. The content of supervision could be broadened to include more non-clinical matters such as teaching and careers guidance.

The Royal College of Psychiatrists stipulates that all psychiatrists in training should receive regular, timetabled, weekly supervision by their trainer. Specialist registrar (SpR) training guidelines (Royal College of Psychiatrists, 1998) do not quantify the time-period. It is specified, however, that senior house officers (SHOs) should have a "protected hour per week" with their educational supervisor (Cottrell, 1999). As supervision is a relatively new requirement, very few trainers will have been supervised – let alone trained in supervision. Informal discussion suggests that the practice of supervision varies widely. It has been emphasised that supervision should be based on the needs of the trainee and, hence, will vary over time, but should be structured with clear aims and objectives (Cottrell, 1999). Cottrell suggests that good supervision should cover the following topics: clinical management, teaching and research, management and pastoral care. However, he points out that it may not be possible for all trainers to offer supervision in each of these areas personally. Previous research (Herriot *et al* 1994; Azuonye, 1997) has found approximately three-quarters of trainees in London received weekly supervision, but that many trainees and trainers were dissatisfied with it.

The aim of the project was, therefore, to find out trainers' and trainees' views about the purpose and content of supervision and the practicalities of current practice. This information could then be used as a basis for suggestions to improve and standardise supervision.

The study

All trainers and trainees on the University College London/North London psychiatry rotation were sent a questionnaire asking about their current supervision practice and experiences. This was devised from literature regarding the purpose and content of supervision (Herriot *et al*, 1994; Robertson & Dean, 1997; Royal College of Psychiatrists, 1998; Cottrell, 1999). The questionnaire was piloted and amended as necessary. The final questionnaire began with questions regarding the concepts of supervision and had open questions regarding the ideal content and time spent in supervision. The second part consisted of a list of the possible content of supervision and asked respondents to tick 'yes' or 'no' for each category (see Table 1). We also asked how long was spent in supervision and there was a space inviting respondents to make comments.

Initially, we numbered the last page to enable us to identify non-respondents and so gather as complete a data set as possible. This page was then discarded to preserve anonymity. Those who had not returned the questionnaire after the first mailing were sent it once

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