



**Sudan University of Science and Technology
Collage of Graduate Studies**

Total Quality & Excellence Centre



***Impact of Complaints Management system effectiveness in the health
services quality***

Case Study of Royal Care International Hospital (RCIH)

***A Thesis submitted in fulfillment of the requirements for the degree of
master of Total Quality Management & Excellence***

اثر فعالية نظام ادارة الشكاوي في جودة الخدمات الصحية

دراسة حالة مستشفى رويال كير العالمي

بحث تكميلي لنيل درجة الماجستير في ادارة الجودة الشاملة والامتياز

Prepared by:

Weam Abbas Abdlwahab Abbas

Supervisor:

Ibrahim Fadul ELMula Elbasheer

January 2017



Approval Page

(To be completed after the college council approval)

Name of Candidate:

Thesis title: *Impact of Complaints Management System effectiveness on the health Services quality.*

Degree Examined for: *Master of Total Quality mgmt. and Excellence.*

Approved by:

1. External Examiner

Name: *Ahmed Musa Ismail*

Signature: *[Signature]* Date: *5/11/2017*

2. Internal Examiner

Name: *A. Mna. Mohamed Omer*

Signature: *[Signature]* Date: *5/11/2017*

3. Supervisor

Name: *Ibrahim Fadel Ghmala Elbashir*

Signature: *[Signature]* Date: *5/11/2017*

بِسْمِ اللّٰهِ الرَّحْمٰنِ الرَّحِیْمِ

الاستهلال

قال تعالى:

(وَقُلْ رَبِّيَ زُنَيْي عِلْمًا)

سورة طه - الآية 114

Dedication

This thesis is dedicated to my parents whom encouraged me to be the best I can be, to have high expectation and to fight hard for what I believe, you always provide me with best opportunities in life, you always with me supporting and guiding this is for you.

Acknowledgement

Praise is to Allah, the lord of the words. The blessing and peace be upon our Prophet Mohammad (peace is upon him). First of all, I would like to thank Allah for providing me the health and the ability to finish this thesis and it is him I seek to support me in my upcoming life.

I would like to thank Sudan University of science and technology to give me a chance to do this thesis in this picture. I also want to thank all of the department faculty members for their help support especially Mohammed Ali thank you for your support and guidance.

I would like to express my special appreciation and thanks to my supervisor DR. Ibrahim Fadul EL Mula, you have been a tremendous mentor for me, I would like to thank you for encouraging my research and for allowing me to grow as a research scientist, your advices have been priceless. . Also I would like to thank Royal Care International Hospital to give me all information I need to complete this thesis.

A special thanks to my family, words cannot express how grateful I am to my father, my mother, my brother and sisters for all the sacrifices that you have made on my behalf. At the end I would like to thank my friend Mohilum Osman who incentives and supported me to strive towards my goal

Abstract

This study aimed to evaluate the complaint management system procedure in Royal Care International Hospital, Where researcher used descriptive approach.

The questionnaire was designed to collect the necessary data consisting of three dimensions include 20 phrases. The community study of hospital had been selected from staff of the hospital; the total number of staff is 215 peoples. The researcher used stratified random sample of data collection in the field where the total sample size of 100 peoples, the respondents were 80, the respond rate was 80%.

Result of the study showed that there is positive impact of the effectiveness of complaints management system on improving health services quality, which leads to increase consumer satisfaction (patient), also showed that senior management commitment would affect a high degree in the effectiveness of complaints management system in the hospital, and awareness of the employees about their responsibility toward the complaints management system have a role in improving a health services quality.

The study recommended the need of deploying the complaints management policy within the responsibility of the workers and staff, and the need of involving all staff in designing of complaints management system to enhance their awareness about how to deal with complaints in different situations, to improve service quality.

المستخلص

هدفت هذه الدراسة الى تقييم نظام ادارة الشكاوي في المستشفيات السودانية من وجهة نظر العاملين واثرها في تحسين جودة الخدمات الطبية ، وقد تم اختيار مستشفى رويال كير العالمي كحالة لدراسة الموضوع. وقد تم استخدام المنهج الوصفي في جمع البيانات وتحليلها.

تم تصميم استبانة لجمع البيانات مكونة من 3 ابعاد تشمل 20 عبارة، وقد تكون مجتمع الدراسة من العاملين بالمستشفى حيث بلغ عددهم 215 موظف. تم اختيار عينة عشوائية لجمع البيانات الميدانية بلغ حجم العينة 100 شخصا وبلغت نسبة الاسترداد 80%.

اوضحت نتائج الدراسة انه يوجد اثر ايجابي لفعالية نظام ادارة الشكاوي في تحسين جودة الخدمات الصحية الامر الذي يقود الى زيادة رضا المستهلك (المريض)، واوضحت ايضا ان التزام الادارة العليا بالتوجه نحو المستهلك وتحسين الجودة يؤثر بدرجة كبيرة في فعالية نظام ادارة الشكاوي في المستشفى كما ان ادراك الموظفين لمسئوليتهم تجاه نظام ادارة الشكاوي له دور في تحسين جودة الخدمات الطبية.

واوصت الدراسة بضرورة نشر سياسة ادارة الشكاوي داخل المؤسسات الصحية وادراجها ضمن مسؤوليات الموظفين ، وضرورة اشراك العاملين في تصميم نظام ادارة الشكاوي لتعزيز الوعي لديهم عن كيفية التعامل مع الشكاوي بمختلف انواعها، من اجل تحسين جودة الخدمات الصحية.

List of contents

Content	Page
الاستهلال	I
Dedication	II
Acknowledgement	III
Abstract	IV
المستخلص	V
List of content	VI
List of tables	IX
List of figures	X
CHAPTER I: Basic of research & previous study	
Theme one: basic of research	2
1. introduction	2
2. the research problem	2
3. the significance of research	3
4. the research objectives	3
5. the research hypotheses	3
6. the research methodology	3
7. information sources	3
8. study limits	4
Theme two: previous studies	4
1. previous studies	4
2- The difference between this study and other previous studies	8
CHAPTER II: Literature review	
Introduction	10
Theme one: The Complaints management system	10
1- Definition of the complaints	10
2- Benefits of complaints management	10
3- Fairness	11
4- Good complaints handling	11
5- Complaints and quality	11
6- Learning from mistakes	11
7- Attitudes to complaining	12
8- Consumer participation	12
9- Health care complaints commissioners	12
10- Indicators of good complaints management	13
11- Implement the Better Practice Guidelines on Complaints Management for Health Care Services	13
Theme two: The services quality	29
FIRST: Services as general	29

1-Service Definition	29
2- Features of Service	29
3- Characteristic of Service	29
SECOND: Service Quality	30
1- Definition	30
2- Dimension of Service Quality	30
3- Importance of Service Quality	33
4-Evaluating Services Quality	34
5- Approaches to the Improvement of Service Quality	39
6- Approaches to Improve The Conformity Of Service Quality	40
7- Service Quality and Customer Satisfaction	40
THIRD: Quality in health care	40
1- Quality and safety	41
2-measuring the health care quality	41
3- Quality measures or quality indicators	41
4- Accreditation and its important	41
5- The role of patient when it comes to quality care	42
6- Using of quality information	42
Theme three: Patients satisfaction	42
1-Definition	42
2- Understanding a patient	43
3- Patient education	44
4- Feedback given by patient	44
5- The role of patient satisfaction data in quality improvement	44
6- Methods for measuring patient satisfaction	44
7- Patient complaint data	45
Theme four: The organizational performance	45
1-Performance Definition	46
2- Performance Improvement	46
3- Factors That Affect Performance	46
4- The Performance Improvement Process Framework	47
CHAPTER III: Study field & analysis	
Theme one: The study field (RCIH)	49
1-Overview about RCIH	49
2-Services provided by RCIH	50
3- Quality and patient safety directorate in RCIH	51
4- Accreditation	52
5- Joint commission international accreditation (JCI)	52
6- Patient complaints and satisfaction in RCIH	52
7- Handling patient complaints and conflict in RCIH	53

Theme two: Analysis of the questionnaire data	53
1- Study methodology	53
2- Study population	53
3- Study sample	54
4- Study tool	58
5-believe study tool	58
6-statistical processing	58
CHAPTER IV: Results of research & discussion	
1- Results concerning the study questionnaire	60
2- Results concerning the research hypotheses	63
3- Discussion	64
4- Conclusion	65
5- Recommendation	65
References	66
Appendix	67

List of tables

NO. Of table	Table title	Page
3-1	Gender	54
3-2	Age	55
3-3	Level of education	56
3-4	Job title	57
4-1	Results of the questionnaire analysis	60
4-2	Chi-Square Tests results of the first hypothesis	63
4-3	ANOVA one way Test of the second hypotheses	63
4-4	Chi-Square Tests results of the third hypothesis	64

List of figures

Figure NO.	Figure title	Page NO.
2.1	Process of complaints management	28
2.2	Conceptual model of services quality	35
2.3	Performance improvement frame work	47
3-1	Gender	54
3-2	Age	55
3-3	The level of education	56
3-4	The job title	57

CHAPTER I

Basic of research and previous studies

CHAPTER I

BASIC OF RESEARCH & PREVIOUS STUDIES

THEME ONE: BASIC OF RESEARCH

1. Introduction:

Everybody makes mistakes. However, few people can easily accept their own mistakes. This is probably more the case in medicine than in most other occupations, because errors can have such serious consequences. The critical question for individuals is how they react when such mistakes are made and things go wrong.

Complaints are an inevitable consequence of errors; consequently, an understanding of the way things are done around here is a fundamental first step to developing proper and effective complaint handling procedures.

Most people instinctively regard complaints as unpleasant because they can be very personal comment on performance. In the hospital context once the word complaints is used there is always the danger of a personal and usually negative reaction. Clearly there may be a fear that complaints will have a significant and lasting impact on those to whom blame is attributed.

However it's essential that they view the handling of complaints and patient safety as an integral part of clinical governance and risk management. Clinical governance is about using information so as to manage processes in a way which will ensure the effectiveness and safety of clinical outcomes. Information may come from clinical audit, adverse incident reporting, risk management and complaints procedures. This can lead to the systemic identification, treatment and evaluation of risk, incident and near misses with consequent learning from the lessons observed.

This study focuses on evaluating the effectiveness of complaints management systems in Sudanese hospital to improve health care quality and create effective organizational performance system.

2. The research problem:

The main problem of this study is to know is there is impact of the complaints management system in improving the quality of health services. And identify the extent of royal care international hospital to embrace and applying the complaints management system

3. The Significance of the study:

- The importance of research came from the importance of improving health services quality to achieve patient's satisfaction.
- The importance of research came from the importance of measuring and evaluating performance to achieve continuous improvement in the organizational performance.
- The lack of previous study on this topic.

4. The Research objectives:

The objective of this study is improving quality of the health services and the responsiveness of health systems to the patients needs, and emerge the role of complaints in achieving patient satisfaction. Also improving the performance by addressing the areas of dissatisfaction and fix it. And driving learning into the health organization.

5. The Research Hypotheses:

Main hypotheses:

H1: There is impact of the effectiveness of complaints management system in improving a health services quality.

Sub hypotheses:

H2: The top management in RCIH is committed to implement the complaints management system.

H3: There is significant relation between the complaints management system and the organizational performance.

6. The Research Methodology:

In this research I will use the descriptive analysis method because it is fit with the subject nature.

7. Information Sources:

Primary sources:

Questionnaire as a key tool to search, designed specifically for this purpose

Secondary sources:

- Books

- Researcher, academic studies and references.
- Report and record of RCIH and relevant authorities.
- Specialized studies in the study field.
- Web sites relevant.

8. Study Limits:

Time limits:

May 2016 - November 2016

Place limits:

Royal Care International Hospital- Khartoum Sudan

THEME TWO: PREVIOUS STUDIES

1-previous studies:

Study NO.1 study of Hsieh, S. Y., Thomas, D. and Rotem, A. (2005). "The organizational response to patient complaints: a case study in Taiwan." *International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services* 18(4-5): 308-20.

Purpose: To explore and evaluate how hospital staff respond to patient complaints.

Design/methodology/approach: A teaching hospital with 1,500 beds in Taiwan was purposefully chosen as a case study of hospital response to patients' complaints. Data was obtained through interviews with quality surveying managers (n = 53), government managers (n = 4), staff of non-government organizations (n = 3) and a senior social worker, as well as analysis of documents (September 2001-April 2002). **Findings:** Using the managerial-operational-technical framework developed by the researchers, the study demonstrated problematic aspects of handling complaints at the case hospital. It was revealed that: complaint handlers were not sufficiently empowered, information sharing was limited within the organization, communication among professional staff and with management was inadequate, the physical safety of workers had been threatened, and improvements could not be sustained. Moreover, it became apparent that the case study hospital generally responded to patient complaints in a reactive and defensive manner.

Originality/Value: It is evident that the hospital did not use patient complaints as a source of learning that could have promoted higher standards of care. The case study reveals some of the constraints and identifies requirements for appropriate use of information and feedback from patients. The study raises some issues requiring further research to ensure more appropriate use of patient complaints to improve quality of care.

Study NO.2 study of Bendall-Lyon, D. and Powers, T. L. (2001). "The role of complaint management in the service recovery process" *Joint Commission Journal on Quality Improvement* 27(5): 278-86.

Background: Patient satisfaction and retention can be influenced by the development of an effective service recovery program that can identify complaints and remedy failure points in the service system. Patient complaints provide organizations with an opportunity to resolve unsatisfactory situations and to track complaint data for quality improvement purposes. **Service recovery:** Service recovery is an important and effective customer retention tool. One way an organization can ensure repeat business is by developing a strong customer service program that includes service recovery as an essential component. The concept of service recovery involves the service provider taking responsive action to "recover" lost or dissatisfied customers and convert them into satisfied customers. Service recovery has proven to be cost-effective in other service industries. **The complaint management process:** The complaint management process involves six steps that organizations can use to influence effective service recovery: (1) encourage complaints as a quality improvement tool; (2) establish a team of representatives to handle complaints; (3) resolve customer problems quickly and effectively; (4) develop a complaint database; (5) commit to identifying failure points in the service system; and (6) track trends and use information to improve service processes. **Summary and conclusion:** Customer retention is enhanced when an organization can reclaim disgruntled patients through the development of effective service recovery programs. Health care organizations can become more customers oriented by taking advantage of the information provided by patient complaints, increasing patient satisfaction and retention in the process.

Study NO.3 Study of Boudreaux, E. D., Mandry, C. V. and Wood, K. (2003). "Patient satisfaction data as a quality indicator: a tale of two emergency departments." *Academic Emergency Medicine* 10(3): 261-8.

Objective: Patient satisfaction is a commonly measured indicator of quality emergency care. However, the existing empirical literature on emergency department (ED) patient satisfaction provides little guidance on how to analyze, interpret, and use data obtained in the clinical setting. Using two EDs as examples, the authors describe practical strategies designed to identify priority areas for potential improvement. **Methods** The authors used a cross-sectional, observational design. All patients who presented for emergency care during the designated time periods were eligible. Patients were randomly selected, contacted by telephone, and surveyed using three measures of global satisfaction, 23 perceived quality-of-care indicators, and six perceived wait times. Descriptive statistics were calculated. Comparisons were made of each of the perceived care and wait time indicators against explicitly defined acceptability criteria to determine satisfiers/dissatisfies. Each indicator was correlated with the three global satisfaction indices. The authors integrated results obtained from applying the acceptability criteria with those obtained from the correlations to yield priority indicators for remediation and maintenance strategies. **Result:** For

hospitals A and B, respectively, 15 (52%) and 16 (55%) of perceived care and wait time indicators failed to meet acceptability criteria. Using the correlations with overall satisfaction, the authors further narrowed the priority areas for remediation to six indicators for hospital A and three indicators for hospital B. One maintenance indicator was revealed for hospital A and four for hospital B. **conclusion** A combination of applying explicit acceptability criteria to descriptive statistics and using correlation coefficients with overall satisfaction can help to maximize the usefulness of patient satisfaction data by uncovering priority areas. These priority areas were broken down into maintenance and remediation indicators and were found to vary considerably depending on the hospital in question.

Study NO.4 Study of Chavan, R., Porter, C. and Sandramouli, S. (2007). "Formal complaints at an eye hospital:

A three-year analysis" *Clinical Governance* 12(2): 85-92.

Purpose: Complaints can provide the health provider with vital information on its performance and can point towards areas for improvement. The purpose of this study was to undertake a retrospective study of all formal complaints in an eye hospital over a three-year period in order to look at the complaint rate, demographics, their nature, how they were resolved and the lessons learned. **Design/methodology/approach:** Complaints received were entered onto the complaints module of the DATIX database system. Formal patient complaints between April 2003 and March 2006 available on the DATIX database were analyzed retrospectively. **Findings:** The study found that there were total of 94 formal complaints out of 186,323 attendances at the hospital. The overall complaint rate was 5.09 per 10,000 attendances. 52(55.31 per cent) complaints were about rescheduling or cancellation of appointments. Complaints related to communication failure were 17(18.08 per cent) followed by clinical complaints, which totaled 13 (13.82 per cent). Four (4.25 per cent) complaints each under the category of amenities, administrative and waiting times were also recorded. The complaint rate for Outpatients Department was 1.5 per 10,000 attendances. The in-patient ward had a complaint rate of 0.91 per 1000. The complaint rate for A&E department was 0.88 per 10,000 attendances. The operation theatre plus laser sessions had a complaint rate of 0.95 per 10,000. 79 (84.04 per cent) complaints were resolved at the first stage of local resolution. Complaints during the study period brought about two clinical changes in practice. **Originality/value:** The use of complaints data as an important tool to learn from less satisfied patients is recommended. Comparing and sharing data on complaints between hospitals can help to highlight common deficient areas and can also be used to plan strategies.

Study NO.5 Study of Taylor, D. M., Wolfe, R. and Cameron, P. A. (2002). "Complaints from emergency department patients largely result from treatment and communication problems." *Emergency Medicine* 14(1): 43-49.

Objective: Emergency department patient complaints are often justified and may lead to apology, remedial action or compensation. The aim of the present study was to analyze emergency department patient complaints in order to identify procedures or practices that

require change and to make recommendations for intervention strategies aimed at decreasing complaint rates. **Methods:** We undertook a retrospective analysis of patient complaints from 36 Victorian emergency departments during a 61 month period. Data were obtained from the Health Complaint Information Program (Health Services Commissioner). **Result:** In all, 2419 emergency department patients complained about a total of 3418 separate issues (15.4% of all issues from all hospital departments). Of these, 1157 complaints (47.8%) were received by telephone and 829 (34.3%) were received by letter; 1526 (63.1%) complaints were made by a person other than the patient. Highest complaint rates were received from patients who were female, born in non-English-speaking countries and very young or very old. One thousand one hundred and forty-one issues (33.4%) related to patient treatment, including inadequate treatment (329 issues) and inadequate diagnosis (249 issues); 1079 (31.6%) issues related to communication, including poor staff attitude, discourtesy and rudeness (444 issues); 407 (11.9%) issues related to delay in treatment. Overall, 2516 issues (73.6%) were resolved satisfactorily, usually by explanation or apology. Only 59 issues (1.7%) resulted in a procedure or policy change. Remedial action was taken in 109 issues (3.2%) and compensation was paid to eight patients. **Conclusion:** Communication remains a significant factor in emergency department patient dissatisfaction. While patient complaints have resulted in major changes to policy and procedure, research and intervention strategies into communication problems are indicated. In the short term, focused staff training is recommended.

Study NO.6 Study of Stevenson, D. G. (2005). "Nursing home consumer complaints and their potential role in assessing quality of care.[see comment]." *Medical Care* 43(2): 102-11.

Background: State survey agencies collect and investigate consumer complaints for care in nursing homes and other health care settings. Complaint investigations play a key role in quality assurance, because they can respond to concerns of consumers and families. **Objective:** This study uses 5 years of nursing home complaints data from Massachusetts (1998-2002) to investigate whether complaints might be used to assess nursing home quality of care. **Research design:** The investigator matches facility-level complaints data with On-Line Survey Certification and Reporting (OSCAR) data and Minimum Data Set Quality Indicator (MDS QI) data to evaluate the association between consumer complaints, facility and resident characteristics, and other nursing home quality measures. **Results:** Consumer complaints varied across facility characteristics in ways consistent with the nursing home quality literature. Complaints were consistently and significantly associated with survey deficiencies, the presence of a serious survey deficiency, and nurse aide staffing. Complaints were not significantly associated with nurse staffing, and associations with 6 MDS QIs were mixed. The number of complaints was significantly predictive of survey deficiencies identified at the subsequent inspection. **Conclusions:** Nursing home consumer complaints provide a supplemental tool with which to differentiate nursing homes on quality. Despite limitations, complaints data have potential strengths when used

in combination with other quality measures. The potential of using consumer complaints to assess nursing home quality of care should be evaluated in states beyond Massachusetts.

2-The difference between this study and other previous studies:

1- This study conforms to the previous studies in its role to emerge the impact of complaints management in improving services quality in health care.

2- This study distinguishes from other previous studies because it's reflecting the role of complaints in evaluating and improving the organizational performance. Also this study considered as the first study in the private hospitals in Khartoum Sudan

CHAPTER II

Literature review

CHAPTER II

LITERATURE REVIEW

INTRODUCTION

Comments and complaints from consumers provide unique information about their needs and the quality of care they receive. Open discussion of consumers' concerns helps healthcare professionals to understand potential problems and how to improve their service to the public.

Only a small proportion of people who are dissatisfied will lodge a complaint (less than 4 per cent), but they will tell their family and friends about their bad experience and go elsewhere if they can. A proactive approach to capturing consumer feedback is needed if consumers are to make a useful contribution to quality improvement, whether it's through complaints, suggestions or comments.

THEME ONE: COMPLAINTS MANAGEMENT SYSTEM

1-Definition of the complaints(Council for safety and quality (2005) "Complaints management hand book for health care services, Australian council for safety and quality in health care):

Complaints are an expression of dissatisfaction they may be an informal, verbal complaint or they may be a more formal, written complaint. Consumers complain about various aspects of health care, ranging from the minor to the catastrophic. However, even the most minor complaint can reveal issues that potentially affect patients' health outcomes, and all complaints should be taken seriously. Consumers are not only focused on themselves when they make a complaint they are often concerned with the quality of the health system generally.

2- Benefits of complaints management

While poor complaints management can damage your service, good complaints management systems help:

- a) Improve the safety and quality of the service, by providing information about the experiences of consumers and careers.
- b) Restore the trust and confidence of a consumer or career.
- c) Save management time by the quick and simple resolution of complaints, avoiding escalation.
- d) Promote a culture of reporting and accountability.
- e) Prevent wasteful practices and reduce the costs, such as insurance.
- f) Create a more satisfactory working environment for clinicians and staff; and
- g) Enhance the reputation of the service and prevent negative comments or publicity.

3- Fairness

Good complaints management procedures are based on the principles of fairness and natural justice. Fairness means that decisions are fair and seen to be fair, and based on what is regarded as good practice in the health care sector. Natural justice requires that consumers, health care professionals and other staff know the claims that have been made in a complaint and their views are considered without bias or prejudice.

Fairness requires that information provided for the purpose of complaints is kept confidential, unless the law requires disclosure. Fairness also means people can go to an independent health care complaints commission at any time if they wish.

4- Good complaints handling

The traditional approach to dealing with complaints in the health care sector was to avoid them and deal with them separately from other risk management and compliance issues.

Under this approach the investigation of complaints examined only what happened, not why, with a focus on the individuals directly involved rather than the systems of care.

The quality improvement approach to handling complaints has a number of elements:

- a) Actively encouraging feedback from consumers about the service.
- b) Negotiating with consumers about outcomes and not just ‘telling them’.
- c) Managing complaints as part of risk management, enabling appropriate reporting, assessment and follow up action; and
- d) Learning from complaints and consumer feedback, enabling improvements to the systems of care.

Good complaints management means being open with consumers, investigating the causes of what happened and developing strategies to prevent re-occurrence.

5- Complaints and quality

Quality improvement in the health care sector emphasizes the need for reporting and analyze is of all types of incidents that have, or may have, caused harm so they might be prevented in future. Quality improvement promotes:

- a) A new culture of trust so adverse events are reported and discussed, instead of a culture of blaming and isolating individuals.
- b) A greater partnership between consumers and health care professionals.
- c) Clear lines of accountability for individuals and the organization; and
- d) Services that are designed from the consumer’s perspective, rather than the ‘silos’ of professional specialty or types of care.

Information on poor quality services is available from a range of sources: mortality and morbidity rates; confidential surveys of doctors; clinical and medical audit; post operative infection rates and rates of re-admission. Consumers’ views about the quality of care are equally relevant to the quality improvement jigsaw.

6- Learning from mistakes

Recognizing the factors that enable learning from mistakes is an essential element of effective quality improvement. Lessons can be learned from error regardless of the consequences that flow from the mistake. Monitoring all types of incidents that have the

potential to result in harm is, therefore, important. This preventive approach is reflected in the Australian Council for Safety and Quality in Health Care's definition of 'incident'.

Organizational culture is central at every stage of the quality improvement cycle, from identifying and reporting incidents, through to making sure the necessary changes occur.

A 'safety culture' promotes reporting and balanced analysis, in principle and practice.

Conversely, a 'blame culture' encourages cover up for fear of retribution, with a heavy focus on individual actions and largely ignoring the role of underlying systems of work and systems of care.

Reporting systems are vital for providing useful and reliable information for analysis and recommendations. Experience in other industry sectors demonstrates the value of systemic recording and reporting of a wide range of performance-based information.

7- Attitudes to complaining

The first and most important step in good complaints management is to be open to complaints and see them as an opportunity for improvement. In the health care sector, this poses a significant challenge as neither doctor nor consumers are comfortable with complaints.

Consumers and their careers are reluctant to complain about health care services because they generally place a high level of trust in health care professionals and rely on them for their expertise. The fact that people are unwell makes them reluctant to express dissatisfaction or even to ask for explanations. Fear of repercussions and simply not knowing how to go about lodging a complaint have also been found to be significant deterrents.

One approach to overcoming these feelings is to treat complaints as part of a wider consumer feedback strategy. This encourages consumers to talk about whether their needs are being met, and invites compliments as well as criticism.

Changing the way health care professionals feel about complaints and error requires training, and structured time for clinicians to reflect on their performance among trusted colleagues. Trusted and credible systems for reporting and analyzing error are also essential.

8- Consumer participation

The quality improvement approach supports consumers being active participants in their health care. Consumers, and nominated family members, need to be included in discussions about their care, and treated as a member of the care team. This helps to enable consumers to take responsibility for decisions about their care. When something goes wrong consumers need to be informed, be involved in discussions about any remedial treatment required, be told the findings of an investigation and action that will be taken to improve the service in the future.

In the context of complaints, health care services need to find out what the complainant wants, be open about what happened and be prepared to come to a mutual agreement about the outcomes.

9- Health care complaints commissioners

Since the early 1990s every state and territory government has established an independent, statutory body to deal with complaints about health care services. The commissioners conciliate complaints where appropriate and refer serious complaints about health professionals to the relevant professional registration authorities. Some commissioners also investigate complaints and provider reports about standards of care.

10- Indicators of good complaints management

Good complaints management in a health care service is evident when:

- a) Principals and executive managers demonstrate support for consumer feedback about the quality of the service, including complaints;
- b) All clinicians and staff are trained in complaints resolution and understand their responsibilities for dealing with complaints;
- c) Consumers and their families are aware of the complaints policy and feel comfortable using it;
- d) The service promotes awareness of health care complaints commissioners;
- e) Prompt and appropriate resolution of complaints takes place, using a joint problem solving approach;
- f) Complaints are recorded to support effective management of individual complaints and analysis of trends in all types of complaints;
- g) All complaints are assessed for risk and appropriate steps are taken;
- h) Complaints are investigated to determine the events that occurred, the causes and to identify preventive strategies;
- i) Complaints resolution procedures reflect the principles of fairness and natural justice;
- j) Clinicians and staff routinely discuss complaints and other incidents;
- k) Complaints are reported to the community as part of quality improvement reporting;
- l) The performance of the complaints management system is monitored and regularly evaluated with advice from consumers, clinicians and staff;
- m) Complainants, clinicians and staff are satisfied with the complaints process and outcomes; and
- n) Changes are made to improve the service in response to issues raised in complaints.

11- Implement the Better Practice Guidelines on Complaints Management for Health Care Services (Council for safety and quality (2005) "Complaints management hand book for health care services, Australian council for safety and quality in health care):

The Guidelines asset out the key principles for good complaints management and indicators that describe practices consistent with each principle

The eight Guidelines are:

- 1- Commitment to consumers and improvement
- 2- Accessibility
- 3- Responsiveness
- 4- Effective assessment
- 5- Appropriate resolution

- 6- Privacy and open disclosure
- 7- Gathering and using information
- 8- Making improvements

Guideline 1: Commitment to consumers and improvement

Leaders in the health care service promote a consumer focused approach to complaints as part of a continuous quality improvement program.

1-Leadership

Every organization has a unique culture, reflected in the beliefs and philosophies about how things are done and the reasons why. The most influential factor in changing attitudes and culture in an organization is leadership from those in authority—practice partners, senior clinicians, chief executive officers and board members.

Leaders need to be visible in their support of quality improvement processes and promotion of consumer-centered care. If good complaints handling is a genuine priority, the CEO (Chive Executive Officer) or practice partner will be actively involved because of their belief that they regard this as a good use of their time.

2-Complaints policy

A formal complaints policy and procedure enables your clinicians and staff to understand what is expected of them. It promotes the view that complaints are an integral part of modern health care practice, not just an annoyance or distraction. A policy is also important to inform consumers and their families about your approach to dealing with complaints.

Complaints management policy needs to be clear, and indicate how:

- a) Your service encourages feedback and complaints;
- b) Risk assessment and follow up occur;
- c) Complaints are investigated;
- d) Complaints are recorded and reported;
- e) Serious complaints are dealt with; and
- f) Complaints can lead to improvement in the quality of service.

3-Staff training and awareness

All clinicians and staff need to know and understand how your service's complaints and risk management processes work. Training about the complaints policy should be provided as part of the initial induction program and in follow up training on the service's procedures.

Clinicians and staff who are dealing with informal complaints at the point of service will need specific training and support in customer service, communication and dispute management techniques. The level and quality of training will reflect the commitment of principal partners and executive management

Promoting the discussion of complaints among clinicians and staff helps to promote awareness and understanding of complaints management.

4-Communication and informed consent

Effective communication with consumers is fundamental to good health care services.

Poor or inadequate communication with consumers is the reason behind many complaints and legal claims, so good communication is an essential part of risk management.

A written policy and procedure on informed consent and communication with consumers helps to support good practices.

An informed consent policy needs to address:

- a) Effective approaches to communication
- b) The subjective nature of comprehension, particularly in stressful circumstances.
- c) Techniques to check the level of understanding of information.
- d) Use of written information sheets; and
- e) Recording the details of what has been communicated.

Checking the effectiveness of informed consent practices is also essential.

5-The complaints manager

Good complaints management requires a senior clinician or staff member to have the specific responsibility for making it work properly. The complaints manager to be effective, need to:

- a) Have sufficient authority to address the issues that are raised in complaints.
- b) Be of a level and position that will attract the respect and cooperation of all clinicians and staff;
- c) Report to the chief executive officer or principal who has the authority to follow up an issue; and
- d) Be accessible to consumers and their families.

The position needs to be linked to the systems and personnel who are responsible for risk management, quality improvement and compliance.

The complaints manager's job is to:

- e) Attempt to achieve a satisfactory resolution of complaints;
- f) Assist complainants to describe their concerns and to understand complaints procedures and responses that the service may provide;
- g) Assist clinicians and staff to gather information about individual complaints, and any strategies for improvement in service as a result;
- h) Ensure clinicians and staff understand the complaints policy, and know how complaints are handled;
- i) Ensure that risks are assessed and immediately notify senior management of any high risk complaints; and
- j) Ensure that the lessons learned from complaints are used to improve the service.

These tasks require special skills. Therefore, a complaints manager needs to:

- k) Have skills in assessing a complaint, gathering information, managing timelines and negotiating with people;
- l) Be impartial;

- m) Be ethical when promoting the service or eliciting information from any person involved in a complaint;
- n) Ensure equal and fair participation of all parties involved in a complaint;
- o) Maintain confidentiality;
- p) Be able to identify and acknowledge concerns;
- q) Show understanding through listening and questioning skills;
- r) Use appropriate language and terminology;
- s) Be able to use conflict resolution strategies; and
- t) Be accessible, well organized and consistent.

The complaints manager needs sufficient resources to be efficient and effective in their job. A good system for recording and reporting complaints is essential if the service wishes to save time and generate useful information.

Complaints managers and others frequently dealing with complaints need:

- a) Complaints handling procedures and reference materials that are easy to access.
- b) A good complaints handling environment (for example, interview facilities and a private space).
- c) Adequate work tools (for example, telephone, computer, printer and copier).
- d) Secure facilities to record and store information about complaints.
- e) Access to clinical assistance, medical records and other information to help interpret the events that have occurred and the reasons behind them, and to help resolve any misunderstandings.
- f) Access to senior management for reporting of any high risk complaints; and
- g) Authority to disclose information to consumers, where required.

The job of the complaints manager is to coordinate complaints as part of the quality improvement framework. All clinicians and staff are responsible for communicating with consumers and attempting to resolve complaints and concerns as they arise.

Guideline 2: Accessibility

Encourage consumers to provide feedback, including concerns and complaints, and make it easy to do so.

1-Promote your policy

In general, people are reluctant to complain about health care services. Your service needs to actively promote the message that your service welcomes discussion and comments about the quality of service and care that you provide.

The most effective way to obtain consumer feedback is for clinicians and staff to invite them to comment in the course of conversation and discussion. Clinicians and staff need training and guidance for this task, and assurances that their efforts will be supported. Other ways to promote awareness of your consumer feedback and complaints program are:

- a) A Consumer feedback brochure
- b) Placing posters or signs in public areas.

- c) Publishing a summary of the Complaints Policy in a prominent position on your service's website; and
- d) Mentioning the program in general publicity.

2-A variety of ways to give feedback

Encouraging people to provide feedback is best achieved if a variety of methods are offered.

The most effective methods are:

- a) Clinicians and staff recording comments from consumers or making observations
- b) A consumer feedback brochure
- c) A suggestion box (when combined with signage and feedback forms); and
- d) Consumer satisfaction surveys.

3-Anonymous complaints

One of the common reasons people are reluctant to complain about health care services are a fear that it will adversely affect their future treatment or access to the service. While providing assurances that complaints will not result in any kind of retribution, allowing people the option of providing feedback anonymously is also important. Complaints and other feedback received anonymously can be valuable in providing information about trends and specific issues. The information is valuable, even if issues cannot be thoroughly pursued due to a lack of information.

4-Special needs

Special measures may be needed to ensure everyone in your client base is aware of our consumer feedback policy and is comfortable with raising their concerns.

Some people are less likely to complain for cultural reasons.

People with certain conditions such as hepatitis C or with a mental illness, may have concerns about discrimination that will make them less likely to speak up if they are not satisfied or if something is wrong.

Some people need assistance if they wish to make a complaint.

Guideline 3: Responsiveness

Acknowledge all complaints and concerns and respond promptly and sensitively.

Managing complaints should be the responsibility of everyone in a health care service because it is part of effective communication with consumers and providing quality healthcare.

People with a complaint about health care services want to be treated with dignity and be assured that their complaint will be treated seriously. A positive attitude to complaints by clinicians and staff is crucial in successful complaints management.

1-Three levels of complaints handling:

Level one: Informal

Straightforward matters that clinicians and staff can resolve at the point of service;

Many complaints can be resolved immediately at the point of service—on the ward, clinic, office or home. Clinicians and staff need to be encouraged to resolve complaints at the point of service, before frustration and delays worsen the situation.

Level two: Formal

More complex matters that may need to be referred to a supervisor or complaints manager; If a complaint is not resolved at the point of service, and the complainant wishes to pursue the matter, they need to be told the complaint is being handled formally. A follow up letter acknowledging the complaint is useful. If a complaint has been received by mail or email, a written acknowledgement needs to follow

Level three: Serious and unresolved

Complaints that may require notification to external bodies such as insurers or regulatory bodies will be referred to principals or senior management

2-Minimizing conflict

To help minimize conflict and move towards resolving the problem, clinicians and staff need to:

- a) Provide their name;
- b) Listen to the complaint without interrupting;
- c) Be empathetic and recognize the person's feelings;
- d) Be attentive and courteous;
- e) Use clear language and avoid inflammatory language;
- f) Be open and respectful; and
- g) Provide and accept feedback.

After the complainant has spoken, the information they have given needs to be summarized to confirm the basis of the complaint. Clarification or questions about desired outcomes can then be pursued.

3-Timeframes

The most common causes of dissatisfaction in complaints management are the long delays in resolution and the failure to inform complainants of the progress in their case.

The complaints policy of your service needs to set target timeframes for:

- a) How soon your service will acknowledge complaints (within two days is good practice);
- b) How soon your service will refer serious issues to external agencies (no more than three days);
- c) How quickly complaints will be discussed, investigated and resolved; and
- d) How often your service will provide information to complainants.

4-Tracking complaints

Using a tracking system will support essential tasks being completed within the time frames stated in your service's complaints policy. This could consist of a tracking sheet to provide a summary record of the progress of each complaint, including the dates of letters, interviews, phone calls and meetings. Tracking sheets also support continuity when staff changes occur or where numerous people in large organizations may be involved in handling a complaint.

Tracking can be performed effectively by paper-based file or a computer record.

Guideline 4: Effective assessment

Assess complaints to determine appropriate responses by considering risk factors, the wishes of the complainant and accountability.

Complaints need to be assessed to decide the most appropriate course of action and to ensure serious incidents receive immediate attention. The first level of assessment occurs at the point of service, where clinicians and staff assess whether they can deal with the complaint or not

The first step is to take some time to understand the problem. In some cases, what is said or written down by a complainant may not reflect their real concerns. It can require time and patience to gain an understanding of their underlying issues.

1-Resolution options

Most complaints will be resolved directly through a simple process of negotiation and discussion with the complainant, which will usually follow an investigation of the events and why they occurred. However, in some circumstances, it may be more appropriate to have a complaint dealt with by a health care complaints commissioner, or an independent mediator. The complaints manager should understand the processes used by health complaints commissioners and how long they take.

A complaint might need to be referred for external resolution if:

- a) There are complex technical issues or a large number of people involved and the healthcare service does not have the expertise to manage it;
- b) The issues raised are so serious that managing the complaint internally would be inappropriate; and
- c) The person who is the subject of the complaint is the person who manages complaints, which may be perceived as compromising impartially.

2-Assessing risk

Risk management strategies help your service to identify, assess and manage risk. Risk management is not necessarily designed to reduce or eliminate risk, but to understand and consciously manage it. All formal complaints should be assessed immediately after they have been received to identify the level of risk and the appropriate course of action that needs to be taken. The purpose of risk assessment at this stage is to identify high risk complaints that raise significant safety, legal or regulatory issues, that need to be notified to senior management immediately.

The severity assessment code or seriousness assessment matrix is a useful tool to assist with consistent and reliable risk assessment. A fixed rank rating can be obtained by combining the consequences (or impact) of an incident with the probability (or likelihood) of the same type of incident recurring.

3-Performance of individuals

Risk assessment also requires assessment of individual clinicians to identify behavior that may be unsatisfactory professional conduct, requiring consultation with health care complaints commissioners or professional registration boards. Unsatisfactory conduct by a health professional includes:

A lack of knowledge, skill, care or judgment;

- a) In appropriate behavior, including criminal acts (for example, assault or fraud);
- b) Inappropriate sexual relationships with consumers; or
- c) Inappropriate prescribing.

4-External referral

Your service needs to have a clear policy setting out when you are legally obliged to notify regulatory bodies, such as coroners, and circumstances where you will consult with professional registration boards and health care complaints commissioners about the behavior of individual.

The CEO or principal should consult with the relevant professional registration board or health care complaints commissioner where there is behavior that raises a significant risk to the health and safety of consumers or raises a significant concern as to the appropriate care or treatment of a consumer.

All clinicians and staff need to have a basic awareness of this policy and the person responsible for making notifications. The circumstances in which notifications should be made to insurers will also be included.

Guideline 5: Appropriate resolution processes

Deal with complaints in a manner that is complete, fair to all parties and provides just outcomes.

1-Fairness

Natural justice, or procedural fairness, is a legal principle that requires investigations into complaints to be conducted in a fair and even-handed way. It requires attention to be given to any power imbalance that may exist between the complainant and your service, or a staff member. Natural justice also requires decisions to be based on relevant material, and the decision maker to be free of prejudice or bias.

The process for investigating and resolving complaints needs to be clear so complainants, clinicians and staff who are directly affected can follow what is happening. Uncertainty and delays should be avoided by setting timeframes for completing the key stages of the process. If investigating and resolving a complaint is likely to be a complicated process, the investigation can be broken up into stages.

Natural justice also requires:

- a) The complainant and any clinicians and staff directly affected by a complaint to be informed of the nature of the claims that have been made and have an opportunity to provide information relating to the complaint;
- b) Policies and procedures to be followed, so the process is well known and predictable;

- c) Decisions to be based on relevant information, including the views of the complainant, clinicians and staff directly involved; and
- d) All interested parties to be informed of final decisions and the reasons for the decisions.

2-Joint problem solving

Negotiation is the process of people attempting to work through their differences and reach an agreed solution. This is a two-way process that requires people to explore options, listen to each other and identify common ground. In most cases, negotiation can only be effective after there has been an investigation into a complaint.

Providing an opportunity for people to discuss their concerns can result in information that is more useful and more detailed. Telephone contact and face-to-face meetings are essential for an exchange of information and to rebuild trust. A joint problem solving approach to negotiation is particularly important where there is a continuing relationship between a health care service and a consumer

Joint problem solving negotiation requires the person conducting the negotiation to:

- a) Have knowledge about the subject matter;
- b) Be able to think clearly;
- c) Listen actively and ask questions, not just provide a lecture;
- d) Identify the issues and interests (underlying motivations), not just the respective positions (demands);
- e) Separate the person from the content of the complaint;
- f) Discuss what would happen if there was no agreement between the parties;
- g) Develop a range of options; and
- h) Ensure that any agreement is workable for all parties.

3-Investigating complaints

The nature of an investigation into a complaint will vary according to the nature of the complaint. Investigating a complaint consists of:

- a) Collecting relevant facts—interviewing all people involved in the complaint, collecting relevant records, accessing policy and procedure documents and examining equipment;
- b) Analyzing the information collected;
- c) Making findings about the events and the underlying causes of the complaint; and
- d) Considering strategies and making recommendations for improvements.

In serious matters, it is important that investigations begin as soon as possible while memories are fresh and before material relevant to the case is lost or destroyed.

The investigation process needs to analyze the underlying causes of complaints from an organizational and systems perspective.

Once the cause of the problem has been correctly identified, strategies to prevent it occurring in the future can be developed. Once again, the person making the decision needs to keep an open mind, and avoid the assumption that the solutions lie entirely with increased funding or resources.

4- Informing complainants and others

After an investigation has been completed, the results should be provided to the complainant and any clinicians and staff directly involved. The Open Disclosure Standard advises that at the conclusion of an investigation health care services should provide consumers with:

- a) An expression of regret for the harm suffered;
- b) Clinical and other relevant facts;
- c) Details of the concerns raised by the consumer;
- d) A summary of the factors contributing to the adverse event; and
- e) Information on what has been done and will be done to avoid repetition of the adverse event, and how this will be monitored.

The information may be provided in a letter or a face-to-face meeting, or both. Care needs to be taken to ensure it is presented in a sensitive and clear manner. If sensitive information is discussed during or after an investigation, the people who discuss the information with the complainant should be:

- i) Already known to the complainant;
- ii) Familiar with the facts;
- iii) Senior and credible; and
- iv) Able to communicate well and offer reassurance and feedback

5-Just outcomes

The action a health service is prepared to take to resolve a complaint should be just that is, it should be appropriate and respond to the needs of participants as far as possible. A policy of aiming to achieve the best outcome for everyone is fair.

The most commonly sought-after outcomes from a complaint to health care services are:

- a) An explanation;
- b) An apology;
- c) A request for the health care professional to show they care;
- d) Rectifying the problem: for example, an earlier appointment or a bill adjustment;
- e) Reassurance and sympathy; and
- f) To prevent the same incident occurring to other people.

Compensation may need to be considered in some cases. Contact your service's insurer or indemnity provider for advice on the options that are available.

The service should confirm that the complainant is satisfied with the outcome of the complaint by telephone call or letter.

If a complaint is not resolved everyone should have a clear understanding about what the next steps might be. Consumers should be reminded that they can take their complaint to an external complaints body such as a health care complaints commission.

A letter should be sent to the complainant confirming that you understand the matter remains unresolved and informing them of the options that are available to them.

Guideline 6: Privacy and open disclosure

Manage information in a fair manner so relevant facts and decisions are openly communicated while confidentiality and personal privacy is protected.

Confidentiality and fairness are important principles for any complaints management system. The principles create a tension between keeping some information confidential, while being open with consumers, clinicians and staff about information and decisions that directly affect them. The service's complaints policy and procedures need to provide clear guidance on these issues.

1-Confidentiality

Information gathered during the course of an investigation will generally be kept confidential because it:

- a) Helps people to feel safe about coming forward with a complaint, as their name will not be disclosed (unless they want this to happen);
- b) Prevents incomplete or inaccurate information being released until all the facts are established; and
- c) Protects individual reputations from being harmed by unsubstantiated allegations.

2-Open disclosure

The Open Disclosure Standard provides for consumers and their nominated family member to be given information, including the following, when they have suffered harm as a result of an adverse event:

- a) An acknowledgement that an adverse event has occurred;
- b) The known facts about what has happened;
- c) Information about further treatment required;
- d) An explanation of how the adverse event will change anticipated care and short-term effects; and
- e) Advice that an investigation will occur and how feedback from the investigation will be provided.

The Standard advises that while disclosure is required where harm has occurred, it may also be appropriate to disclose to a consumer where an incident has occurred, but no harm is immediately apparent. This is a matter of judgment by the health care treating team.

3-Privacy

Privacy obligations apply to personal information, including personal information collected and used for the purpose of resolving a complaint. Personal information is information that identifies or could identify an individual, not just a name, address and Medicare number.

The key elements of privacy, relevant to managing complaints records, are:

- a) Keeping complete, accurate and up-to-date records of complaints;
- b) Collecting only the information that is relevant to the complaint;
- c) Keeping records secure and confidential; and
- d) Informing the complainant at the outset of investigation about how their personal information is likely to be shared with others, such as insurers and other clinicians.

Take care not to include any information that identifies individuals in reports about complaints, whether for internal or public use. ‘De -identify’ the information by removing details that enable the identification of a consumer, staff member, clinician or other person. Privacy laws also generally require that personal records be destroyed once they are no longer required for the purpose for which they were collected. Laws applying to the public sector, such as archives and state privacy laws specify retention periods.

4-Access to medical records

Providing people with access to their medical records, and an explanation of what they mean is often important in addressing misunderstandings that have led to a complaint. The privacy policy of your service will set out how to deal with requests by consumers for access to their records, and requests from family members. The complaints manager needs to be familiar with the privacy policy and have access to medical records to help facilitate a solution.

Guideline 7: Gathering and using information

Record all complaints to enable review of individual cases, to identify trends and risks, and report on how complaints have led to improvements.

1-Recording informal concerns

Information about informal complaints and concerns that have been resolved at the point of service is enormously valuable for quality improvement purposes. By analyzing the types of issues raised in these complaints and the outcomes agreed, the service can recognize recurring problems and devise strategies to prevent them recurring.

Staff and clinicians will need to be encouraged to record informal complaints and concerns.

A quick and easy method for recording complaints is essential.

2-Formal complaint records

Records of formal complaints need to be complete, but does not need to be elaborating a simple paper file is sufficient for smaller health care services. The record needs to:

- a) Identify the person responsible for managing the complaint;
- b) Track the progress of the investigation and resolution of the complaint;
- c) Record the views of the complainant about the events that have occurred and the outcome they are seeking;
- d) Keep a log of conversations, correspondence and other documents;
- e) Outline how and when a risk was assessed and follows up action taken, including any notifications to managers, to insurers and to others;
- f) Record decisions about the facts and the cause(s) of the complaint;
- g) Record the outcomes for the complainant; and
- h) Record any recommendations for change and how they will be implemented.

Complaints managers who administer the complaints records should distinguish established facts from speculation or claims.

3-Reports on complaints

The way your service reports on complaints will vary according to the size of the organization. In large organizations statistical reports on the number and types of complaints are likely to be provided on a monthly or three-monthly basis, whereas in smaller services with small numbers of complaints, statistical information may only be useful on an annual basis.

In smaller services, the system of recording complaints can be simple, but someone needs to be responsible for analyzing and reporting the information!

4-Reporting to staff and management

Structured time for clinicians and staff to discuss consumer complaints and other incidents is one of the most important strategies for supporting a quality improvement culture in a health care service. Statistics on trends and narrative reporting of individual complaint provide a useful contribution to discussion of the issues and help to reinforce their role in resolution and improvement.

In addition to the immediate referral of serious matters to senior management, there should also be regular reports on complaints to senior clinicians and management. These reports need to address clinical governance and organizational performance issues. The reports should cover:

- a) The number and type of complaints (formal and informal) in a specified period (in larger organizations provide this for each service unit or department);
- b) Trends in the number and types of complaints over time and factors influencing the trends;
- c) Significant individual complaints that highlight systemic problems;
- d) Information about the risk ratings of complaints;
- e) The time taken to resolve formal complaints compared with timelines in the complaints policy;
- f) The types of outcomes achieved for complainants;
- g) Recommended improvements;
- h) Whether previous recommendations have been implemented; and
- i) Monitoring of the impacts of changes that have been implemented.

5-Reporting to the public

Publicizing how complaints resulted in improvements to your service educates consumers about the benefits of speaking up if they have a concern and improves your reputation.

Complaints information can be in the annual report or in stand-alone quality improvement reports. Smaller services can report on complaints and other consumer feedback in general publicity.

Reports to the public should offer useful information about complaints, such as:

- a) The number and type of complaints in the current year, compared with previous years;
- b) The common types of outcomes from complaints;
- c) Initiatives taken to address consumer complaints or feedback;
- d) The impact of improvements made as a result of the complaints process; and
- e) The performance of the complaints process when compared with the complaints policy.

If your service conducts surveys of consumer satisfaction or consumer experiences, include a summary of the results in the reports.

Guideline 8: Making improvements

Use complaints to improve the service, and regularly evaluate the complaints management policy and practices.

1-Using complaints to improve the service

Executive management, including hospital boards or principal partners, need to regularly receive reports on complaints so they can analyze trends in complaints, and identify where and how complaints are addressed within the organization. The focus should be on the organizational systems, such as work flow and systems of care that create those trends, rather than on individuals.

Complaints and consumer feedback information should be used when making strategic and operational decisions about planning, professional development and quality improvement.

Consumer feedback and complaints should appear in strategic and business plans, annual reports, and mission statements.

Complaints and other incidents rated as high risk should always be notified promptly to designated senior clinicians or executive managers. Their responsibility to respond appropriately to these notifications should be included in their job descriptions and assessed regularly in performance appraisals. The responsibilities are to instigate investigation, reporting, analysis, review and implementation of follow up action.

An exit survey can be a useful way to check if people are satisfied with the complaints process and the outcomes.

Contact people by telephone or use a written survey form to ask if the process was timely, fair or effective and whether they were satisfied with the outcomes.

2-Routine monitoring and review

Routine monitoring and review of your service's complaints system is necessary to check that the system works in the way the complaints policy intended. Performance reports should be compiled regularly against preset performance criteria, which will typically cover:

- a) How long it takes to resolve formal complaints compared to the timeline in the complaints policy;
- b) Levels of clinician, staff and consumer awareness of the complaints process, measured through the results of spot quizzes;
- c) How high risk complaints were managed by senior clinicians or managers;
- d) Recommendations from board meetings or principal partners' meetings arising from complaints reports;
- e) Recommendations that have been implemented and the impacts monitored;
- f) Trends in the number and types of complaints, formal and informal, and factors that may have influenced trends, such as specific quality improvement initiatives; and

g) Levels of complainant, clinician and staff satisfaction with the processes and outcomes of complaints.

When devising your service's performance criteria or measures of success, be careful with numbers and statistics. If you are seeking to improve consumer awareness of complaints or consumer feedback, a relevant measure of success may be an increase in the number of complaints, not a decrease.

3-Evaluation

A more detailed evaluation of your complaints system should be conducted every few years to assess where it is working well and where improvements may need to be made.

Evaluating your complaints system involves:

- a) Asking people who have used the complaints system what they thought of the process and the outcomes;
- b) Asking all consumers what they know about the complaints process and what they expect;
- c) Using statistical information to check timelines, the number and types of complaints that have been made and how this has changed over time, and the outcomes of individual complaints;
- d) Using complaints records and reports to determine the changes that have been implemented and how they have been monitored; and
- e) Comparing your complaints system against external standards, and where possible, with services of similar size and nature.

Your service needs to consider revising the complaints policy and procedure if there have been significant changes in organizational structure, or client base.

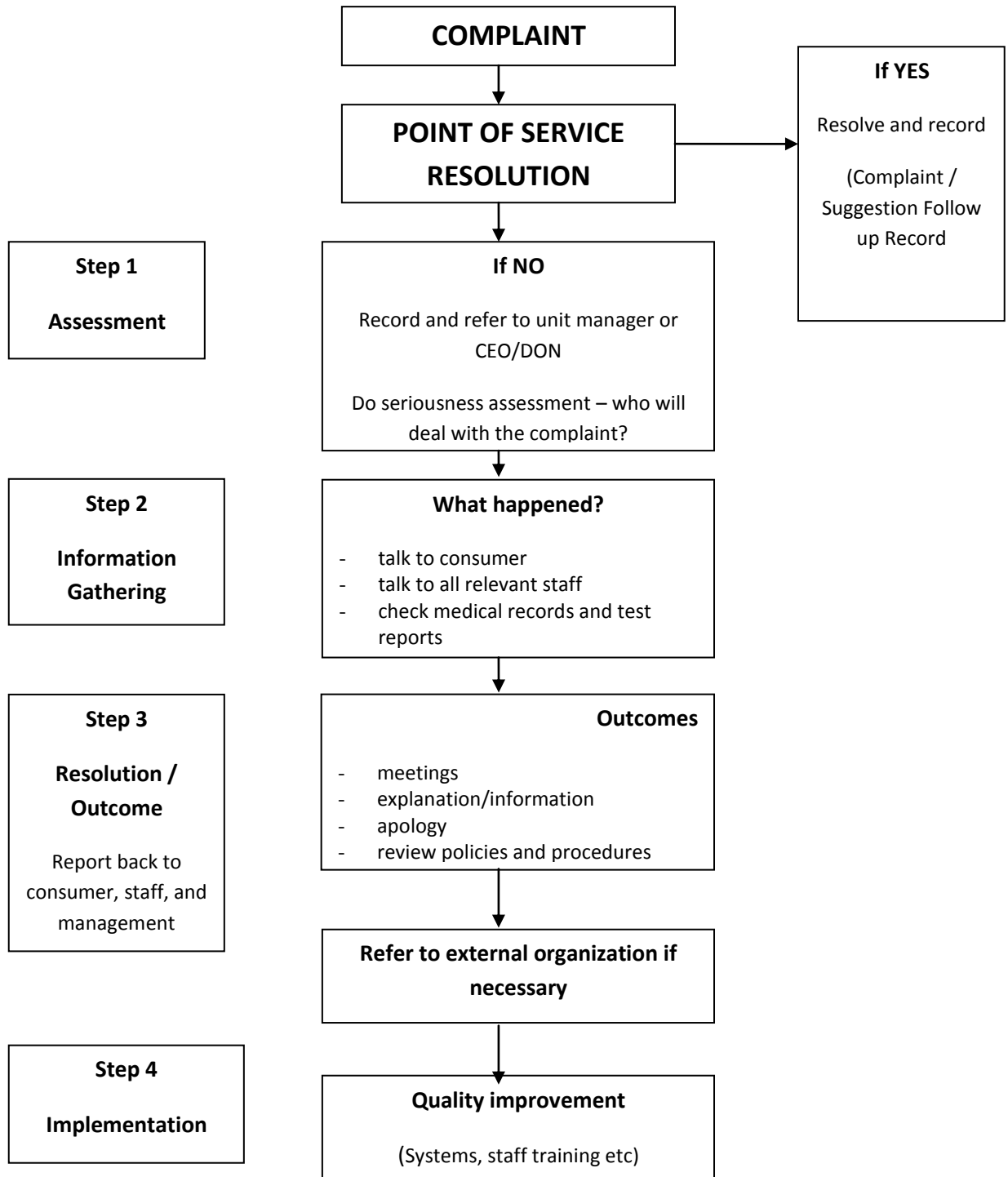
To determine what clinicians, staff and consumers think of the complaints system, your service needs to ask them. Clinicians and staff can be asked about issues such as the adequacy of training and support and whether they are comfortable dealing with complaints.

Written and telephone surveys are the most common method of obtaining consumer views, but a special purpose discussion group, or focus group, can also be helpful. These groups offer interactive discussion, which can provide more information than surveys. Consider the type of people you are trying to attract and what is likely to make the discussion interesting for the participants. Support groups for people with specific health conditions can be a good place to find people who would be interested.

Use questions about people's specific experiences and knowledge to measure the performance of the complaints system. Use open-ended questions to find out where people believe improvements could be made.

FLOW CHART OF COMPLAINT MANAGEMENT

The key to handling complaints is making the process easy for all parties and adhering to timeframes. Figure (2.1)



Source: Council for safety and quality (2005) "Complaints management hand book for health care services, Australian council for safety and quality in health care".

THEME TWO: THE SERVICES QUALITY

FIRST: Services as general

1-Service Definition:

A social act, which takes place in direct contact between the customer and representative of the service company (Sudan University of Science and Technology (2007)" Module 7 Customer Service Management)

2- Features of Service:

Supporting facility-a

The physical resources, i.e. location, supporting equipment

Facilitating goods:-b

The materials purchased or consumed by the buyer.

Explicit service:-c

The benefits really observable by the customer

Implicit service:-d

The psychological benefits the customer may observe.

3- Characteristic of Service:

The important of service can be difficult to pin down as the judgment of a given service can only be seen through the eyes of the person receiving it. Nonetheless, service commentators have attempt to define the characteristics so that we can try to understand the nature of service in order to give basis for service design and the development of methods to measure the performance of service delivery.

In looking at the characteristic of service, it is helpful to make comparisons between services and manufactured goods:

a-Intangible

b- Simultaneous production and consumption

c-Time perish ability

d-Variability

e-Personal encounter

f-Labour intensive

g- Transaction numbers

SECOND: Service Quality

1- Definition:

The importance of service quality as an indicator of customer satisfaction

Zeithmal and parasuraman and berry define service quality in terms of the discrepancy between the customer's expectation and their perceptions.

2- Dimension of Service Quality:

An empirical and theoretical analysis of previous and contemporary literature on service quality has been performed in order to discover the common and key dimensions of service quality in the traditional service environment. This analysis was carried out chiefly in regard to studies that implemented the SERVQUAL, considered to be the key model in the service quality research. The research studies analyzed cover a diverse mixture of service industries including, for example, hospitals and the health-care sector, banking and the financial services sector, fast food chains, the telecommunications industry, retail chains, information systems, library services, hotels and leisure services, travel and tourism, car servicing, higher education, hospitality, business-to-business channel partners, accounting firms, architectural services, recreational services, airline catering, apparel retailing and local government (Carman, 1990; Johns, 1993; Parasuraman et al., 1994). Moreover, they were implemented in various cultural environments including, for example, the US, China, Australia, Cyprus, Hong Kong, Korea, South Africa, the Netherlands, the United Arab Emirates and the United Kingdom (Babakus and Boller, 1992; Pitt et al., 1995; Lam 2002). Examples of empirical research papers implementing the SERVQUAL model in their measurements of the service quality concept include those by Cornin and Taylor (1992), Augustyn and Ho (1998) and Wong (2002).

Researchers have put a lot of effort into discovering the key dimensions and attributes used by consumers in the process of evaluating service quality (Ibrahim et al., 2006; Sohn and Tadisina, 2008; Lau et al., 2011). Rosen and Karwan (1994) stated that building a group of attributes to be used to assess service quality is the first move in evaluating the quality of the actual service. Parasuraman et al. (1985) outlined ten dimensions of service quality: reliability, responsiveness, competence, access, courtesy, communication, credibility, security, understanding/knowing the customer, and tangibles. Subsequently, Parasuraman et al. (1988) refined the ten service quality dimensions and reduced them to the SERVQUAL's five generic dimensions of reliability, assurance, tangibles, empathy, and responsiveness. In the marketing literature, these refined five attributes are considered to be the common service quality dimensions. Most academic studies have since adopted these attributes and in most cases they have been the starting point for conceptualizing and developing further service quality research this is due to in

large part to their founders' assumptions, since they represent a generic battery that can be used to evaluate service quality in any service industry. The following sub-sections provide brief explanations of these variables.

a) Reliability

Parasuraman et al. (1988, p. 23) defined the term "reliability" as "the ability to perform the promised service dependably and accurately". Reliability entails performing the service in a consistent and dependable way. It means that it is a fundamental requirement that the service providers perform the service correctly at the first time of being asked to do so. Also, reliability has a deeper meaning by indicating that service providers are required to honor and respect their promises. In particular, the three main elements of reliability are completing and carrying out the service at the assigned time, correctly requisitioning payment of services provided, and maintaining accurate records of invoices made and payments received. Barry et al. (1990) point out that in order for customers to be convinced that the required service would be delivered; service providers must keep their promises and offer their services in a dependable and accurate way. In providing a reliable service, the general themes include promise fulfillment, dependable service, quick service, security, and accuracy:

- i. Promise fulfillment: This theme refers to the service providers delivering exactly the promised service (Al-Dlaigan and Buttle, 2002).
- ii. Dependable service: This means providing a level of service that the customer can rely on (Stafford, 1996).
- iii. Quick service: This theme clarifies the level of speed which the service providers have to maintain in delivering fast and efficient services (Mersha and Adlakha, 1992).
- iv. Security: This theme stands for a secure transaction, safety, confidentiality, and privacy (Dobholkar et al., 1996).
- v. Accuracy: This theme explains how accurate the service providers have to be in performing the service (Bouman and van der Wiele, 1992).

b) Responsiveness

Parasuraman et al. (1988, p. 23) defined the term "responsiveness" as "willingness to help customers and provide prompt service". A number of studies suggest that five themes fall within the responsiveness dimension: confirmation, prompt service, help availability, and updated information.

- i. Confirmation: This theme highlights the requirement and obligation for service providers to inform their customers about the timing of the delivery of the service (Avkiran, 1994).
- ii. Prompt service: This theme describes the speed of the service providers in responding to customers' requests. Also, it represents the extent to which the response is well organized and satisfies the customers' requests. Prompt service addresses the customers' waiting time in regard to receiving a response from the service provider (Philip and Stewart, 1999).

iii. Help availability: This theme explains the level of help employees can offer to customers (Zeithaml, 2002).

iv. Flexibility: This theme underlines the necessity for service providers to adjust the service process in order to allow customers to make changes or modify their orders (Johnston, 1995).

v. Updated information: This theme refers to the frequency which service providers offer the latest full information and how often it is updated (Lassar et al., 2000).

c) Tangibles

Parasuraman et al. (1988, p. 23) defined the term “tangibles” as “physical facilities, equipment, and appearance of personnel”. Some other studies refer to this dimension using different wording. For example, Bitner (1992) suggested that the use of the term “service-space” reflected a number of physical tangibles such as employees’ appearance and the office environment associated with any service organization. Regardless of the different terminologies and words used, however, they all come together as a number of determinants for the same dimension. Previous academic studies included the tangibility dimension in their empirical works of service quality measurement. They concluded that a number of themes fall within the tangible dimension in a variety of service industries, including physical atmosphere, physical location, physical environment, ease to use physical materials, and physical design:

i. Physical atmosphere: This theme refers to having a new or refurbished physical location including a reception area and available parking (Sower et al., 2001).

ii. Physical location: This theme stands for having easy access to the location of the service provider (Philip and Stewart, 1999).

iii. Physical environment: This theme means having comfortable and neat facilities including employees with a clean and a professional-looking appearance (Bahia and Nantel, 2000).

iv. Ease to use physical materials: This theme refers to the organisation having modern and new equipment (Wong et al., 1999).

v. Physical design: This theme describes the presenting of a professional image during the process of delivering the actual service (Johnston, 1995).

d) Empathy

Parasuraman et al. (1988, p. 23) defined “empathy” as “caring and individualised attention the firm provides its customers”. Different studies have identified a number of the themes which might be included as part of the empathy dimension. These might include personal attention, customers knowing the employees, individualised service, employees understanding customer needs, and employees providing good advice.

- i. Personal attention: This theme refers to offering individual attention to each customer (Robeldo, 2001).
- ii. Customers know the employees: This theme stands for the relationship between customers and employees (Brady and Cronin, 2001).
- iii. Individualized service: This theme stands for offering individual attention to each customer (Bouman and van der Wiele, 1992).
- iv. Employee understands customer needs: This theme explains how employees understand and know each customer's specific requirements (Parasuraman et al., 1991).
- v. Employees provide good advice: This theme means that the service providers explain very well and in an organized way to the customers some alternative service options that match their specific requirements (Bouman and van der Wiele, 1992).

e) Assurance

Parasuraman et al. (1988, p. 23) defined the term “assurance” as the “knowledge and courtesy of employees and their ability to inspire trust and confidence”. A number of studies have examined the assurance dimension within different service settings and identified security as its main theme. This theme stands for the service organization's assurance of physical and financial safety and security, along with upholding confidentiality in all their dealings with customers (Stafford, 1996).

3- Importance of Service Quality

Nowadays, in a severely competitive environment, the most central factor in a sustainable competitive advantage is to provide the best possible service quality, which will result in improved customer satisfaction, customer retention, and profitability (Khan, 2010; Carlson and O’Cass, 2011). The original service-profit chain model proposed that internal service quality within the organization leads to improved employee satisfaction and retention. Consequently, employee retention results in improving employee productivity, which ultimately contributes to improvement in overall external service value, customer satisfaction, customer loyalty, organizational revenue growth, and profitability (Heskett et al., 1994; Hallowell, 1996). As a result, service organizations have recognized a number of potential benefits deriving from implementing service quality programs, including increasing customer satisfaction, customer retention, customer loyalty and positive word-of-mouth, enhanced corporate image, profit gains, and improved financial performance.

Parasuraman, Zeithaml, and Berry (1985) are considered to be the key contributors to the North American School (Gap Analysis School) of thought concerning service quality. They have discovered a number of service quality factors including the following:

- 1. Reliability;
- 2. Responsiveness;

3. Tangibles;
4. Empathy; and
5. Assurance.

The combined five factors represent the most widely reported theoretical model of service quality – the SERVQUAL Scale. This instrument was the most frequent model utilized to represent service quality assessment from end-user attitudes and within the general public and private service sectors globally.

The North American (Gap Analysis) School's contribution will be reviewed in detailed in

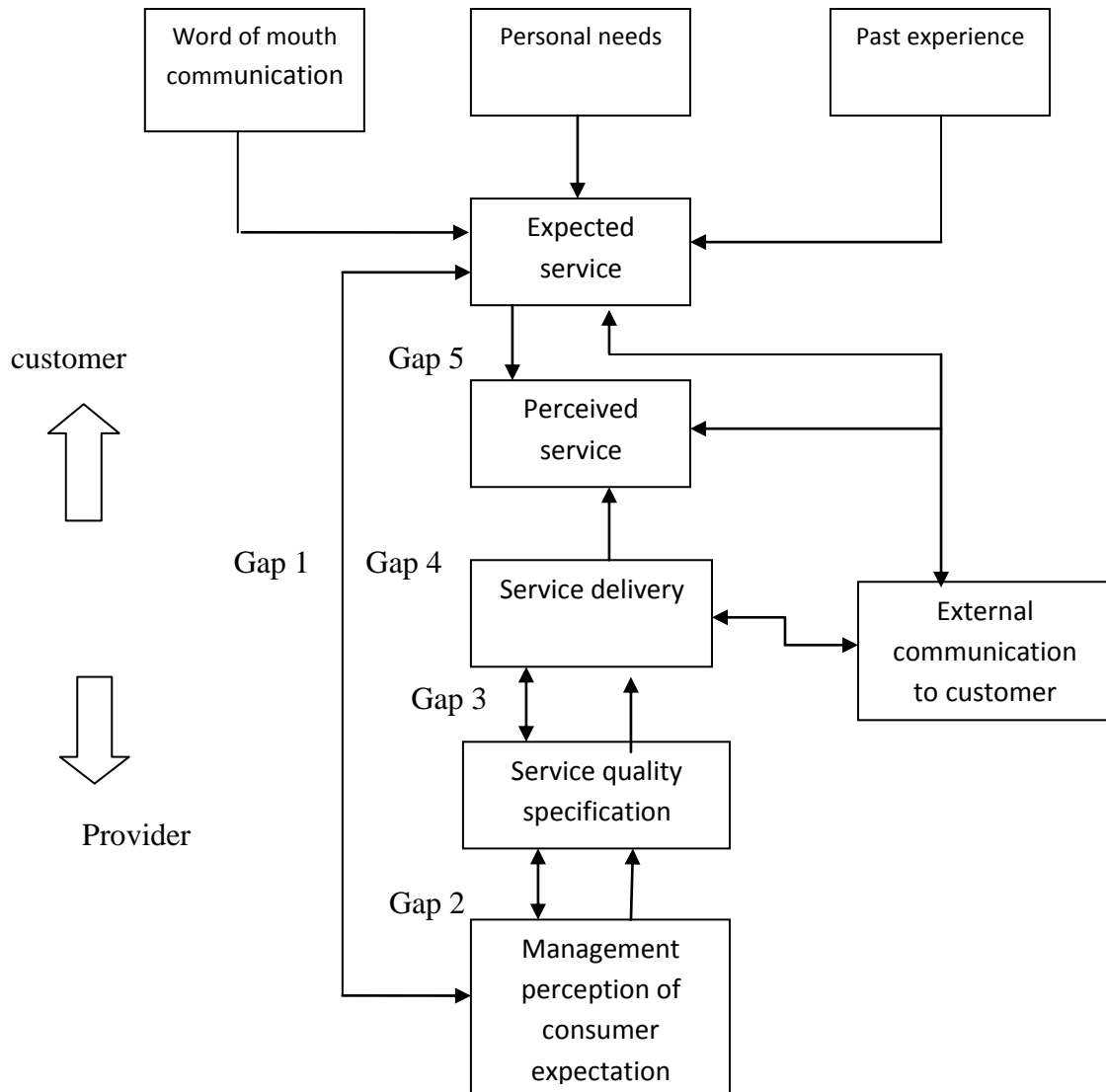
4-Evaluating Services Quality:

The Zeithaml, Parasuraman and Berry (ZPB) research define servQual model to evaluate and assessing service quality. The ZPB research developed the notion of the gap between the customers' perception and their expectations of service. Furthermore, they concluded that this gap is the result of a number of potential gaps which can exist throughout the process of:

- a-Understanding customer needs,
- b- Designing the service,
- c- Delivering the service,
- d- Communicating the service promise.

Understanding the potential for the various gaps that contribute to the key perception/expectation gap should enable both measurement and corrective action to take place. Diagram shows the gaps in a conceptual model of service quality.

Conceptual model of service quality



Source: Zeithaml et al. 1990 "customer assessment of services quality, p.46"

ServQual gaps

Gap 1: Between the customers' expectations and the management's perception of those expectations. A gap here is capable of setting in motion a chain of events through poor decision-making which could result in poor service quality.

Gap 2: Between the management's perception of customer expectations and the service quality specification. This gap may demonstrate a lack of management commitment to service quality, although this may be disguised in a belief that the customers' expectations are unrealistic. It is important to set realistic service standards, to measure performance against them and do more than just talk about service quality.

Gap 3: Between the service quality specification and the service delivery.

Gap 4: Between service delivery and the company's external communications. The organization makes promises through advertising, sales staff and customer documentation, all of which will influence the expectations of the customer. Any mismatch between these and the actual delivery will impact on the customers' perception of the final delivery.

Gap5: Between the customers' expectations and their perception of the service. The key to closing this gap is to close the others and keep them closed.

It is clear that gaps 1–4 are related to the design, marketing, and delivery of the services within the service organisations, while Gap 5 is on the consumers' side. This means that service quality as it is perceived by consumers depends on the size of Gap 5, which is the difference between expected service and perceived service.

Concerning Gap 5, the findings of Parasuraman et al. (1985) showed that the criteria used by customers in assessing and evaluating service quality can be categorised into ten dimensions:

- 1. Reliability:** This represents the firm carrying out the service accurately and at the earliest moment.
- 2. Responsiveness:** This represents the keenness of employees to carry out the service – it involves appropriateness of service.
- 3. Competence:** This represents the skills and knowledge required by employees to carry out the service.
- 4. Access:** This represents customers' ability to approach and contact the service simply and without any difficulty.
- 5. Courtesy:** This represents the employees' behaviour in being polite, respectful and friendly.
- 6. Communication:** This represents reporting to the customers in an understandable language.
- 7. Credibility:** This represents the personal characteristics of the employees, including trustworthiness, believability, sincerity, and honesty.
- 8. Security:** This represents risk-free physical and financial issues and privacy and confidentiality.
- 9. Understanding/knowing the customer:** This represents knowing and understanding customers' needs, wants, and requirements.
- 10. Tangibles:** This represents the physical facilities of the service, such as personnel appearance and tools applied to deliver the service.

Parasuraman et al. (1988) undertook further research, analysis, and testing of their original proposed service quality model beyond 1985. The model was validated and refined through several stages of data collection and analysis. The data used for validation and refinement was collected from customers across four different service settings: Appliance Repair and Maintenance (R&M), Retail Banking (B), Long-Distance Telephone Company (LDT), and Credit Card Company (CC). The findings of the statistical analysis produced a valid research instrument including 22 items grouped into five dimensions:

1. Reliability: This includes the ability to carry out the promised service accurately and timely.

REL1: Providing services as promised.

REL2: Dependability in handling customers' service problems.

REL3: Performing services right the first time.

REL4: Performing services at the promised time.

REL5: Maintaining error-free records.

2. Responsiveness: This includes the keenness to help customers and offer a timely service.

RES1: Keeping customers informed about when services will be performed.

RES2: Prompt service to customers.

RES3: Willingness to help customers.

RES4: Readiness to respond to customers' requests.

3. Tangibility: This includes the aspects related to physical facilities, equipment and tools, and employees' appearance.

T1: Modern equipment.

T2: Visually appealing facilities.

T3: Employees who have a neat, professional appearance.

T4: Appearance of physical facilities.

4. Empathy: This includes the level of compassionate, special, and private concentration from the firm to its customers.

E1: Giving customers individual attention.

E2: Convenient business hours.

E3: Having the customers' best interests at heart.

E4: Employees who deal with customers in a caring fashion.

E5: Employees who understand the needs of their customers

5. Assurance: This includes employees' knowledge and their ability to encourage trust.

A1: Employees who instil confidence in customers.

A2: Making customers feel safe in their transactions.

A3: Employees who are consistently courteous.

A4: Employees who get adequate support from their company to do their job well.

Zeithaml et al. (1988) undertook a further two stages of research studies. The first stage consisted of in-depth personal interviews consisting of open-ended questions with three or four executives in four different service organisations, including a Bank (B), a Brokerage House (BH), a Repair and Maintenance Firm (R&M), and a Credit Card Company (CC). The second stage includes a systematic group interview with senior managers on a comprehensive case study of a well-known American bank. The main aim was to explore and identify a set of comprehensive factors affecting the magnitude and direction of the four gaps on the marketer's side of the service quality model (Gaps 1–4). The extended comprehensive service quality model as shown in Figure 2.3 covers the following four gaps:

Gap 1:

- a) The extent of marketing research orientation;
- b) The extent and quality of upward communication; and
- c) Levels of management.

Gap 2:

- a) Management commitment to service quality;
- b) Setting of goals relating to service quality;
- c) Task standardization; and
- d) Perception of feasibility of meeting customer expectations.

Gap 3:

- a) Extent of teamwork perceived by employees;
- b) Employee–job fit and technology job fit;
- c) Extent of perceived control experienced by customer contact personnel;
- d) Extent to which behavioral control systems supplement output control systems;
- e) Extent of role conflict experienced by customer contact personnel; and
- f) Extent of role of ambiguity experienced by customer contact personnel.

Gap 4:

- a) Extent of horizontal communication; and

b) Propensity to overpromise.

Reliability, responsiveness, and tangibles were the original dimensions of service quality identified in 1985 and, while they were refined in 1988, they remain unchanged. However, the empathy dimension is different. It is rather a multifaceted dimension. In 1985, three dimensions were generated – access, communication, and understanding and knowing the customer. Access involves the ability of the customer to obtain the service and for it to be provided in an easy way. Communication refers to the ability of the service provider to customize their language so that all customers can understand it. Understanding and knowing their customers reflects the service provider's ability to understand each customer's needs. As a result of the validation of the SERVQUAL model in 1988, these three attributes were grouped together in a single dimension known as "empathy".

Assurance is known, also, as a combined service quality dimension. It has been proposed that the four service quality attributes were competence, courtesy, credibility, and security. Competence describes the actual skills requirements for employees to be able to carry out the service. Courtesy refers to the level of respect that employees have toward customers, with a special emphasis on front-line employees. Credibility stands for employees' trustworthiness for customers. Security means employees delivering the actual service free of any danger. In 1988, these four service attributes were refined and grouped together under the assurance dimension.

5- Approaches to the Improvement of Service Quality:

Ghobadian et al. (1994) argued that it is important to define the quality concept as it represents the first step in most quality improvement programs. In fact, quality is a complicated concept that can be defined from different perspectives depending on the specific industry or purpose of study. Even though there are different definitions of quality, they can be categorized into a number of broad groups, principally the value-led approach and customer-led approach. The value-led approach defines the term "quality" as the cost to the producer and price to the customer (Crosby, 1980; Taguchi, 1986).

The customer-led approach defines quality as satisfying the customer's needs and wants. This definition is based on exploring and identifying customers' requirements and the meeting of these requirements by the organization. This definition is for organizations offering high contact, skill/knowledge-based, or labour-intensive services, such as health-care, law, accountancy, hairdressing, education, consultancy, leisure, hotels, and information technology (Juran et al., 1974; Deming, 1986).

In general, an improvement in service design and delivery help achieve higher levels of service quality. For example, in service design, change can be brought about in the design of service product and facilities. On the other hand, in service delivery, change can be brought about in the service delivery process, the environment in which the service

delivery takes place and improvements in the interaction process between customer and service provider.

Various techniques can be used to make improvement such as:

Quality function development (QFD)-a

Falsifying: moving the line of visibility and the line of accessibility.-b

Blueprinting.-c

6- Approaches to Improve The Conformity Of Service Quality:

In order to ensure and increase the conformance quality of service that is service delivery happening as designed, various methods are available some of these include:

a- Guaranteeing

b- Mystery Shopping: recovering, setting standards and measuring.

c- Statistical process control.

d- Customer involvement.

Source: (Sudan University of Science and Technology (2007)" Module 7 Customer Service Management)

7- Service Quality and Customer Satisfaction:

The relationship between service quality and customer satisfaction has received considerable attention in academic literature.

The result of most research studies have indicated that the service quality and customer satisfaction are indeed independent but are closely related that and arise in one is likely to result in an increase in another construct.

Third: Quality in health care:

In many ways quality means safety, health care providers, the government and many other groups are working hard to improve health care quality because quality care often means safer care for consumers.

Quality health care is easily defined as doing the right things (getting the health care services you need), at the right time (when you need it).in the right way (using the appropriate test or procedure), to achieve the best possible results (- Rashad Massoud & Rafeal Bengoa (2006)"quality of care a process for making strategic choice in health system").

The institute of medicine defines health care quality by six attributes:

1-Safety: patient should not be harmed by the care that is intended to help them.

2-Patient centered: care should be based on individual needs.

3-Timely: waits and delays in care should be reduced.

4-Effective: care should be evidence based.

5-Efficient: reduce waste.

6-Equitable: care should be equal for all people.

Quality means different things to different people. Some consumers think that getting quality health care means seeing the doctor right away, being treated courteously by the doctor or hospital staff, or having the doctor spend a lot of time with the patient and his family.

While we, as a hospital, understand agree that these things are very important, we believe clinical quality of care is even more significant, because offering high quality evidence based care(care that is proven) leads to more lives saved and less time in the hospital.

1- Quality and safety:

In many ways quality means safety, health care providers, the government and many other groups are working hard to improve health care quality because quality care often means safer care for consumers.

2-measuring the health care quality:

Quality is measured many ways. There are process indicator (those that measuring things such as timeliness and base line practices) and outcome indicators (such as mortality rates, infection rates and complication rates), a consumer can look at these indicator and compare them among hospitals. We should also look at a hospital's state and national recognitions and accreditations (seals of approval).

Finally look at a hospital's awards to help you measure quality.

3- Quality measures or quality indicators:

A quality measure is medical information from patient records converted into a rate or percentage that shows how well hospital care for their patients. For example, one quality indicator reported is the percentage of heart attack patients who are prescribed aspirin at discharge. Quality measure gives you information about how well a hospital provides care for many of its patients. We can use this quality information to help us compare hospitals.

4- Accreditation and its important:

Accreditation is another way to judge quality. Accreditation is a seals of approval given by a private independent group. Health care organization must meet national standards, including clinical measures, in order to be accredited.

5- The role of patient when it comes to quality care:

A patient or family member has a key role to play to ensure they receive the best quality care possible. Patient can do this by being active in care:

- a- Work with doctor and other members of the health care team to make decision about your car
- b- Ask questions
- c- Ask the doctor about what the scientific evidence has to say about your condition
- d- Do your home work; go online or to the library to find out more about your condition
- e- Find and use quality information in making your health care choices.

6- Using of quality information:

Use it wisely and carefully. Information on quality lets consumers and their health care providers compare the quality of care provided in hospitals. This quality information not only helps us make good decision about our health care, but also encourages hospitals to improve the quality of health care they provided.

THEME THREE: PATIENTS SATISFACTION

1-Definition

Patient satisfaction has been often defined as the extent of agreement between what a patient expects to result or obtain from the healthcare experience and the perception of care they actually receive (LaMonica, Oberst, Madea, & Wolf, 1986). This definition implies that the individual has formed expectations prior to or during the healthcare experience, and that at some point, must consider whether or not the services received during the experience meet, do not meet, or exceed those expectations.

High patient satisfaction leads to benefits for the health industry in a number of ways, which have been supported by different studies:

1-patient satisfaction leads to customer (patient) loyalty.

2-improved patient retention according to the technical assistant research programs (TARPs), if we satisfy one customer, the information reaches four others. If we alienate one customer, it spreads to 10, or even more if the problem is serious. So, if we annoy one customer, we will have to satisfy three other.

3-consistent profitability

4-increased staff morale with reduced staff turnover also leads to increased productivity.

5-increased personal and professional satisfaction, patients who improved with our care definitely make us happier.

Undoubtedly, the physicians have twin responsibilities of giving the best health care to the patient and leading the team or the organization in attaining the goal of satisfying the patient. List below are few "house rules" to handle the patient so as to attain a satisfying and a no complaining patient:

a -Break the ice: make your eye contact, smile, and call people by name, express with words of concern.

b- Show courtesy: kind gestures and polite words make a patient very comfortable.

c- Listen and understand: encourage patient to tell their problem. Invite and answer their question.

d- Inform and explain: it promotes compliance. People are less anxious when they know what's happening.

e- See the whole person: see beyond illness the whole person.

f- Share the responsibility: risks and uncertainty are facts of life in medical practice. Acknowledging risks builds trust.

g- Pay undivided attention

h- Secure confidentiality and privacy

i- Preserve dignity

j- Remember the patient's family

k- Respond quickly

2- Understanding a patient:

A patient's liking the doctor has a lot to do with the patient getting better. A patient's expectations of a good service depend on age, gender, nature of illness, hour of the day, his or her attitude toward the problem and the circumstances.

In general, patient expects their doctor to keep up the timings, behave cordially, and communicate in their language. They expect care, concern, and courtesy in addition to a good professional job.

Certain tips can help a doctor or a hospital to understand the patients better:

- a- Recognize that patient expect a personal relationship that shows compassion and care.
- b- Recognize that the patient has got certain right. Various regulatory authorities and hospitals have drawn a charter of rights for the patients.
- c- Make sure a patient has got a good first impression of you and your set up.
- d- Step into your patient's shoes: see through their eyes and hear through their ears.
- e- Minimize the patient's waiting time to the least possible.
- f- Try to make your problem solving system to be functional.
- g- Always obtain feedback from your patients and correct shortcomings if any

3- Patient education:

Typically, today's patients are more educated, computer savvy, and much richer. It is essential to clear all their rightly or wrongly earned doubts with much patient and compassion.

Successful education increases patient satisfaction and results in improved adherence to treatment and thus to a better outcome.

Various methods like verbal education, written information (handouts, articles in popular magazines, etc.), group - based learning, audiotapes, videotapes, computer-assisted education, and the internet can be used to educate the patient about the disease.

4- Feedback given by patient:

The feedback given by the patient helps to improve the work of the physician, place, and also the system. Despite the advantages of self assessment, dermatologists rarely have a system to analyze and evaluate quality of care rendered in the practice. Patient feedback can be obtained by patient questionnaires, follow up phone calls, suggestion box, and referral physicians, etc.

5- The role of patient satisfaction data in quality improvement

The evidence for the role of patient satisfaction data in quality improvement is mixed. While some research reports no effect of feedback based on patient evaluations on behavior change, other studies report the opposite. There is evidence that patient satisfaction survey data is under utilized by staff which may contribute to the reported lack of change. Measures relying on complaints have been shown to be more responsive to change than those relying on satisfaction measures.

Measures of patient satisfaction with different components of care may or may not be correlated with each other and with the overall measure of patient satisfaction. For example, in the reviewed literature, a correlation between quality care measures

(accreditation and patient satisfaction) was not demonstrated nor a correlation between lower patient satisfaction and poorer ratings of technical process of care.

6- Methods for measuring patient satisfaction:

Most studies rely on multiple criteria of patient satisfaction for quality measurements. To date there is no single universal method for measuring patient satisfaction. The utilization of both qualitative and quantitative methods to assess patient satisfaction is recommended. A myriad of tools to measure patient satisfaction have been developed. The tools most frequently cited in the literature to measure patient satisfaction are surveys, critical incident technique and questionnaires. Case studies, interviews and observation are also used to gather data. A recent review of the literature identified a lack of standardization in delivery method, of instruments designed to measure patients' assessment of individual physicians and limited construct validity or correlation with other attributes. On the one hand there is a call for standardization of tools, on the other a recognition that different consumer groups, organizational settings and goals (for example benchmarking versus internal quality improvement) call for different techniques. As technical quality of care and satisfaction are associated but not the same, both measures of technical quality of care and patient satisfaction are necessary for assessing quality of care.

7- Patient complaint data

Patient complaint data has been utilized in the quality improvement process and has resulted in changes to policy and procedure. However, detrimental effects of patient complaints on doctors and the relationship with their patients and on fragile local health systems and perceptions that complaint data have no effect on quality improvement suggest that the role of complaints in the improvement of delivery of care is complicated. Complaints by health care providers are also an important source of information. Methodological issues associated with the evaluation and processing of complaints, the interpretation of complaint data and the process by which complaint data can best influence decisions about quality improvement have been examined. The importance of classifying complaints, calculating the rate of complaints per clinical activity, the mean response time in affecting improvement has been explored and taxonomy to standardize the coding of complaints developed.

THEME FOUR: THE ORGANIZATIONAL PERFORMANCE

Better performance can mean a number of things. In commercial organizations, better performance is normally associated with improving the 'bottom line' – either financial performance in terms of profit, shareholder value and market share, or non-financial performance in terms of achieving specific goals or objectives. This is essentially success from the owner or shareholder viewpoint. However, improved results may be assessed from a number of perspectives, including for example:

a-the customer's perspective: improved satisfaction with products or services, leading to customer loyalty and repeat business

- b-**the employee's perspective: a better-trained, more motivated, committed and efficient workforce
- c-**the supplier's or other partner organization's perspective: improved collaboration leading to a better overall service to the end customer
- d-** society's perspective: an enhanced image with the public as a whole

In order to understand improvement, we have to understand the nature of organizations themselves.

1-Performance Definition:

Performance refers to the way people do their jobs and the result of their work.

The authors Lebars & Euske (2006: p. 71) provide a set of definitions to illustrate the concept of organizational performance:

- Performance is a set of financial and nonfinancial indicators which offer information on the degree of achievement of objectives and results (Lebars & Euske 2006 after Kaplan & Norton, 1992).
- Performance is dynamic, requiring judgment and interpretation.
- Performance may be illustrated by using a causal model that describes how current actions may affect future results.

Organization seeking to solve performance problem frequently implement a specific intervention, such as training, without fully understanding the nature of the problem or determining whether or not the chosen intervention is likely to succeed.

2- Performance Improvement:

Performance improvement is a method for analyzing performance problems and setting up system to ensure good performance. Performance improvement is applied most effectively to group of workers within the same organization or performing similar jobs. While performance improvement principles are relevant to workers in any field, this publication focuses on primary provider of family planning and reproductive health (FP/RC) care services.

There are number of methods for improving the performance of the organization's teams and individuals. Organization development, industrial engineering, training and development, quality assurance and human resource development address performance gap in particular ways. Performance improvement differs from these approaches by using a systematic methodology to find the root causes of a performance problem and then implement an intervention or fix that applies to that specific performance deficit.

Performance improvement help to ensure that selected intervention are supported and sustained by involving stockholder group from the outset and ensuring that an organization's staff participates actively in every step of the process.

3- Factors That Affect Performance:

Certain factors need to be in place for workers to be able to perform well on their jobs:

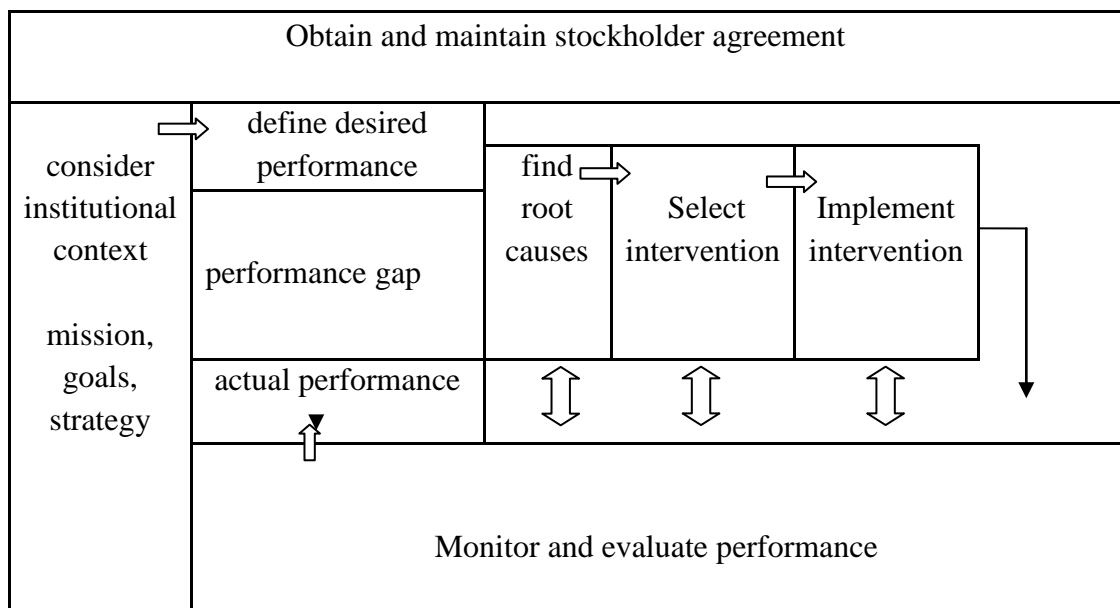
- a- Clear job expectations
- b- Clear and immediate performance feedback
- c- Adequate physical environment, including proper tools, supplies and workspace.
- d- Motivation and incentives to perform as expected.
- e- Skills and knowledge required for the job.

Successful organization supports their workers by instituting and sustaining these performance factors. This support can be provided by a supervisor or emanate from a variety of other sources.

When a performance factor is missing and a gap in performance has occurred, a solution or intervention usually becomes clear.

4- The Performance Improvement Process Framework:

The following graphic illustrates the typical performance improvement process:



Source Charles Lusthaus (2002) "Organizational Assessment: A Framework for Improving Performance, International Development Research Centre, Ottawa, Canada".

CHAPTER III

Study field and analysis

CHAPTER III

Study field and analysis

THEME ONE: THE STUDY FIELD

ROYAL CARE INTERNATIONAL HOSPITAL

1-Overview about RCIH:

The royal care international hospital (RCIH) is located in Khartoum Sudan, and is a multi specialty hospital focusing on health care service that are of paramount of importance to the region. RCIH is multi disciplinary medieval center that incorporates hospital and clinical care with education and future research. RCIH was founded in 2010 by Sudanese founders by vision of providing outstanding patient care based upon the principles of quality, cooperation, compassion, innovation and Islamic ethics.

The royal care international hospital's reputation attracts patients from all over the region. Many have complex medical problems or have been undergoing treatments that are not producing the expected results. Some are healthy and simply want to stay that way. Others are seeking a second opinion. In all cases, our patient receives the most appropriate care delivered by knowledgeable, compassionate physicians who are among the leaders in their respective field.

a) RCIH mission:

To deliver high quality and safe care through innovative design by dedicated competent professional staff seeking efficient, equitable and timely services to achieve the most attainable satisfaction for patients and their families.

b) RCIH vision:

- To be medical center of excellence in the Middle East and Africa.
- To lead a patient centered and high quality care facility in Sudan
- To be the health care facility of choice in the region.

c) RCIH values:

- Focus on patient and their family
- Respect all patient, their rights, dignity, privacy and confidentiality
- Provide full care without discrimination, regardless of the patient's gender, race, religion or social class.

- Ensure safety, equate, efficiency, effectiveness, transparency and fairness.
- Comply with and commit to medical ethics and professional laws, rules and regulation.

2-Services provided by RCIH:

Background:

The 150 bed royal care international hospital (RCIH) is a multi specialty hospital focusing on health care services that are of paramount importance to the country, such as diabetes treatment and management, women's health, musculoskeletal and cardiac diseases. The concept of RCIH and its holistic approach to hilling as well as its concern for national health needs was first supported by the nobles group company, which was later joined by a team of experienced and dedicated leaders and managers sharing the same mission and vision.

Services provided by RCIH:

a- Medical Centers:

- Cardiac Center
- Neurosciences Center
- Renal and Urology Center
- Diabetic and Endocrinology Center
- G-I Center
- Musculoskeletal Center
- Ophthalmology Center
- Obstetrics and Gynecology women's health center
- Dental Center
- Assisted Reproduction (IVE) Center

b- Medical Department:

- Internal Medicine
- Pediatric Department
- Family Medicine Department
- Anesthesia Department

- Emergency Department
- Laboratory
- Medical Imaging (Radiology) Department
- Pathology Laboratory Department
- Pharmacy Department

c- Medical Units:

- Intensive Care Unit (ICU)
- Neonatal ICU (NICU)
- Coronary Care Unit (CCU)
- Day Care Unit
- Operating Rooms (ORs)
- High Dependency Unit
- Burns Unit

d- Unique services:

i- Operating room (OR):

- OR (One)
- Patient transfer system
- Sterilization center

ii-Pharmacy

- Unit dose drug distribution
- Non-sterilization compounding lab
- IV room (TPN cytotoxic and electrolytes preparation)

iii- Dental center

Panoramic X-Ra-

3- Quality and patient safety directorate in RCIH:

Quality and patient safety directorate is committed to realize the vision and support the mission of RCIH.

Mission:

Ensuring an environment of quality and care that promotes patient and staff safety practices, as well as a culture of continuous quality improvement to fulfill and exceed the ambition of the RCIH clients

Vision:

To provide an exemplary performance and to be recognized for excellence within the RCIH by meeting the target of paralleling our highest quality and ethical standards with that of providing the best level of customer service to our patient and staff.

Values:

Our staff draws strength from the RCIH values, RCIH places great emphasis on building trust as an inherent value through the following domains:

Patient first value: focus, integrity, respect, safety, and teamwork.

Staff: leadership, stewardship, fairness and teamwork.

Internal process: holistic paradigm, quality and excellence.

4- Accreditation:

- Monitors compliance with national and international standards.

- Ensure the joint commission international accreditation (JCIA) and Arab tool for accreditation standards are maintained.

5- Joint commission international accreditation (JCI):

JCI Accreditation is a variety of initiatives designed to respond to a growing demand around the world for standards based evaluation in health care. The purpose is to offer the international community standard based objective process for evaluating health care organizations. The goal of the program is to stimulate demonstration of continuous, sustained improvement in health care organizations by applying international consensus standard, international patient safety goals, and data measurement support.

The mission of joint commission international (JCI) is to improve the safety and quality of care in the international community through the provision of education, publications, consultation and evaluation services.

6- Patient complaints and satisfaction in RCIH:

RCIH is committed to support the rights of all patient, their families, and visitors, to submit expression of satisfaction or dissatisfaction, written or verbal (including telephone complaints), regarding health care services received from RCIH. And regardless of point of origin, these shall be recorded on a patient complaint form and forwarded to seek resolution and response to such concerns.

All complaints, or comments shall be documented, preferable by the patient (or his/her representative) on a patient complaint/comment/compliment form. If the patient is unwilling or unable to put his/her compliment, or comment in writing, then someone within the hospital staff shall assist the patient in documenting these.

7- Handling patient complaints and conflict in RCIH:

All patient complaints, written or verbal (including telephone complaints), and regardless of point or origin, are recorded on a patient complaint form and forwarded to the director of patient and public relations located in RCIH administration., Complaints are addressed immediately by relevant personnel.

Upon resolution, and in no case later than thirty (30) days, the individual filling the complaint shall be sent a follow-up letter from the responsible administrator. The letter shall outline the resolution of the situation, and advise the complaining individual of their right to a hearing if they are not satisfied with the outcome of the review and the mechanism by which that hearing may be obtained.

This chapter contains description of the materials and methods followed by the researcher for determining the study population, the study sample, and questionnaire for the study design and statistical methods that used in data analysis.

THEME TWO: ANALYSIS OF THE QUESTIONNAIRE DATA

1-Study Methodology:

This study based on the questionnaire designed dependent on the hypotheses approach.

The questionnaire contains two sections the first one describe the demographic data of the study sample like (gender, age, level of education and the job title), and the second section contains of the basic data which aims to testing research hypothesis and it's have three perspectives (commitment to apply the complaints management system, evaluating of the organizational performance & improving the health services quality), this three dimensions contains of 20 statements which serve research purposes.

100 questionnaires were distributed among the employees, the total number of respondents were 80 the respond rate 80%

2- Study population:

Royal Care International Hospital (RCIH) employees

3- Study sample:

The study sample contains of (100) of employees from Royal Care International Hospital, were selected as stratified random method.

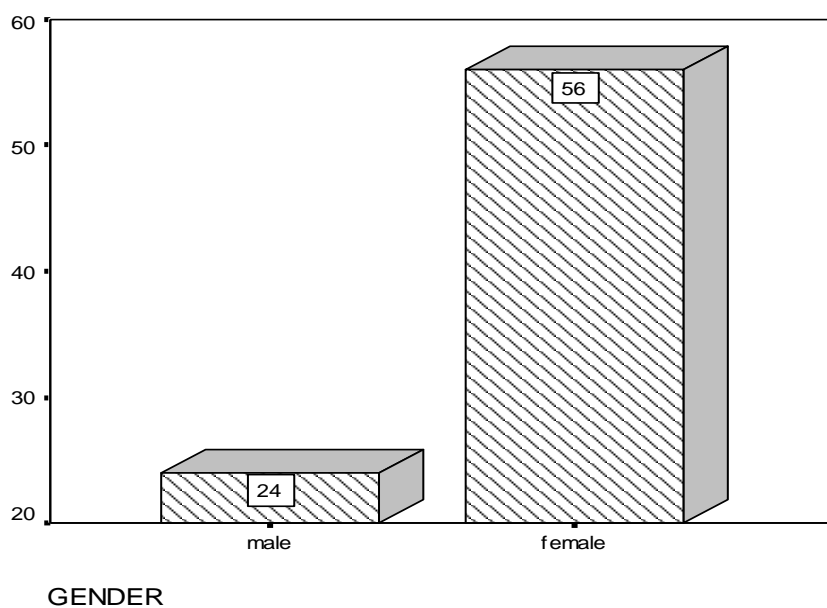
Analysis of demographic characteristic of study sample

Table (3-1) gender

Type	Frequency	Percentage
Male	24	30
Female	56	70
Total	80	100

Source: student's study (2016)

Figure (3-1) gender



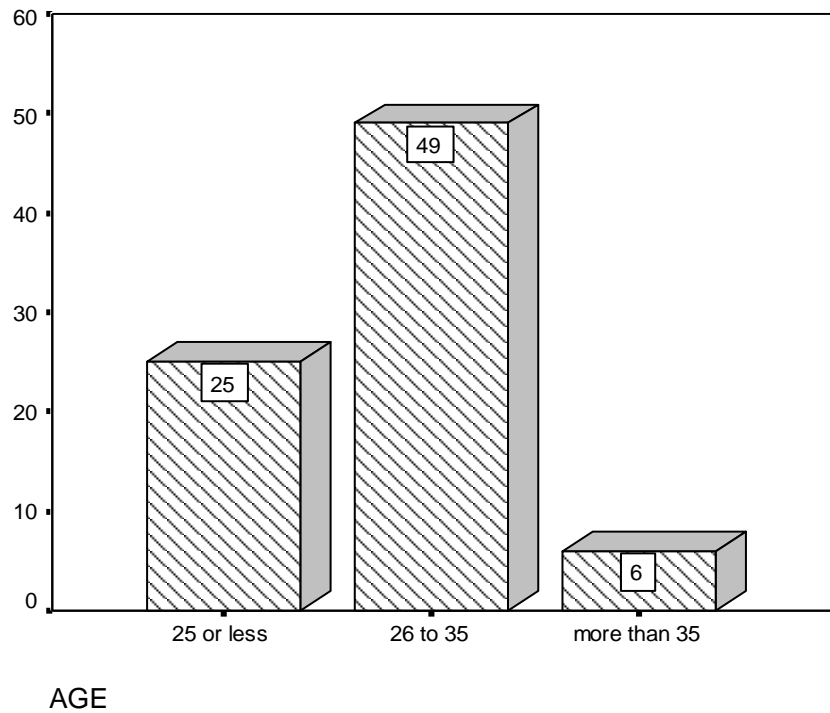
From the table and graph we find that the highest percentage is (70%) from the female, while the percentage of the male is (30%)

Table (3-2) age

Type	Frequency	Percentage
25 years or less	25	31.25
26 years to 35	49	61.25
More than 35 years	6	7.5
Total	80	100

Source: student's study (2016)

Figure (3-2) age



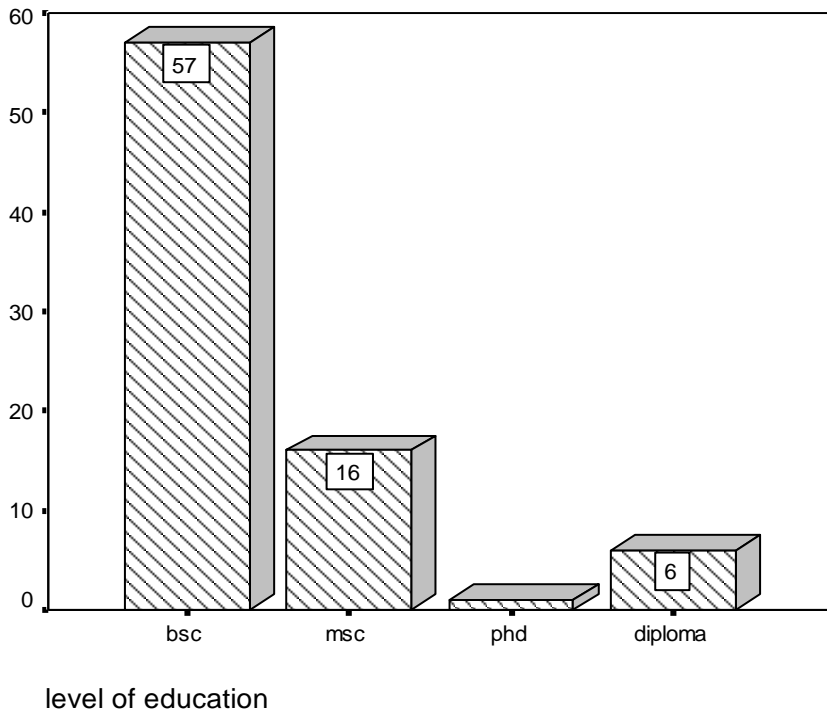
From the table and graph we find that the highest percentage of the age in the study sample is (61.25%) for the age around 26 years to 35 years, the percentage of people who have age 25 years or less is (31.25%), and the percentage of people who have age more than 35 years is (7.5%)

Table (3-3) level of education

type	Frequency	Percentage
Diploma	6	7.5
B SC	57	71.25
MSC	16	20
PHD	1	1.25
Total	80	100

Source: student's study (2016)

Figure (3-3) the level of education



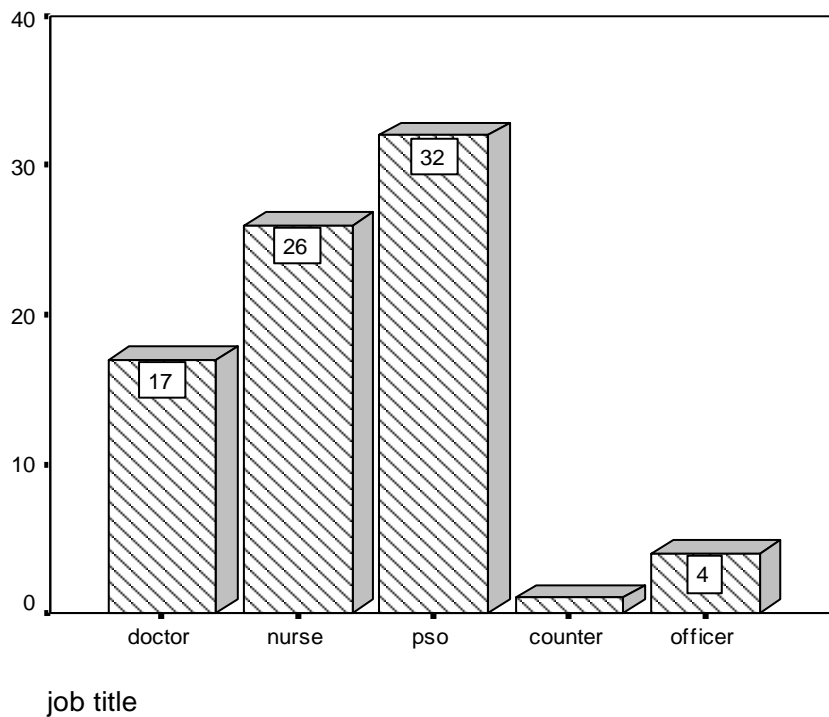
From the table and graph we find that the highest percentage is (71.25%) for the people who have the first degree (BSC) certificate, (20%) for the people who have master certificate, (7.5%) for the people who have diploma certificate and (1.25%) for the people who have doctoral certification.

Table (3-4) job title

Type	Frequency	Percentage
Doctors	17	21.25
Nurses	25	31.25
PSO	32	40
Counters	2	2.5
Officers	4	5
Total	80	100

Source: student's study (2016)

Figure (3-4) the job title



From the table and graph we find that the highest percentage is (40%) for the patient services officers (PSO) which include (information technologist, statistical, receptionist), (31.25%) for the nurses, (21.25%) for the doctors which include (general doctors, pharmacist, radiation doctors, Laboratory doctors and specialist doctors), (5%) for the management officers and the lowest percentage is (2.5%) for the counters

4-Study tool

The researcher has developed a study tool to become a tool for data collection in this study, and that a review of previous literature on the subject of the impact of the complaints management system effectiveness in improving the health services quality. The study tool includes three main parts see (appendix A):

The first: deals with the general demographic information about the respondent on the questionnaire.

The second: devoted to measures the impact of the complaints management system in improving the health services quality of royal care international hospital.

The third: the researcher used the Likert scale, which calculates the weight of the questionnaire paragraph as a follow:

(80 - 100)% High agree

(70 – 79.9)% Agree

(60 – 69.9)% medium agree

(50 – 59.9)% Disagree

5-Believe study tool

The study was presented on number of validates in the field of study.

6-Statistical processing

Data are encoded and processed statistically using the statistical package for social science (SPSS).

Statistically processer used:

1- Frequencies and percentage to determine the characteristics of the study sample in the light of demographic characteristics and all with regard to the study.

2- Frequency distribution

3-person correlation coefficient

4-non paramatic chi square test

5- One way analysis of variance (ANOVA) to determine the sign of the difference between the view points of sample members according to more than bilateral variables.

CHAPTER IV
**Results of research &
discussion**

CHAPTER IV

Results of Research & discussion

This research aims to identify the impact of the complaints management in improving the health services in ROYAL CARE INTERNATIONAL HOSPITAL (RCIH) and to identify to what extent RCIH is committed to embrace complaints management system and to what extent it's committed to provide high service quality to achieving patient satisfaction.

1- Results concerning the study questionnaire

to achieve the objective of this study, questionnaire was prepared and to ensure its sincerity, and the coefficient of stability, and after the data collection process are encoded and entered a computer and processed statistically using the Statistical Package for Social Sciences (SPSS) here are the result of the study according to the research problem and hypotheses of research. By using Likert scale:

(80 - 100)% High agree

(70 – 79.9)% Agree

(60 – 69.9)% medium agree

(50 – 59.9)% Disagree

(Less than 50%) High disagree

Table (4-1) results of the questionnaire analysis

No	Paragraphs	Average	Standard deviation	Percentage%	Degree
1	complaint management is an integral part of quality management	1.58	0.96	90%	High agree
2	Leaders in the service promote consumer-focused care as part of quality improvement	1.95	1.07	81.25%	High agree
3	there is policy in relation to adverse events & complaint	2.12	1.14	70%	Agree
4	senior management committed to provide support for complaint management to operate	2.23	1.25	65%	Medium agree

	effectively				
5	Clinicians and staff understand and routinely use the complaints management policy within the scope of their responsibilities	2.46	1.30	61.25%	Medium agree
6	workers trained to deal with complaints in its various kinds	2.14	1.45	62.5%	Medium agree
	the first area of: top management commitment to apply the complaints management system	2.08	1.20	72%	Agree
7	Consumer feedback is actively sought by offering a variety of ways to raise concerns and suggestions	2.21	1.16	62.5%	Medium agree
8	Clinicians and other staff understand that the handling of complaints is the responsibility of everyone	1.85	1.20	78.75%	Agree
9	The progress of resolution and investigation of complaints is tracked by the complaints manager	2.08	1.22	72.5%	Agree
10	follow up to respond to the complaints	2.37	1.29	60%	Medium agree
11	Understand complaints ,its dimension, its risk and making decision about	2.31	1.42	65%	Medium agree
12	preparing a report describing the complaint carefully	2.28	1.28	62.5%	Medium agree
13	exploit all available resources to solve the patient's problem	2.10	1.18	70%	Agree
14	The complaints resolution process is fair and lead to satisfaction	2.27	1.22	58.75%	Low agree
	The second area :improving the organizational performance	2.18	1.25	66.25	Medium agree
15	Complaints are recorded in a manner that allows review of individual complaints, and	2.27	1.33	63.75%	Medium agree

	analysis to identify trends and patterns for the purpose of clinical governance and quality improvement				
16	The service periodically reports information to the public about consumer feedback, including complaints, as part of reporting on quality improvement	2.38	1.41	60%	Medium agree
17	used suggestions and complaints of patient as reference to improvement	2.23	1.17	58.75%	Low agree
18	complaint management system updating regularly	2.51	1.22	50%	Low agree
19	Use Information's come from the complaints analysis in improving the performance& services quality	2.20	1.15	62.5%	Medium agree
20	Consumers, clinicians and other staff are involved in the design of the complaints management system	2.77	1.48	43.75%	Very low agree
	The third area: improving the quality of health area	2.39	1.29	56.5%	Low agree
	Sum	2.22	1.25	65	Medium agree

Source: student's study (2016)

Seen from the table (4.1) the impact of complaints management system in improving the health services quality from the view point of the employee got MEAN (2.39), and standard deviation (1.29) and low significant response and a percentage (56.5%). Also seen from the table the impact of complaints management system in improving the organizational performance from the view point of the employee got MEAN (2.18), and standard deviation (1.25) and medium significant response and a percentage (66.25%), and the commitment of the top management of RCIH got MEAN (2.08), and standard deviation (1.20), and high significant response and percentage (72%).

2- Results concerning the research hypotheses

Hypotheses one: there is impact of effectiveness of complaints management system in improving the health services quality.

Table (4-2) Chi-Square Tests results of the first hypothesis

	Value	Df	Asymp. Sig. (2- sided)
Person chi square	171.902(a)	16	.000
Likelihood ratio	156.032	16	.000
Linear-by-linear association	69.833	1	.000
N of valid cases	80		

a 19 cells (76.0%) have expected count less than 5. The minimum expected count is .38.
Source: student's study

From the table (4-2) The calculated value of chi-square for the significant differences of the respondents 'answers was (171.902) which is greater than the tabulated value of chi-square at the degree of freedom (16) and the significant value level (5%) which was (156.032).and the significant level of chi square is (0.00) it's less than the significant value level, this indicates that: there are statistically significant differences at the level (5%). That means there is positive impact of the effectiveness of the complaints management system in improving health services quality.

Hypotheses two: the top management of RCIH is committed to implement the complaints management system

Table (4-3) ANOVA one way Test of the second hypotheses
ANOVA

Commitment to implement complaints management system

Sig.	F	Mean Square	df	Sum of Squares	
.000	181.895	27.987	4	111.948	Between Groups
		.154	75	11.540	Within Groups
			79	123.488	Total

Source: student's study

From the table (4-3) The significant value level is (5%) at the degree of freedom (4), and the significant level of commitment to apply the complaints management system is (0.00) it's less than the significant value level, this indicates that: there are statistically significant differences at the level (5%). That means the top management of RCIH is committed to implement the complaints management system.

Hypotheses three: There is significant relation between the complaints management system and the organizational performance.

Table (4-4) Chi-Square Tests of the third hypotheses

	Value	Df	Asymp. Sig. (2- sided)
Person chi square	289.641(a)	16	.000
Likelihood ratio	205.308	16	.000
Linear-by-linear association	76.623	1	.000
N of valid cases	80		

a 20 cells (80.0%) have expected count less than 5. The minimum expected count is .31.
Source: student's study

From the table (4-4) The calculated value of chi-square for the significant differences for the respondents 'answers is (289.641) which is greater than the tabulated value of chi-square at the degree of freedom (16) and the significant value level (5%) which was (205.308).and the significant level of chi square is (0.00) it's less than the significant value level, this indicates that: there are statistically significant differences at the level (5%). That means there is significant relation between the complaints management system and the organizational performance.

3- Discussion:

This discussion includes a presentation and discussion of the most important finding of the study and providing the conclusion and a set of recommendations that come out from the study results. The study was conducted on a sample of Royal Care International Hospital employees .the researcher distributed the questionnaires to (100) employees and received (80) which formed the study sample. The data were input into the computer and processed statistically using the Statistical Package for Social Sciences (SPSS).

Observed from the study results, there is a positive impact of the effectiveness of the complaints management in improving a health services quality and achieving patient satisfaction, also we find that the top management of RCIH is committed to implement the

complaints management system and evaluating the organizational performance through the identification of weakness area and fix it.

This study distinguishes from other previous studies, because its focus on all factors which effect on the effectiveness of complaints management system, and to what extent the Sudanese hospital committed to embrace this conceptual management to improve its services.

This study consider as the first in the Khartoum-Sudan on the knowledge of researcher because it deals with hospital as a service institutions and to know the environment that employees and patient lives in to create good services quality for them.

4- Conclusion:

From this study we can conclude that:

- 1- There is positive impact of the effectiveness of the complaints management in improving a health services quality and achieving patient satisfaction.
- 2- There is a positive impact of complaints management system in evaluating and improving the organizational performance.
- 3-RCIH senior management is committed to apply the complaints management system.

5- Recommendations:

This research concluded the following recommendations:

- 1- Implementing the complaints management system in the governance health organizations to know the patient's needs and to improve the quality of services.
- 2- Concern by improving the health service to enhance the organization's reputation.
- 3- Training the employee to know how they can deal with the patient complaints.
- 4- Using feedback from the consumer in improving complaints system.
- 5-Engage and involve staff in designing of complaints management system.
- 6- Using of complaints data as an important tool to learn from less satisfied patients
- 7- Looking at the complaints management system as a conceptual management to improving the service and using it as a tool to achieve the patient satisfaction.
- 8- Comparing and sharing data on complaints between hospitals to highlight common deficient areas and also be used to plan strategies.
- 9- The study raises some issues requiring further research to ensure more appropriate use of patient's complaints to improve quality of care.

REFERENCES:

- 1- القران الكريم
- 2- Austrian Research Centres Seibersdorf (1999): Intellectual Capital Report 1999, Vienna.
- 3- Council for safety and quality (2005) "Complaints management hand book for health care services, Australian council for safety and quality in health care".
- 4- Charles Lusthaus (2002) "Organizational Assessment: A Framework for Improving Performance, International Development Research Centre, Ottawa, Canada".
- 5- Debono D.Travaglia J. (2009) "Complaints and patient satisfaction: comprehensive review for clinical governance research in health"
- 6- Dianna Spartel& Lynn Bochanan (2005) "Guide to complaint handling in health care services, health service review council".
- 7- Rashad Massoud & Rafeal Bengoa (2006)"quality of care a process for making strategic choice in health system".
- 8- Steve Brain Widmar (2012)"satisfaction with patient centered care and self care education in left ventricular assist device patients"
- 9- Sudan University of Science and Technology (2007)" Module 7 Customer Service Management"
- 10- Tameem A.A.Albassam (2013) "A Model for Measuring Service Quality in Internet-Based Services, Brunel Business School, Brunel University, Uxbridge, Middlesex, UK"
- 11- World Health Organization
- 12- ZUZU FATIMA ALZHRA (2011) " the role of services quality in achieving customer satisfaction".
- 13- [Http://www.ncbi.nlm.gov](http://www.ncbi.nlm.gov)
- 14- [Http://www.drscore.com](http://www.drscore.com)
- 15- www.arcs.ac.at
- 16- www.google scholar.net
- 17-www.pdfdrive.net

Appendix (A)

Questionnaire

جامعة السودان للعلوم والتكنولوجيا

كلية الدراسات العليا

عمادة الجودة والتطوير

ماجستير ادارة الجودة الشاملة والامتياز

استبانة بحث علمي

السادة/ مستشفى رويال كير العالمي

تحية طيبة وبعد ،،،

نضع بين ايديكم استبانة لاغراض البحث العلمي لموضوع (فعالية نظام ادارة الشكاوي في تحسين جودة الخدمات الصحية) يرجى التفضل والتعاون بالاجابة على جميع العبارات الواردة في الاستبانة، ونؤكد بان المعلومات التي سيتم جمعها من خلال اجاباتكم ستحاط بالسرية التامة وتستخدم لاغراض البحث العلمي والصالح العام لذلك نامل تعاونكم والاجابة على هذه الاسئلة بموضوعية.

الباحثة/ وئام عباس عبدالوهاب عباس

About your self/المعلومات الشخصية

gender/الجنس

male/ذكر

female/انثى

Age/العمر

25 years or less / 25 سنة او يساوي

26 years to 35 years / 26 سنة الى 35 سنة

more than 35 years / اكثر من 35 سنة

Level of education/المستوى التعليمي

secondary/ثانوي

first degree/بكالوريوس

other/أخرى

يرجى التحديد/please specify

المسمى الوظيفي/job title

Measurement of the complaints management system effectiveness

1 =strongly agree / أوافق بشدة

2 = agree/أوافق

3 = neutral / محايد

4=disagree/لا أوافق

5=strongly disagree/لا أوافق بشدة

	paragaphs/العبارات	1	2	3	4	5
	1-commitment to applying complaints management system 1- الالتزام بتطبيق نظام ادارة الشكاوي					
1	complaint management is an integral part of quality management ادارة الشكاوي جزء مكمل لادارة الجودة في المستشفى					
2	Leaders in the service promote consumer-focused care as part of quality improvement مدراء الخدمات يعززون حماية المستهلك كجزء من تحسين الجودة					
3	there is policy in relation to adverse events & complaint تتبع المستشفى سياسة محددة لجمع الشكاوي وتحليلها					
4	senior management committed to provide support for complaint management to operate effectively التزام الادارة العليا بتقديم الدعم الحقيقي للحصول على نظام تحليل فعال					
5	Clinicians and staff understand and routinely use the complaints management policy within the scope of their responsibilities كل الموظفون يستخدمون سياسة ادارة الشكاوي فيما يتعلق بمسؤوليتهم ووظائفهم					
6	workers trained to deal with complaints in its various kinds العاملون مدربون بصورة جيدة للتعامل مع الشكاوي بمختلف انواعها					
	2-Evaluating of the organizational performance 2-تقييم الاداء المؤسسي					
7	Consumer feedback is actively sought by offering a variety of ways to raise concerns and suggestions التفاعل مع اراء المستهلكين بطرق متعددة لتعزيز ارائهم واقتراحاتهم					
8	Clinicians and other staff understand that the handling of complaints is the responsibility of everyone الادراك التام بان التعامل مع الشكاوي مسؤولية الجميع					
9	The progress of resolution and investigation of complaints is tracked by the complaints manager يقوم مدير الشكاوي بمتابعة الحلول والتحقق منها					
10	follow up to respond to the complaints متابعة الرد على الشكاوي مع الجهة المعنية خلال الفترة المتوقعة للاجابة					
11	Understand complaints ,its dimension, its risk and making decision					

	about يتم دراسة الشكاوي وفهم ابعادها ومدى خطورتها واتخاذ القرار بشأنها					
12	preparing a report describing the complaint carefully يتم اعداد تقرير يصف الشكوى بدقة					
13	exploit all available resources to solve the patient's problem يتم استغلال كل الموارد المتاحة لحل مشكلة المريض					
14	The complaints resolution process is fair and lead to satisfaction عملية حل الشكاوي عادلة ومنصفة وتؤدي الى الرضا					
	3-improving services quality 3-تحسين جودة الخدمات					
15	Complaints are recorded in a manner that allows review of individual complaints, and analysis to identify trends and patterns for the purpose of clinical governance and quality improvement تسجل الشكاوي بطريقة تمكن من مراجعتها وتحليلها واستخدامها في تحسين جودة الخدمات					
16	The service periodically reports information to the public about consumer feedback, including complaints, as part of reporting on quality improvement نشر المعلومات والآراء الواردة من تحليل الشكاوي الى المجتمع لتحسين جودة الخدمات					
17	used suggestions and complaints of patient as reference to improvement تستخدم اقتراحات وشكاوي المرضى كمرجعية في تحسين النظام					
18	complaint management system updating regularly يتم تحديث وقياس فعالية نظام الشكاوي بصورة منتظمة					
19	Use Information's come from the complaints analysis in improving the performance & services quality تستخدم المعلومات الواردة من تحليل الشكاوي في تحسين الاداء وجودة الخدمات					
20	Consumers, clinicians and other staff are involved in the design of the complaints management system يتم اشراك الموظفين والاطباء في تصميم نظام ادارة الشكاوي					