Health care organizations today are finding that simply providing a "good" health care experience is insufficient to meet patient expectations. Organizations must train staff to provide excellent customer service to all patients. Many patients have become savvy health care "consumers" and consider customer service when they evaluate the quality of care they receive. The challenge for health care organizations is that patients want and expect not only outstanding clinical interventions but also excellent customer service—on every single visit.1(p. 25)

A growing body of evidence suggests that patient (including family) feedback can provide compelling opportunities for developing risk management and quality improvement strategies, as well as improving customer satisfaction.2–5 Research links patient dissatisfaction with malpractice claims and unnecessary expenses.6–10 Cold food, rude behavior, long waiting periods, and quality of care concerns should be taken seriously by hospital leadership not only because such attention is addressed in Joint Commission accreditation standards or required by the Centers for Medicare & Medicaid Services (CMS) but because it is the right thing to do. The Joint Commission standards speak to the collection of, response to, and documentation of complaints from hospital patients and their families,*11 and CMS deems a time frame of 7 days appropriate for resolution for most complaints, with 21 days for complex complaints.112 In addition, in July 2008 Joint Commission Sentinel Event Alert 40 stated that disruptive and intimidating physician behavior toward patients and colleagues may lead to medical errors, poor patient satisfaction, preventable adverse outcomes

* Rights and Responsibilities of the Individual (RI) Standard RI.01.07.01: The patient and his or her family have the right to have complaints reviewed by the hospital.

† According to CMS, a patient grievance is "a written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient’s representative, regarding the patient’s care, abuse or neglect, issues related to the hospital’s compliance with the CMS Hospital Conditions of Participation (CoP), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR §489."

Patient-Centered Care

Creating a Patient Complaint Capture and Resolution Process to Incorporate Best Practices for Patient-Centered Representation

Cynthia Mahood Levin, MHSA; Joseph Hopkins, MD, MMM

Article-at-a-Glance

Background: A growing body of evidence suggests that patient (including family) feedback can provide compelling opportunities for developing risk management and quality improvement strategies, as well as improving customer satisfaction. The Patient Representative Department (PRD) at Stanford Health Care (SHC) (Stanford, California) created a streamlined patient complaint capture and resolution process to improve the capture of patient complaints and grievances from multiple parts of the organization and manage them in a centralized database.

Methods: In March 2008 the PRD rolled out a data management system for tracking patient complaints and generating reports to SHC leadership, and SHC needed to modify and address its data input procedures. A reevaluation of the overall work flow showed it to be complex, with overlapping and redundant steps, and to lack standard processes and actions. Best-practice changes were implemented: (1) leadership engagement, (2) increased capture of complaints, (3) centralized data and reporting, (4) improved average response times to patient grievances and complaints, and (5) improved service recovery. Standard work flows were created for each category of complaint linked to specific actions.

Results: Complaints captured increased from 20 to 270 per month. Links to a specific physician rose from 16%–36% to more than 80%. In addition, 68% of high-complaint physicians improved. With improved work flows, responses to patients expressing concerns met a requirement of less than seven days.

Conclusions: Standardized work flows for managing complaints and grievances, centralized data management and clear leadership accountability can improve responsiveness to patients, capture incidents more consistently, and meet regulatory and accreditation requirements.
and increased costs of care. Therefore, all health care entities must thoroughly investigate and document patient complaints and grievances and respond in a timely fashion. Stanford Health Care (known as Stanford Hospital & Clinics until July 2014) (SHC; Stanford, California) implemented a robust process to measure and analyze all patient feedback to improve processes and patient satisfaction. SHC views management of patient complaints and grievances as an area to infuse patient-centered care. The institution is committed to hear, record, and respond to patient concerns. Hearing is critical because an organization cannot fix problems if it is not aware of them; recording is essential to allow for providing metrics of performance and identifying patterns; and responding is the hallmark of service recovery. SHC’s Patient Representation Department (PRD), which is part of Guest Services, is tasked with the responsibility of managing all complaints and grievances on behalf of the organization. During an 18-month period, the PRD embarked on a mission to develop robust processes to monitor and address patient feedback with service recovery, thereby improving customer service and patient care, safety, and satisfaction. In this article, we describe SHC’s methodology and use of various metrics to drive quality improvements in its patient complaint capture and resolution process.

Methods

Setting
SHC is a 613-bed general medical and surgical facility. In 2013, this not-for-profit teaching hospital had 26,147 admissions and 520,882 outpatient visits, and its emergency room had 57,606 visits, all resulting in a wealth of useful patient data to be mined for service improvement opportunities.

Data Management
In March 2008 the PRD rolled out a data management system for tracking patient complaints and generating reports to SHC leadership. The system was designed to increase departmental operational efficiency by enabling complaints to be easily recorded, tracked, and transmitted for additional analysis. PRD staff were trained on proper input and management of data in this system, with the aim of reducing various errors such as duplicate records and incomplete or outdated data.

Process Improvements: From Work Flow to Templates

Analysis of Current Work Flow. SHC needed to modify and address data input procedures to take advantage of tracking system capabilities and produce more reliable and accurate reports. In reevaluating its overall work flow in 2008 (Appendix 1, available in online article), PRD found it to be complex, with overlapping and redundant steps; lacking in standard processes and actions; and not meeting certain requirements, such as the CMS requirement for 7- and 21-day resolution. The PRD collaborated with the Compliance, Risk Management, and Quality and Safety Departments in an effort to better understand how to quickly and efficiently move patient concerns through the review, investigation, and response process. The review revealed uncertainty as to when to hand off patient concerns to the appropriate department(s), the level of collaboration needed, and when to consider the file closed.

Modification of Work Flow. Following this analysis, workflow improvements were developed. Modifications included adding very specific steps for documentation and handoffs, contacting appropriate parties for investigation, and collaborating with appropriate departments to conclude and close a complaint. Figure 1 (page 486) depicts the new revised work flow from initial complaint in the Guest Services Department to final resolution and file closing. The new approach, which was implemented in stages in a nine-month period beginning in December 2008, employed an initial single work flow for all complaints. These were categorized with specific procedures and actions for each.

Creation of Templates. New templates were created for note taking during in-person patient interviews by SHC Patient Representation staff. These new templates facilitated responses. For example, a template was designed and produced as a notepad with a checklist of questions for staff to use during a phone call with a patient or an in-person meeting on SHC’s inpatient units (Appendix 2, available in online article). A template was also created to ensure consistent use of clear and concise direct language in all e-mail communications to physicians and clinic staff (Figure 2, page 487). SHC found that slow return responses from physicians and managers were partially due to inconsistent messages from members of the PRD. The e-mails often did not capture or clearly communicate important information from the patient. This inefficiency required follow-up calls to track down details. Also, in general, physicians and clinic staff lacked knowledge of the regulatory mandated grievance resolution process. The new e-mail templates contained a brief explanation of the grievance process, including that communications were intended to be objective and part of an effort to timely resolve patient concerns. Finally, SHC designed additional templates for the final response letter to the patient that would accompany a summary of the investigatory findings (Figure 3, page 487). SHC worked
Complaint Management Process After Redesign

Guest Services receives concern via phone, e-mail, letter, face-to-face meetings, as well as from physicians/billing, nurses, SHC staff, patients, family members, friends, outside agencies or insurance companies, and patient satisfaction surveys.

Senior Patient Representative (SPR) contacts patient or caller for details of concern. Consent is obtained from patient. Holding letter is sent within 7 business days if concern is related to standard of care.

SPR documents concern in database.

SPR contacts appropriate party to assist in the review and initiates bill hold. If issue involves a risk of adverse publicity, then contact Media Relations Department.

- **Claims/Litigation**
  - Contact Claims Department
  - Contact the Office of Compliance and Privacy Assurance

- **Confidentiality/HIPAA issues**
  - The Office of Compliance and Privacy reviews issues internally

- **Clinical Care Issues**
  - Contact Risk Mgmt, Quality Dept., physicians, and/or Pt. Care Mgr (Service Chief)

- **Customer service issues**
  - Contact appropriate Patient Care Manager and/or physician (Service Chief)

- **Physician behavioral issues**
  - Contact Physician (Chief of Medical Staff & Service Chief)

- **Security issues and/or lost items**
  - Contact Security Manager

- **End**

"Vanderbilt Patient Advocacy Reporting System (PARS) assists with identifying physicians at increased risk for malpractice claims and promotes changes in physician's behavior to improve patient satisfaction"

At house staff (intern, resident, fellow) issues are copied to Director of Graduate Medical Education

For patient concerns that are simple, CMS requires they be resolved on an average timeframe of 7 days. If a concern cannot be resolved within 7 days, the patient or patient's representative will be informed that Guest Services is still working to resolve the concern. Billing Department is contacted to make appropriate financial adjustments.

Enter resolution into database and close file.

Figure 1. The redesigned complaint management process employed a single initial workflow for all complaints, which were categorized, with specific procedures and actions for each. SHC, Stanford Hospital & Clinics; pt, patient; CMS, Centers for Medicare & Medicaid Services.
Template for Correspondence with Physicians

Dear Dr. [Name]

We need your help in reviewing concerns expressed by a patient to Guest Services. The narrative text attached to this message represents a patient/family viewpoint as it was shared with us, and we recognize that some concerns are valid while others are based on faulty perceptions or a different viewpoint. The intent in bringing this issue to your attention is to ensure that you are aware of concerns that have been expressed, to ascertain your involvement in the episode, and to seek your help in addressing the patient’s concerns if you were involved.

• Do you have any insight into this patient’s concerns?
• Have these concerns previously been addressed, and if so, how?

We would greatly appreciate it if you would briefly relay your perspective regarding this episode. Providing your feedback will allow Guest Services to draft a response to the patient and may further help us to improve patient care processes and systems at Stanford. Because we must comply with state and federal regulations to respond to the patient within 7 days, please respond to this message by secure e-mail or feel free to call me by (date).

Thank you in advance for your help.

Sincerely,
(Name and Phone #)

Figure 2. This template was also created to ensure consistent use of clear, concise and direct language in all e-mail communications to physicians and clinic staff.

with professional writers, consulted writing guides and best practices, and collaborated with risk management and quality groups to create template-style letters that could be customized for different outcomes or needs. The templates also offered letter-writing tips and guidance to help staff carefully consider the tone and implication of their words.

PARS PARTNERSHIP: PROMOTING CHANGES IN PHYSICIAN BEHAVIOR AND IMPROVING PATIENT SATISFACTION

Another important aspect of SHC’s methodology involved establishing a partnership with the Vanderbilt University Medical Center for Patient and Professional Advocacy (CPPA) in January 2008 and beginning to use their Patient Advocacy Reporting System (PARS®). This system uses evidence-based tools to code and analyze patient complaints and generate a “risk score” to identify those physicians who are at greatest risk for medical malpractice claims. PARS uses these data in a standard intervention to promote changes in physician behavior that lead to increased professional self-regulation, improved patient satisfaction, and reduction of malpractice claims. CPPA trained SHC physician peer messengers to share PARS data with the identified high-risk physicians in a confidential and collegial manner. In general, when made aware of these data, 70% to 80% of physicians are able to reduce complaints associated with their practice—and thereby reduce their risk for claims. A guided intervention by an authority figure is reserved for those physicians who do not respond to the data alone.

BEST PRACTICES

The PRD incorporated five best practices, as we now describe, in its patient complaint capture and resolution process.

Best Practice 1. Leadership Engagement. Senior SHC leadership was engaged early in this effort to ensure that mutual goals and expectations could be set. SHC leaders were encouraged to voice buy-in of the process to others, with emphasis on the importance of patient/family concerns. A key goal was to gain leadership’s commitment to support the PARS program. We resumed providing the data to the leadership in the organization in April 2010, with inclusion of all data from multiple sources (see page 488, right). Managers were instructed on how to analyze the data and to focus on the two highest areas of concern as identified by the patients through all feedback sources. They were directed to formulate action plans for these trends, system issues, or behavioral problems and to offer focused staff training in customer service and service recovery.

SHC also updated its Administrative Grievance Policy, which provides hospital staff with a comprehensive document that covers procedures, documentation by guest services, the pur-
pose of complaint tracking, administration, and compliance. Detailed guidelines on handling complaints from a government agency or an accreditation agency such as The Joint Commission or CMS, and on how to prepare for potential litigation are included.

**Best Practice 2. Increased Capture of Patient Complaints.**

Patients underreport their unhappiness with their health care. Studies show, for example, that 22% of patients take no action when they have a disagreement with their physicians,22 that only 9.5% of patients with cause to complain do so,23 and that only 1/5 to 1/3 of 293 female patients reported a serious ethical transgression, depending on the nature of the transgression.24 Reporting varies by ethnicity,2,25 age,24 lower self-rated knowledge of patient rights,24 and previous medical events.23

SHC established the capture of patient complaints as a top priority in the belief that it is important to make it as easy as possible for patients to report their dissatisfaction regarding their experience. If SHC fails to meet the expectations of any patient for any reason, the organization wants to hear about it and record it. Complaints are a valuable source of data to guide problem solving. Working with CPPA, SHC leaders set goals to increase annual complaint capture by 50% over previous levels and tracked progress of collecting complaints using established guidelines from the PARS program. Capturing patient complaints allowed SHC to identify patterns and opportunities for service recovery, enable reliable identification of at-risk physicians, and improve patient satisfaction.

To achieve the quarterly goal of increasing the capture of patient complaints, SHC promoted the availability of patient representation and redesigned a patient complaints brochure—translated into four languages—to catch people’s interest and provide more space to write their comments (Appendix 3, available in online article). In addition, the PRD published articles in SHC’s print and online publications to educate staff about the grievance policies. Flyers providing numbers to call for clinical emergencies and for Guest Services were displayed in all 475 patient rooms in highly visible positions, such as across from the patient’s bed or beneath wall clocks.

**Best Practice 3. Centralized Data and Reporting.** Before the creation of the patient complaint capture and resolution process, SHC was solely dependent on the Quality and Safety Department for aggregated, detailed data regarding complaints. The Process Excellence Department was tasked with investigating current grievance and complaint management practices. The department interviewed managers in major departments—Lab, Admitting, Emergency Department, Cancer Center, and Billing—to determine how complaints and grievances were being handled. The interviews indicated that the process for the capture and reporting of complaints was decentralized and highly variable, with many staff members not knowing where to send complaints or even aware of the need to report or document them in the first place.

During a period of a few months, patient representation and service quality teams identified all existing repositories of patient comments and concerns and then made staff aware through management meetings and new employee orientation that all such communications should be referred to the PRD. By February 2010 all departments had agreed to funnel formal grievances, including written letters or patient requests to make a formal verbal complaint, to the PRD team to ensure that proper procedures were followed. SHC centralized the process for complaint capture to include the variety of ways the hospital hears from patients: letters, e-mails, walk-ins, telephone calls to the PRD and hospital executives, complaints entered in the electronic record system, comments made directly to nursing staff and unit/clinic managers, comments on patient satisfaction surveys and “Same Day Feedback” (responses by patients in the hospital or emergency department using feedback cards gathered by the Process Excellence Department). Patients were asked if all their needs were being met during their hospital or emergency room stays and, if not, what could be done better.

Managers were previously inundated with as many as 90 types of reports concerning operations of the hospital activities, from quality improvement to financial performance, and were resistant to any more reports about complaints. By bringing all patient feedback into one tracking system, the consolidated data became more accurate, reliable, and easier to act upon. When nurse managers develop action plans, they can now look at one source of data. Grievances that related to quality of care, patient safety, and risk issues were further investigated by these departments. Collecting and analyzing data gets at the heart of “guestology”—“the scientific study of guests’ [patients’].”21(p. 26) Guestology is intended to not only sustain a customer-centered experience but also meet the organization’s financial and clinical objectives.1

In August 2009 the PRD produced its first basic patient complaint report in two years for the leadership team. These reports, which were e-mailed monthly to the managers, directors, vice presidents, and chief operating officer, guided improvement efforts throughout the organization. Periodically, reports were presented at the hospital Medical Staff Quality Committee and managers’ meetings. Starting in October 2009, copies of all complaints were sent to the chairs of the clinical departments of the School of Medicine and the hospital chief of staff.
Best Practice 4. Improved Average Response Times to Patient Grievances and Complaints. From the very beginning, SHC set out to raise the bar on its average turnaround time to close a patient grievance investigation within the CMS time frame of 7 and 21 days.11,12 Both CMS and The Joint Commission require that hospitals, in their resolution of a complaint, provide the individual (patient) with a written notice of its decision, which would contain the name of the hospital contact person, the steps taken on behalf of the individual to investigate the complaint, the results of the process, and the date of completion of the complaint process.11,12

To meet or surpass the 7-day deadline, SHC undertook a series of actions during a 9-month period beginning in December 2008. First, it defined and trained staff to understand the nature of a true complaint or grievance, as opposed to service recovery visits, which could be managed by the hospital’s Navigation staff. (Navigators are Guest Services staff members who provide a wide range of assistance from giving directions to handling service recovery and connecting a patient with appropriate resources or departments.) The patient representatives and navigators were also trained on the difference between complaints and grievances so that an expectation of handling or escalating a complaint was clearly understood. Complaints are patient issues that can be resolved promptly or within 24 hours and involve staff that is present (for example, nursing, administration, patient advocates) at the time of the complaint. Complaints typically involve minor issues, such as room housekeeping or food preferences that do not require investigation or peer-review processes.26 Most complaints will not require that the facility send a written response to the patient.

Differentiating processes for service recovery visits, complaints, and grievances enabled the PRD team to resolve complaints more efficiently. Any report of abuse, neglect, privacy violations, or compromised care was thoroughly investigated, and the manager was notified. Grievances that involved physician behavioral issues were directed to the chief of staff for immediate intervention, if necessary. Second, SHC developed an audit process that would resolve the more complex cases within 21 days. Weekly reports were generated to identify any cases exceeding 7 days to allow for management intervention to assist the patient representative. Third, SHC established systems and procedures for physicians and managers to respond to PRD staff within 48 hours. Training was conducted at manager and physician meetings to set expectations for receiving a response to grievance investigations. An escalation process was implemented to require contact with the director when a manager did not respond. The e-mail template (Figure 2) for investigations was launched to assist managers and physicians in recognizing an investigation request. The new patient complaint capture and resolution process involved leveling workloads and ensuring that patients received personal attention from the PRD staff. Two additional staff members and an analyst were added to the department, bringing the total team to seven. Further, the PRD team adopted a process of “touching” every case every day to ensure timely communications and resolution. A stamp on the outside of the patient case folder provided team members with a quick read on the overall case assessment step under way:

- Medical Record Number:
- Date Received:
- Holding Letter:
- Data Entry:
- E-mail Distribution:
- Feedback Received:
- Resolved: Letter/Phone

Team members were observed by the PRD director as they interacted with patients and as they participated in weekly case-load meetings for assessment. PRD staff members were responsible for writing letters to patients to further expedite the process and prevent bottlenecks, and they were trained on how to write reports in a succinct manner. Waiting for physicians or managers to write the final letter was not efficient and compromised the deadline. If the patient representative did not receive a response from the manager or a hospital unit, the complaint was also escalated to the director of the department. We believe this process served to promote professional accountability.

Best Practice 5. Improved Service Recovery. Effectively addressing patient concerns in real time, as they are occurring, significantly improves patient perception of care and of the organization. There was a clear need in the organization for a service recovery initiative. The acronym L.E.A.R.N.27 (Appendix 4, available in online article) resonated with the patient representatives at SHC, a teaching institution: Listen (don’t interrupt; rather, use active listening skills), Empathize (put yourself in their shoes—“I hear that you are frustrated”), Apologize (“I’m sorry that you had that experience”), Resolve (resolve and verify the guest is satisfied), and Notify (appropriate manager and/or physician). A Service Recovery Tool Kit to guide staff training included scripting, practice responding to examples of patient complaints using role playing and coaching feedback, and sometimes giving a patient an amenity such as a voucher for the cafeteria or coffee shop (Appendix 5, available in online article).* Scripting these steps helped the staff feel far more

* Differences in the precise wording of the L.E.A.R.N. terms reflect staff’s respective preferences.
comfortable when handling a situation that has not gone well for the patient. This skill becomes financially important to an organization because keeping an existing customer is less costly than trying to market to a potential new one. Service recovery can achieve a level of satisfaction similar to that before the complaint emerged.

**Results**

**Complaint Report Capture**

SHC’s capture of patient complaints and grievances was compared to the benchmark for institutions with similar numbers of physicians and hospital beds established by CPPA. SHC reached “best practice” status with the collection of approximately 270 reports per month during July 2009 (Figure 4, above). Although monthly rates vary, SHC has stayed in the best-practice zone ever since.

**Physician Identification Rates**

During the 12-month audit period from September 1, 2008, through August 31, 2013, SHC’s Patient Representation and Service Quality team linked a patient’s concern to a specific physician 80% of the time, achieving the best-practice zone (Figure 5, above, right). The result reflects the efforts made to consistently record accurate information regarding the patient’s complaint involving an SHC physician.

**Resolution of Complaints and Grievances**

Initially, resolution of complaints and grievances met the CMS–recommended time frame of seven days for a response. Subsequently, staff turnover and leadership changes were followed by modest deterioration, but SHC was able to identify and rectify the issues, and performance is improving again (Figure 6, page 491). This experience illustrates the importance of having a tool and process for monitoring data and addressing issues as they are identified.

**Improved Physician Interactions with Patients**

PARS interventions are based on a rolling four years of patient and family complaint data summarized in a standard report presented annually to high-risk physicians by a medical staff colleague trained on how to be an effective messenger. The medical staff at SHC formed the Committee for Professionalism to oversee the process. Medical staff leaders met with physicians not responding to data feedback and usually referred them for coaching. Since the implementation of PARS at SHC, 21 (68%) of 31 physicians who initially had a high number or severity of complaints have improved, 10 to such a degree that they no longer require messenger feedback visits to discuss patient complaints about their practice (Figure 7, above, right).
Discussion

SHC made a commitment to establish a streamlined process to capture and centralize complaints and grievances in a collaborative manner with other departments and staff across the organization. Consolidated reporting facilitated identification of problems requiring manager action. The institution partnered with Vanderbilt PARS to provide a tool and an intervention process for improving physician interactions with patients. Accountability of staff fostered a culture of responsibility and empowerment to provide the highest level of quality and customer service. Leadership has to own and support this formal process of accountability, create a process that is fair and effective in building awareness, and establish support systems to improve skills and behaviors. Through all these efforts, patient complaint handling has improved, managers can act effectively and timely on the data, and physician interactions with patients have improved. The organization has a global appreciation of the importance of customer service to its patients and service recovery.

Barriers and Challenges

The barriers and challenges encountered in developing the patient complaint capture and resolution process included initial lack of leadership support; lack of education of physicians, managers, and staff regarding CMS regulations and Joint Commission standards; the lack of standard procedures; and broken work flows. Breaking down these barriers and overcoming these challenges came about as a result of leadership buy-in, staff education about expectations, and building standard work through streamlining work flows. Establishing specific performance metrics for complaint capture, for providing regular feedback about attribution of complaints to a specific physician, and for turnaround time for resolving grievances helped drive improvement.

Next Steps

SHC anticipates that patient expectations will continue to increase and require further improvements in care, patients’ experience, and timely, effective resolution of complaints and grievances. The PRD staff members are working with managers to further improve staff training and new employee orientation sessions, using “words that work” and similar communication guidelines. The organization is increasingly using Lean management as a method of defining problems and improving processes, including complaint and grievance management. Patient volunteers are being trained to interview patients to get a first-hand view of their experience.

Conclusion

Providing high-quality care to patients increasingly includes good service to support an overall favorable patient experience. Standardized work flows for managing complaints and grievances, centralized data management, and clear leadership accountability can improve responsiveness to patients, capture...
incidents more consistently, and meet regulatory and accreditation requirements. The availability of high-quality data supports efforts to help physicians improve their interactions with patients.

Cynthia Mahood Levin, MHSA, formerly Senior Director of Executive Programs & Service Quality, Guest Services, Stanford Health Care, Stanford, California, is Clinical Director of Operations, Palo Alto Medical Foundation, Palo Alto, California. Joseph Hopkins, MD, MMM, is Clinical Professor of Medicine, Stanford University School of Medicine, and Associate Chief Medical Officer, Senior Medical Director for Quality, Stanford Health Care. Please address correspondence to Joseph Hopkins, johopkins@stanfordmed.org.

Online Only Content
http://www.ingentaconnect.com/content/jcaho/jcjqs

References
Appendix 1. Complaint Management Process in 2008 (Before Redesign)

Legend
CM: Clinic Manager
NM: Nurse Manager
PCD: Patient Care Director
PFS: Patient Financial Services
RM: Risk Management

The Patient Representation Department found the workflow to be complex, with overlapping and redundant steps; lacking in standard processes and actions; and not meeting certain requirements. Pt Rep, patient representative; Mgr, manager; Dir, director; CA, California; ED, emergency department; VP, vice president.
Appendix 2. Template for Note Taking During In-Person Patient Interviews by Stanford Hospital & Clinics Patient Representation Staff

| Today’s Date: __________________________ Notes Taken By: __________________________ |
|-----------------------------------------|----------------------------------------|
| Patient’s Name: ________________________ |                                        |
| Date of Birth: _________________________ MRN: ________________________ |
| Contact Info: __________________________ |                                        |
| Caller Name & Relationship: ____________ |                                        |
| Date of Service: ________________________ Location: ____________ |
| Physician (Resident / Fellow / Attending): ________________________ |                                        |
| Staff Involved: ________________________ |                                        |
| Staff’s Manager: ________________________ |                                        |

Circle if RELATED TO the following: Risk / Compliance / Security / Social Worker / Case Manager / Nurse / Dietician / Transport / Scheduler / Coordinator / Registrar

Patient’s Expectations: ____________________________________________
|_________________________________________________________________|
|_________________________________________________________________|
|_________________________________________________________________|

Comments: ______________________________________________________
|_________________________________________________________________|
|_________________________________________________________________|
|_________________________________________________________________|

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Appendix 3. Brochure Available Throughout the Organization to Encourage Patients to Report Concerns

(Continued on page AP4)
Appendix 3. Brochure Available Throughout the Organization to Encourage Patients to Report Concerns (continued)

We’d like to hear what you think.

Please let us know about your experience at Stanford Hospital & Clinics by taking a moment to complete this form and place it in a comment box. You may also mail the form back to us at your convenience. postage is already paid. If you have any immediate concerns, please contact Guest Services at (650) 498-3333.

Spanish
Por favor tómese un momento para completar este formulario y diganos cómo fue su experiencia en el Hospital y las Clinicas de Stanford. Cuando termine, colóquelo en la caja de comentarios. Para su conveniencia, también lo puede enviar por correo; el sobre ya está estampillado. Si tiene alguna inquietud inmediata, por favor comuníquese con la oficina de Servicios para los Huéspedes llamando al (650) 498-3333.

Russian
Пожалуйста, поделитесь с нами своими впечатлениями от посещения Станфордской больницы и клиник. Заполните эту анкету и опустите ее в ящик для отзывов. Вы также можете прислать заполненную анкету по почте – марка не нужна, пересылка уже оплачена. С вопросами и жалобами просим обращаться в Отдел по обслуживанию посетителей, телефон (650) 498-3333.

Service Recovery - Basic Steps

1. Give help or get help
2. L.E.A.R.N.
3. Escalate

How can we help you?
L. E. A. R. N.

Listen (do not interrupt)
Empathize (put yourself in their shoes)
Apologize (“I’m sorry that happened to you”)
Resolve (and verify patient/family is satisfied)
Notify (appropriate supervisor, manager, MD)
Appendix 5. Service Recovery Tool Kit

Service Recovery Tool Kit

Standard Practices for Service Recovery

(continued on page AP7)
Appendix 5. Service Recovery Tool Kit (continued)

Active Daily Management – Service Recovery

Who
  ▶ Everyone takes part in Service Recovery.

What
  ▶ Service Recovery is a way to personally take CARE of every patient every time when there is a concern.

Why
  ▶ Taking CARE of our patients/guests when a concern arises is our responsibility. In doing so, our patients/guests know we care.
  ▶ Our collective IMPACT makes an enormous difference on the patients, guests and families.

How
  ▶ Use the Service Recovery Practices when a concern arises.
  ▶ Use options provided in the Toolkit.
  ▶ Communicate and Practice often within meetings and huddles.
  ▶ Celebrate successes.

(continued on page AP8)
## Appendix 5. Service Recovery Tool Kit (continued)

### Standard Practices for Service Recovery

<table>
<thead>
<tr>
<th>Connect</th>
<th>Ask</th>
<th>Respond</th>
<th>Exit</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Make eye contact</td>
<td>- Clarify information</td>
<td>- Match their urgency</td>
<td>- Indicate that their concern is important</td>
</tr>
<tr>
<td>- Observe guest’s body language</td>
<td>- Provide options</td>
<td>- Agree on next steps and follow up with guest</td>
<td>- State timeframe</td>
</tr>
<tr>
<td>- Be aware of your body language</td>
<td></td>
<td></td>
<td>- Follow up and follow through with appropriate communication</td>
</tr>
</tbody>
</table>

**Introduce**
- Provide your name, title, department

**Communicate**
- Listen Actively
- Sincerely Apologize
- Empathize

(continued on page AP9)
Appendix 5. Service Recovery Tool Kit (continued)


Listen (don’t interrupt)
Empathize (put yourself in their shoes)
Apologize (“I’m so sorry you had that experience”)
Resolve (resolve & verify guest is satisfied)
Notify (appropriate manager, MD)

(continued on page AP10)
### Appendix 5. Service Recovery Tool Kit (continued)


<table>
<thead>
<tr>
<th><strong>DOs</strong></th>
<th><strong>DON’Ts</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please allow me to find out</td>
<td>Babe, Honey, Dear, Folks</td>
</tr>
<tr>
<td>for you.</td>
<td>No Worries, No Problem</td>
</tr>
<tr>
<td>What I can do is...</td>
<td>What’s Up, Huh?</td>
</tr>
<tr>
<td>I apologize.</td>
<td>What did you say?</td>
</tr>
<tr>
<td>I will find someone who can</td>
<td>It’s not my problem.</td>
</tr>
<tr>
<td>better assist you with...</td>
<td>That’s how we do it here.</td>
</tr>
<tr>
<td>I am so sorry you had that</td>
<td>There’s nothing I can do.</td>
</tr>
<tr>
<td>experience.</td>
<td></td>
</tr>
<tr>
<td>Can you provide me with...</td>
<td></td>
</tr>
<tr>
<td>Let me see what I can do for</td>
<td></td>
</tr>
<tr>
<td>you.</td>
<td></td>
</tr>
</tbody>
</table>

(continued on page AP11)
Appendix 5. Service Recovery Tool Kit (continued)

Practice – Role Playing

- Practice using the scenario of a patient with a concern
- Arrange in groups of three and assign roles
  - **Employee**: Use the standard practices to respond to the patient/guest
  - **Patient**: Respond to employee
  - **Coach**: Provide feedback to employee:
    - **Open**: “You were effective in following the Service Recovery steps…”
    - **Continue**: “You can be even more effective if you…”

*Three rounds, 3 minutes each*

- Large Group Debrief
  - What worked well?
  - What would you have done differently to be EVEN more effective next time?

(continued on page AP12)
Appendix 5. Service Recovery Tool Kit (continued)

**Standard Practices of Service Recovery – Amenities & Resources**

- **Toolkits** provide additional amenities and resources for the patient or family based on the situation. It is meant to supplement standard practices.

- **Why?**
  - Provides patient / guest with a gesture that shows we care
  - Provides employees with options and resources to supplement guest services

- **Tune in** to patient / guest. Identify what is needed

- **Customize** each situation

- **Examples:**
  - Wait time too long: consider a free parking pass
  - Elderly patient: connect with Aging Adult Services