AROHA
CANCER CENTRE

LABORATORY DEPARTMENT

SYSTEM PROCEDURE
FOR COMPLAINT RESOLUTION AND FEEDBACK

ACCL/SP/016

Aroha Cancer Centre
Laboratory Department
P.O. Box 414 – 60200, Meru
Tel: +254 799 528973; **Email:** lab@aroha.health

System Procedure	Document No: **ACCL/SP/016** Version: 1.0 Supersedes: None Effective Date: 04-01-2023

Title: **PROCEDURE FOR COMPLAINT RESOLUTION AND FEEDBACK**

	NAME	SIGNATURE	DATE
AUTHOR	GITONGA MILCOM	G.M	04-01-2023
QA UNIT AUTHORITY	HASSAN MASHA THOYA	M.T	06-01-2023
APPROVAL AUTHORITY	Pst. FRANCIS ONDIEKI	F.D	08-01-2023

Document Distribution Table

DATE ISSUED	CONTROLLED COPY NO.	TOTAL NO OF COPIES	DATE OF DISCONTINUATION.
04-08-2023			

TABLE OF CONTENTS

Table of Contents

1. **Introduction/ Purpose;**

1.1. The purpose is to measure customer satisfaction of the services offered in the ACC laboratory. The customer in the case of the ACC laboratory will be the referring clinical facility from all sites that use our laboratory.
1.2. Accrediting organizations and standards, including ISO 15189, require that institutions measure customer satisfaction with laboratory services through ongoing monitors.
1.3. This procedure will assist the laboratory in meeting this requirement while helping to identify improvement areas and to ensure customer satisfaction with our services.
1.4. This procedure shall be reviewed and signed by the laboratory director or designee annually and be incorporated into the ongoing QI activities and patient safety policy.

2. Definitions

2.1. ACC- Aroha Cancer Centre
2.2. ISO – International Organization for Standardization
2.3. SOP- Standard Operating Procedure
2.4. QI-Quality Improvement
2.5. QA-Quality Assurance
2.6. N/A- Not Applicable

3. Scope/Responsibilities

3.1. This procedure applies to all client services offered by ACC laboratory
3.2. The procedure applies to all ACC laboratory and support staff is responsible for ensuring that this procedure is implemented as written.

3.3. Laboratory Director /QA Officer /designee

3.3.1. Ensure that this SOP is implemented and utilized as written
3.3.2. Helps to review and approve this SOP.
3.3.3. Assist in the training and implementation of this SOP.
3.3.4. Reviewing documentation to assure compliance with this SOP.
3.3.5. Responsible for any changes made in this procedure.

3.4. **Lab Technologists/ Technicians,**

3.4.1. Ensure that this SOP is implemented and utilized as written
3.4.2. Responsible for reviewing, signing and dating this policy and the questionnaires.

4. Specimen - N/A

5. Materials and Equipment

5.1. Standardized questionnaire

6. Procedure

6.1. **Client satisfaction surveys;**

6.1.1. Client satisfaction surveys are conducted at least annually.
6.1.2. The QA Officer will schedule the client satisfaction survey

6.1.3. Copies of Clinician Satisfaction survey forms (ACCL/FRM/039) will be distributed to the clinicians to provide feedback and recommendations based on laboratory services provided by the laboratory.

6.1.4. Copies of Patients Satisfaction Survey forms (ACCL/FRM/040) will be provided at the reception/waiting bay areas for clients to give feedback.

6.1.5. Completed forms will be collected from distributed areas and the data analysis done.

6.1.6. Outcome of the survey will be shared with staff members and discussed at management review meeting.

6.1.7. The Clients may also be provided with outcome of the survey if they request through the Laboratory manager.

6.2. Handling of Complaints;

6.2.1. Complaints can be received from clinicians, patients, laboratory staff or other parties in various ways which includes; telephone calls, verbal, e-mail, through the filled Complaints Form (ACCL/FRM/044) at the reception.

6.2.2. Complaints may also be identified through review of feedback from Customer satisfaction surveys.

6.2.3. After receiving the complaints, record them on the Complaints Form (ACCL/FRM/044) and attach any supportive document if applicable

6.2.4. All complaints should be directed to the laboratory director but those that can be resolved by the technical staff should be addressed immediately and feedback provided to the complainant.

6.2.5. However, if the technical staff is unable to address the complaints, they are directed to the Laboratory director for investigations.

6.2.6. If the complaint is such that it affects or has already affected patient/s results, this is treated as a non-conformance and a corrective action should be initiated as per the Non-Conformity Form (ACCL/FRM/052)

6.2.7. The Laboratory director shall investigate/delegate a member of staff to carry out corrective action on the complaint.

6.2.8. If it has been established that the complaint is incorrect or fake or too subjective, the corrective action shall not be conducted and the complaint is closed without investigation.

6.2.9. If the complaint is of the magnitude that it requires hospital management, the Laboratory manager shall inform the Laboratory Director for appropriate action.

6.2.10. All complaints will be resolved within one month and feedback issued to the complainant. Such communication shall be documented in the communication form (ACCL/FRM/031) in the Laboratory or through email.

6.2.11. For those who fail to provide contact details, the complaint will be resolved but feedback will not be given.

6.2.12. All complaints records are filed in the Customer Complaints Records file.

6.2.13. The Quality Officer reviews corrective and preventive actions taken on complaints for effectiveness every six months or earlier based on the nature of complaint to establish any trends and to come up with preventive actions where necessary.

6.3. Performance Indicator

6.3.1. Percentages of Excellent/Good greater than 80%

6.3.2. Improvement of the areas that affects the mean satisfaction should be addressed and observed in the next dispatch; if not improved, training of staff should be performed. Other corrective measures will be taken as per SOP for Nonconformity & corrective action (ACCL/SP/012)

7.0. References:

Reference Number.	Document Title
ACCL/EXT/002	ISO 15189:2012 Medical laboratories requirements for quality and competence

8. Supporting Documents;

Document No.	Title
ACCL/SP/012	Nonconformity & corrective action
ACCL/FRM/031	communication form
ACCL/FRM/052	Non-Conformity Form
ACCL/FRM/044	Complaints Form
ACCL/FRM/040	Patient satisfaction Survey forms
ACCL/FRM/039	Clinician Satisfaction survey forms (ACCL/FRM/039)

9. **document review and approval;**

By Initialing and dating below I understand and approve of the changes to the attached Policy.

Document Changes		Changes Approval Name/Initials & Date		
Date	Nature of Change	Reviewer	QA/ designee	Approving Authority

10. Attestation:

I have read, understood and agree to follow the procedure as documented:

No	Name	signature	Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			