| Reid Health Organizational Policy | |
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| **Name: Patient Complaints and Grievances** | Policy # 31 |
| Final Approval Date: 02/13/2025 | Next Review Date: 02/13/2028 |
| Owner: Ayren Staton (Dir-Women & Childrens Service Line) | |
| Required Approvals: Enter list of required committees/individuals to approve | |

## I. PURPOSE

To establish a process for patients to voice a complaint or grievance to Reid Health.

## II. POLICY

Reid Health is committed to providing high quality care and services to its patients in a safe and secure environment. It is the policy of Reid Health to provide an internal process for patients and/or their representatives to voice dissatisfaction.

Patient concerns will be reviewed, and assistance provided to resolve issues in a timely manner. Reid Health empowers its employees to address patient, family, and other customer complaints. As such, any individual receiving a complaint should make every effort to implement service recovery to resolve that issue promptly.

1. Reid Health staff that become aware of a patient concern or complaint about patient care, patient rights, or who become aware of a concern or complaint about barriers to visitors or patients, are authorized to attempt to resolve the concern or complaint as promptly as the circumstances allow in a courteous and reasonable manner. This should also be used for those complaints that allege discrimination on the basis of race, religion, gender (transgender or non-conforming orientation), sexual orientation, color, national origin, sex, age or disability related to the delivery of care.

a. Immediate attention must be given to grievances about a situation that endangers the patient, such as neglect or abuse due to seriousness of the allegations and the potential for harm to the patient(s).

2. Documentation of the oral or written grievance, including the date of incident, the patient/patient representative name, address and phone number, the employee's name who took the complaint, and all other pertinent information including how the concern or complaint was resolved, must be entered into the Patient Satisfaction system.

3. Notices to patients or their authorized representative of their right to make an oral or written grievance is included in the "Patient's Bill of Rights," which is posted prominently throughout the facility and is included in the Patient Guidebook.

4. The patient/patient representative shall be informed that he or she has the right to file a grievance directly with:

Indiana State Department of Health
Division of Acute Care
2 North Meridian Street, 4A
Indianapolis, IN 46204
(800) 246-8909
complaints@isdh.in.gov

US Dept of Health and Human Services
200 Independence Ave, SW
Room 509F, HHH Building
Washington D.C. 20201
1 (800) 368-1019, (800) 537-7697 TDD
www.hhs.gov/ocr/office/file/index.html

DNV Healthcare USA, Inc.
Attn: Hospital Complaints
4435 Aicholtz Rd, Suite 900
Cincinnati, OH 45245
1 (866) 496-9647  Fax (281) 870-4818
hospitalcomplaint@dnv.com
www.dnvhealthcareportal.com/patient-complaint-report

5. Concerns with Quality/IM Letters: All Medicare inpatients are issued the Important Message from Medicare (IM) within two days of an initial inpatient admission or status change to an inpatient admission. All Medicare inpatients are issued a follow-up IM letter no more than two days prior to discharge. The follow-up IM letter is not required to be given at discharge if the initial IM letter was signed within two days of discharge. The IM letter provides patients with the Quality Improvement Organization (QIO), contact information to report any concerns they may have regarding quality of care. Our QIO is Livanta and that is noted on the IM letter. Patients may also use this contact information to appeal their discharge which is explained on the IM letter.

## III. DEFINITIONS

1. **Complaint** is any concern shared by a patient or his/her representative that can be resolved by any staff member present or someone who can arrive quickly at the location (i.e., supervisor, department director, house supervisor, or administrator on call) to resolve the issue.

2. **Grievance** means a formal or informal written or verbal complaint that is made to the organization regarding the patient's care by a patient or the patient's representative when the complaint cannot be resolved promptly by staff present. If a complaint is made with an allegation of abuse or neglect, or failure of the hospital to comply with one or more CoPs or other CMS requirement, it must be

considered a grievance. It does not apply to the following: complaints unrelated to patient service or care, billing, a request for change of bedding, housekeeping of a room, request for preferred food or beverages, or complaints made to third parties instead of the hospital. Information obtained from patient satisfaction surveys should not be considered a grievance unless the identified patient writes or attaches a complaint to the survey that would have been considered a grievance based on definition above. Post hospital verbal communications regarding patient care that would routinely have been handled by staff present if the communication had occurred during the visit are not required to be defined as a grievance. Any grievance requires a written reply to the patient as to what was done to investigate and resolve the concern or issue.

3. **Grievant** means the patient on whose behalf an oral or written grievance has been filed, or the disabled visitor's or patient's legally authorized representative who has filed the grievance on behalf of the patient.

4. **Staff present** may include any hospital staff present at the time of the complaint or who can quickly be at the patient's location including nursing, nursing leadership, house supervisors, administration, patient experience personnel, etc.

## IV. PROCEDURE

1. Reid Hospital's Board of Directors has delegated the authority for reviewing patient complaints and grievances to a grievance committee. The Grievance Committee consists of members from the following departments: Quality, Patient Safety, Risk Management, Administration, Patient Experience, Nursing, Lab, Patient Resource Services, Radiology, the Emergency Department and others as necessary.
2. Complaints may be entered into the Satisfaction database at the discretion of the employee. However, if the complaint is complicated, involves multiple people, or originates after care was delivered it MUST be entered into the Satisfaction database as a patient satisfaction event.

3. Grievances should be investigated and attempt to be resolved within 7-10 calendar days from the date they are received. If the matter will require additional time for investigation, notice must be provided to the grievant. When cases will require more than 7 days to fully investigate the issues, the owner of the satisfaction issue will have made contact or attempted contact within 7 days of receipt of the issue and the grievant will be notified every 60 days via a formal letter of the status of the investigation if the issue requires an extended time for resolution.

4. It is the responsibility of the department director or his/her designee to write a written resolution letter to the patient/legal representative at the conclusion of the investigation when an event is classified a grievance. The resolution letter must contain the following information:

- Name of the hospital contact person
- Steps taken on behalf of the patient to investigate and resolve the grievance
- Conclusions and any follow-up steps
- Date of completion (listed separately if different than the date on the letter)

5. The resolution letter should be written in language the patient, or their representative can clearly understand. The letter should not include statements that can be used against the hospital and should be approved by the hospital's Risk Director, VP/CXO or designee before sending. All resolution letters will be saved in the Grievance folder, in the satisfaction database and will be printed and sent by Patient Experience to the patient.

6. The department director or designee (or alternate leadership discussed in policy 47) will electronically document the investigation and resolution to the case in the Satisfaction database.

7. Grievances that cannot be resolved by the Grievance Committee will be forwarded to the CEO.

8. Complaints/grievances may be directed to any employee, through the Patient Action Line (PAL) at ext. 2101 or by calling 983-3000.

9. The Grievance Committee will meet as needed and provide reports to the Quality Committee as a regular agenda item.

10. Grievances will not be documented in the patient's paper or electronic medical record.

## V. APPLICABILITY

Reid Health

## VI. PROCEDURE – Write Off

Effective January 1, 2010, Medicare requires notification of any bill adjustment or write-off.

**No one can process Medicare (primary, secondary, tertiary payor) or other insurance write offs due to a patient complaint/grievance without following the steps below**

1. Compliance needs to be notified and is the final approval for these bill adjustment/write offs. Risk Management will be referred on all write offs for tracking purposes and appropriate notifications. Compliance will be referred in the patient satisfaction database as will Risk. The exception to this process is for simple charge or billing errors.

2. Risk Management will document in the Satisfaction database when they notify the claims management company. The claims management company is responsible for reporting to the Center for Medicare Services (CMS) as required by the Medicare, Medicaid and SCHIP Extension Act (MMSEA).

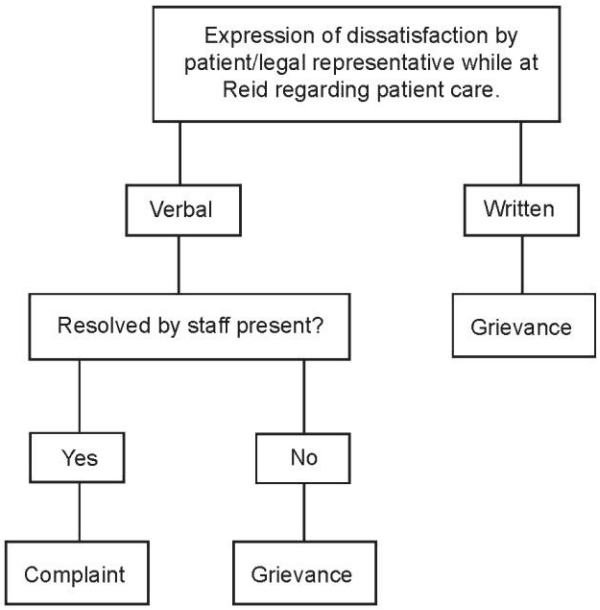
3. Risk Management or Patient Experience will notify Patient Financial Services via the Satisfaction database when a documented Compliance approved adjustment needs made.

**VII.** References

NIAHO Standard PR.6 Grievance Procedure; 23-1
ACA 1557

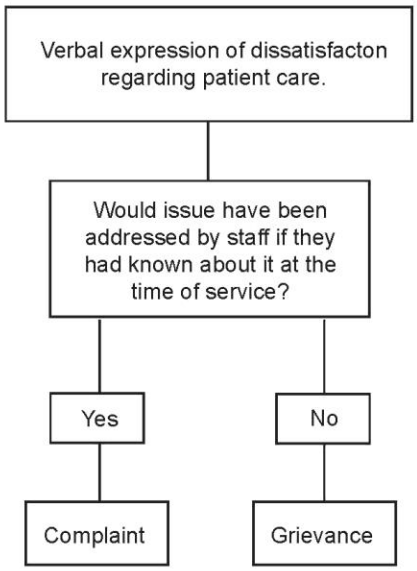
# Current Patient
## Flow Chart

• If patient/legal representative requests dissatisfaction to be handled as a formal complaint/ grievance or when a response is requested from the hospital, it becomes a grievance automatically. If the dissatisfaction is regarding abuse, neglect, or non-compliance with CMS Hospital Conditions of Participation it should also be handled automatically as a grievance.



# Not a Current Patient - Verbal
## Flow Chart

• If patient/legal representative requests dissatisfaction to be handled as a formal complaint/ grievance or when a response is requested from the hospital, it becomes a grievance automatically. If the dissatisfaction is regarding abuse, neglect, or non-compliance with CMS Hospital Conditions of Participation it should also be handled automatically as a grievance.



# Not a Current Patient - Written
## Flow Chart

• If patient/legal representative requests dissatisfaction to be handled as a formal complaint/ grievance or when a response is requested from the hospital, it becomes a grievance automatically. If the dissatisfaction is regarding abuse, neglect, or non-compliance with CMS Hospital Conditions of Participation it should also be handled automatically as a grievance.