Raleigh Neurosurgical & Spine Surgery Center

DEFINITIONS

A "patient grievance" is a formal or informal written or verbal complaint that is made to RNS by a patient or a patient's representative, regarding a patient's care (when such complaint is not resolved at the time of the complaint by the staff present), mistreatment, abuse (mental, physical, or sexual), neglect, or RNS compliance issues.

A complaint from someone other than a patient or a patient's representative is not a grievance.

A complaint that is presented to RNS staff and resolved at that time is not considered a grievance and the grievance process requirements do not apply to such complaints.

If a patient care complaint cannot be resolved at the time of the complaint by the staff present, is postponed for later resolution, is referred to other staff for later resolution, requires an investigation, and /or requires additional actions for resolution, the complaint is then considered a grievance for purposes of these requirements.

Billing issues are not usually considered grievances for the purposes of this policy and procedure.

A written complaint is always considered a grievance. This includes written complaints from a current patient, a released/discharged patient, or a patient's representative regarding the patient care provided, abuse or neglect, or RNS compliance with the Conditions for Coverage (CfC). For the purpose of this policy, an email or fax is considered written.

Information obtained from patient satisfaction surveys conducted by the RNS usually is not considered a grievance. If an identified patient writes or attaches a complaint to the survey, and requests resolution, it should be treated as a grievance. If an identified patient writes or attaches a complaint to the survey, but does not request resolution, it should be treated as a grievance.

Patient complaints that are considered grievances also include situations where a patient or a patient's representative telephones RNS with a complaint regarding the patient's care or with an allegation or abuse or neglect, or a failure of RNS to comply with one (1) or more of the CfCs.

Whenever a patient or a patient's representative requests that his or her complaint be handled as a formal complaint or grievance, or when the patient requests a response from RNS, the complaint is considered a grievance.

POLICY

It is the policy of RNS to investigate all patient and family complaints (grievances) concerning the quality of care and/or services provided. Patients and/or family will be informed of their right to file complaints and the appropriate mechanism for voicing any concerns. All patient complaints will be analyzed and investigated, and when indicated, the responsible manager will provide a written response. Appropriate corrective action will be taken. Each patient and/or family member making a complaint will receive a written or verbal response from RNS that addresses issues regarding treatment or care that is (or fails to be) furnished. It is required that all patients with the same or similar health problems receive the same level of care, and that the presentation of a complaint does not, in itself, serve to compromise a patient's future access to care at RNS.

All staff is provided education regarding their obligation to report all grievances, including whom they should report the grievance to. The grievance process is integrated into RNS's quality assessment and performance improvement program. The patient has the right to:

- Be free of acts of discrimination or reprisal
- Voice grievances regarding treatment or care
- Be fully informed about a treatment or procedure and expected outcome

PROCEDURE

1. **Patient Complaint Mechanism**
   To facilitate the submission of a complaint in writing, a satisfaction form shall be provided to all patients at the time of discharge. Patients may utilize this form or document their concerns in written format as they choose.

2. **Receipt of Patient Complaint.**
   All staff must treat complaints in a serious manner, and make every effort to correct the situation in a manner consistent with RNS's mission and values statements. If necessary, either the complainant or staff may request assistance from administrative staff in resolving the matter.

It is the right and responsibility of the complainant to register a complaint verbally, by telephoning RNS or mailing a written complaint to RNS.

a. All complaints received by telephone or in writing are to be documented on the Patient Compliment/Complaint Form.
b. Complete the top part of the form (from "date received" through "referred to" sections). Please note if the complainant has not reported the complaint to their primary caregiver.
c. Forward the completed form to the Administrator or another manager who has the authority to address grievances on behalf of RNS.

3. **Complaint Response and Resolution**
   All complaints are to be analyzed and investigated to determine the appropriate response. Appropriate actions may include clarification, correction, prevention of future occurrences, and informing the complainant of the actions taken. Complaints that include unsettled patient issue are to be given the highest priority. For these complaints, initial patient or family contact should be made within 72 hours of receipt and the matter resolved as soon as possible.

   All complaints addressed directly to RNS will receive a response from the Administrator within two weeks. The patient and/or patient's representative will be notified of RNS's decision regarding the grievance. The response must include the name of RNS's contact person, the steps taken to investigate the grievance, the results of the investigation, and the date the process was completed.

   Documentation of how the grievance was addressed and the action(s) taken shall be documented on the Compliment/Complaint form. Upon closure, all completed forms should be forwarded to the Administrator for discussion at the QAPI committee meeting.

4. **Complaint Review**
   The QAPI Committee shall establish a mechanism to categorize patient complaints by importance.

Quarterly summary reports will be discussed at the QAPI committee meetings and forwarded to the MEC for further review.

The QAPI Committee will maintain a file of complaints and/or data for at least two years. Any complaint which may have potential legal liability should be preserved in its original form.

5. Comments/Suggestions

Patients and visitors should be encouraged to offer comments or suggestions to any staff member.

CMS Ombudsman 1 800 Medicare (1 800 633-4227)
Ombudsman: www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman

Division of Health Services
Complaint Intake Unit
1 800 624-3004 or 1 919 855-4500
Or by mail
2711 Mail Service RNS
Raleigh, NC 27699-2711

Or
Accreditation Association for Ambulatory Health Care
AAAHC
5200 Old Orchard Rd
Skokie, IL 60077
1 847 853-6060