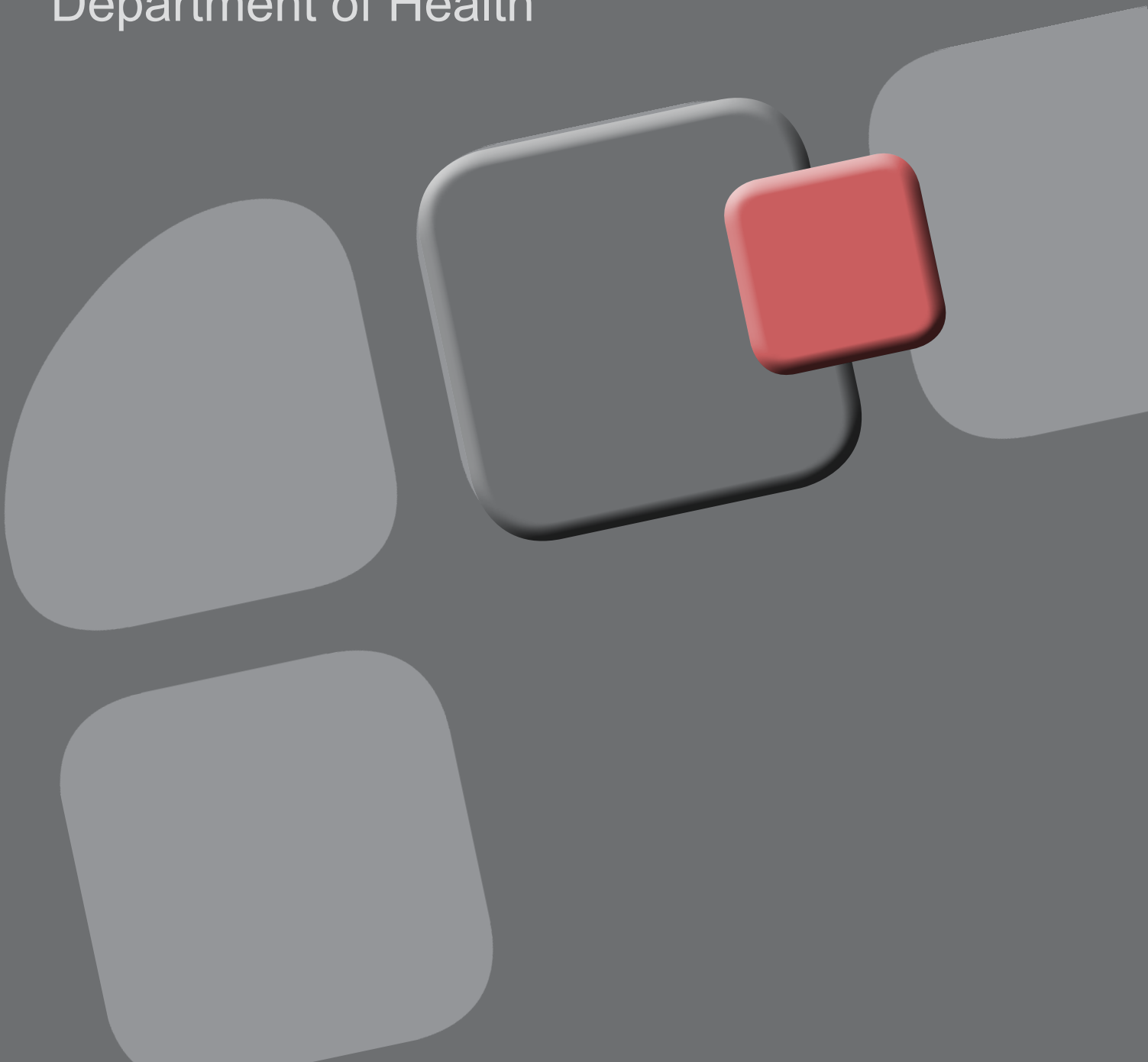




Government of **Western Australia**  
Department of **Health**

# Western Australian Health Complaint Management **Policy 2009**

Department of Health



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## ***Western Australian Health Complaint Management Policy 2009***

### **Third Edition**

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- The Office of Health Review
- The Health Consumers' Council
- The Clinical Governance Network

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## Foreword

A complaints management process is fundamental to delivery of quality health care. An effective and efficient complaints management process enables providers to resolve disputes, obtain feedback from consumers/carers and provide strategies for hospital/health service improvement.

This third edition of the *Western Australian Health Complaint Management Policy* (the Policy) has been reviewed to make sure it is current and adheres to both the Australian Standard on Customer Satisfaction – Guidelines for Complaints Handling in Organizations (AS ISO 10002:2006)<sup>1</sup> and the Australian Commission on Safety and Quality in Health Care's Better Practice Guidelines on Complaint Management for Health Care Services.<sup>2</sup>

It is recognised that the complaint process is bound by various legislative requirements (discussed in the Policy) and should be read in conjunction with other relevant policies and guidelines including:

- Western Australian Health Complaint Management Toolkit 2009
- *WA Open Disclosure Policy: Communication and Disclosure Requirements for Health Professionals Working in Western Australia 2009*
- *Sentinel Event Policy 2007*
- *Clinical Incident Management Policy 2006*
- *Clinical Risk Management Guidelines for Western Australian Health Services 2005*

When the handling of complaints is conducted in a consistent, fair and open manner then the reputation of the hospital/health service is enhanced and public confidence increases.

We encourage all hospital/health service staff to read these policies and participate in the continuous cycle to improve the safety of health care.



Dr Peter Flett  
Director General, Department of Health  
November 2009

# Contents Page

<b>1. Introduction</b>	<b>5</b>
1.1 Purpose	5
1.2 Scope	6
<b>2. Complaint Management Principles</b>	<b>7</b>
2.1 Rights and responsibilities of consumers	7
2.2 Promotion and transparency	8
2.3 Organisational commitment to effective complaint management	9
2.4 Fairness and accountability	9
2.5 Timeliness of response	10
2.6 Continuous service improvement	10
Figure 1: Continuous quality improvement flowchart	11
2.7 Privacy and open disclosure	11
<b>3. Quality Improvement Principles</b>	<b>12</b>
<b>4. Complaint Management Process</b>	<b>13</b>
4.1 Accountability by health service	13
4.2 Management of complaints	13
4.3 Ministerial correspondence	14
4.4 Data collection and analysis	14
4.5 Risk management	14
4.6 Dealing with systemic and recurring problems	15
4.7 Complaint investigation procedure	15
4.8 Complaint management process and investigation flowcharts	16
Figure 2: Complaint management process/procedure flowchart	17
Figure 3: Complaint investigation procedure flowchart	18
<b>5. Staff Complaints</b>	<b>19</b>
<b>6. Accidents and Clinical Incidents</b>	<b>19</b>
6.1 Potential/actual medico-legal claims	19
6.2 Clinical incident management system	19
6.3 Sentinel events	20
6.3.1 Reporting sentinel events to the Chief Psychiatrist	20
<b>7. Storage of Complaint Records</b>	<b>21</b>
<b>8. Categorisation of Complaints</b>	<b>21</b>
<b>9. Complaint Recording and Reporting</b>	<b>22</b>
<b>10. Compliment Recording and Reporting</b>	<b>22</b>

<b>11. Evaluation</b>	<b>23</b>
11.1 Review of hospital/health service complaint management processes	23
11.2 Review of the <i>Western Australian Health Complaint Management Policy</i>	23
<b>12. Additional Information</b>	<b>23</b>
12.1 Involuntary admission (mental health)	23
12.2 Complaints by carers	24
12.3 Patient informed consent	24
12.4 Freedom of Information legislation	24
<b>Appendix 1</b> Definitions	25
<b>Appendix 2</b> Guidelines for Logging Mental Health Complaints	28
<b>Appendix 3</b> Complaint Categorisation List, Definitions and Examples	29
<b>Appendix 4</b> Additional Information for the Classification and Rating of Complaints	37
<b>References</b>	<b>39</b>
<b>Additional Complaint Management Literature</b>	<b>40</b>

# 1. Introduction

Effective management of complaints is a central strategy for improving health services in Western Australia. It is an important aspect of ensuring a consumer-focused and patient-centred approach to health care delivery, as well as a useful risk management tool and a means of identifying areas in need of improvement, both at hospital and system-level.

## 1.1 Purpose

The purpose of the Policy is to set out the procedures to be followed by hospital/health service staff throughout WA Health for managing verbal or written feedback/complaints made by health care consumers.<sup>a</sup>

The Policy aims to promote best practice in complaint management by WA hospital/health services. It advocates an efficient, proactive approach to complaint management that promotes best possible outcomes and resolution. It is important to recognise that the Policy is part of a larger quality improvement system that includes clinical incident reporting, investigation and management systems, risk management and medico-legal claims.

The complaint management process outlined in the Policy is not intended to apportion blame but strives to:

- resolve the complaint if possible
- identify any aspect/s of service delivery which require change and effect those changes where possible.

Ideally a partnership between hospitals, health services and consumers will develop with the common aim of increasing the quality of health care services and improving patient safety in WA.

The Policy recognises:

- the health rights of consumers
- the right of consumers to complain and to receive appropriate and easily understood information regarding the complaint process
- that complaints lead to improvements in the safety and quality of hospitals/health services
- the importance of an open and accessible complaint management process to consumers of hospitals/health services
- the importance of public knowledge of the complaint management process. The complaint process in each hospital/health service should be promoted to consumers in a transparent standardised way, so that the complaint management pathway for consumers can be negotiated with ease.

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<sup>a</sup> See Appendix 1 for the definition of 'consumer'.

- That this complaint procedure must operate within a legal framework which may impose various restrictions and obligations on those who deliver, and access, health care. Examples of legislation which impacts on the health care setting include (but not limited to):
  - *Hospitals and Health Service Act 1927*
  - *Equal Opportunity Act 1984*
  - *Freedom of Information Act 1992*
  - *Disability Services Act 1993*
  - *Mental Health Act 1996*
  - *Carers Recognition Act 2004*
  - *Coroners Act 1996*
  - *Corruption and Crime Commission Act 2003*
  - *Limitation Act 2005*
- That there are a number of complaint agencies external to hospitals and health services available for consumers including the Office of Health Review, Professional Registration Boards (e.g. Medical Board of WA) or the Health Consumers' Council. These organisations may initiate direct contact with the health service provider.

## 1.2 Scope

The Policy applies to all public hospitals and health service providers in Western Australia. The Policy does not apply to private hospitals or health service providers except where this involves the treatment of public patients should they lodge a complaint.

The scope of the Policy includes any complaint lodged by a consumer of a hospital/health service, or their carer (see Appendix 1 Definitions). It does not include complaints lodged by staff or contractors, unless the complaint is made on behalf of the patient (see Section 5 Staff Complaints).

The accompanying Western Australian Health Complaint Management Toolkit 2009 contains some example documentation to assist hospitals/health services to develop documents that are suitable for the local health care environment.

## 2. Complaint Management Principles

The principles underpinning the complaint management process are:

- the rights and responsibilities of consumers
- promotion and transparency
- organisational commitment to effective complaint management
- fairness and accountability
- timeliness of response
- making the complaint process accessible to consumers
- continuous service improvement
- privacy and open disclosure.

### 2.1 Rights and responsibilities of consumers<sup>3</sup>

Consumers can expect to:

- be treated with respect, dignity and consideration for their privacy
- have complaints treated as genuine and be properly investigated
- be given appropriate and easily understood information regarding the complaint process
- be asked what outcome they are seeking from the complaint, to inform resolution
- have their complaint issues adequately addressed
- participate in decisions about the management of their complaint
- have information about their complaint filed separately from their health record
- have personal information remain confidential within the complaint management process, unless otherwise agreed or required at law
- be able to comment on the progress of the complaint management process
- have their comments regarding their experience of the complaint process respected, documented and acted upon as appropriate
- feel that their access to, and treatment by, the hospital/health service has not been compromised because they have made a complaint.

Consumers are expected to:

- provide relevant information to the hospital/health service staff regarding their complaint
- respect the role of health service staff and their right to respond to a complaint
- treat all hospital/health service staff with courtesy and consideration
- request assistance and further information when unsure about information provided to them regarding the complaint management process
- keep appointments, bringing relevant documents and information
- raise any concerns about the complaint management process with the hospital/health service staff as soon as possible.

## 2.2 Promotion, accessibility and transparency of the complaint process

Hospitals/health services shall encourage all consumers to provide feedback, concerns and complaints and these will be actioned in an open, receptive and transparent manner by adhering to the following guidelines:

1. Receive and accept complaints and provide opportunities for consumers to give feedback about their service.
2. Acknowledge the consumer's right to complain by publicising and promoting information on how consumers can lodge a complaint.
3. Promote feedback by offering a variety of ways for consumers to raise concerns and lodge complaints.
4. Encourage complainants to bring a support person to any meetings with hospital/health service staff.
5. Provide information to consumers and staff in a format that they can understand and give further explanation or assistance when requested.
6. Confirm the receipt of a verbal complaint and give a written summary to the complainant.
7. Operate a complaint management process that recognises the importance of:
  - openness
  - accountability
  - service improvement
  - provision of just outcomes.
8. Provide anonymity of complainants, where possible.
9. Where a complaint is submitted anonymously, it must be processed and managed in the same way as ordinary complaints with the exception of correspondence requirements.
10. Assess all complaints against risk assessment criteria to determine the level of risk and appropriate response.
11. Assess all complaints to decide the most appropriate complaint resolution process, taking into account the seriousness, complexity and the wishes of the complainant.
12. Provide assistance to staff on:
  - completing a report in response to a complaint
  - accessing counselling/debriefing services as necessary.
13. Recognise that details of a complaint, and documentation generated in managing the complaint, may be accessible by parties:
  - under the *Freedom of Information Act 1992*
  - in other legal/disciplinary proceedings where relevant.
14. Make sure the documentation of the complaint management process is thorough and consistent.
15. Provide quarterly summary de-identified reports of their complaints, outcomes and quality improvement activities to Community Advisory Councils (CACs) and District Health Advisory Councils (DHACs).
16. Recognise that if the incident, which is the subject of the complaint, is being investigated or managed under another process (e.g. AIMS), that process may impose limitations on the sharing of information. The complaint management process will have to be modified accordingly.

## 2.3 Organisational commitment to effective complaint management

Hospitals/health services shall demonstrate their commitment to appropriate management of complaints regarding health care by the following:

- Provide sufficient human and material resources to make sure all complaints are adequately managed, investigated and reported to senior management.
- Assign the responsibility for effective complaint management to all managers.
- Develop and implement a defined complaint management process.
- Manage the complaint resolution process within required time frames.
- Make available clearly defined information systems and ongoing training and educational resources to enable hospital/health service staff to manage complaints.
- Provide support processes for hospital/health service staff dealing with complaints.

## 2.4 Fairness and accountability

Consistent with the principle of fairness, accountability and the rights and responsibilities of consumers and providers, all complaints are treated as legitimate and investigated without prejudice. Complainants can withdraw their involvement with a complaint at any stage.

The complaint management process will make sure that:

- the type and depth of the investigation is appropriate for each complaint, is complete and demonstrates accountability by the hospital/health service
- complainants receive support during the complaint management process and expect no retribution as a consequence of their complaint/s. Any difficulties should be referred back to the complaints coordinator responsible for the complaint management process.
- complainants and those against whom a complaint is lodged are given procedural fairness/natural justice throughout the investigation
- complaints are recorded separately to the complainants medical record
- complaint documentation is located and stored in a central location with restricted access
- the hospital/health service records all complaints to enable:
  - review of individual cases
  - identifying trends and risks
  - reports on how complaints have led to systemic improvement.

Complaints deemed to be vexatious, ill-intentioned or trivial may be referred to senior executive level by complaints coordinators, where they can be managed on a more discretionary basis. All such actions should be documented thoroughly and communicated with complainants.<sup>b</sup>

<sup>b</sup> Refer to the Australian Standard on Customer Satisfaction (AS ISO 10002:2006). The *Vexatious Proceedings Restriction Act 2002* (section 3) defines vexatious proceedings in the context of cases brought before courts and tribunals. Whilst this Act is not directly applicable in the context of health service complaints, the definition at section 3 of the Act offers guidance on the meaning of 'vexatious'. Also refer to Appendix 1 Definitions.

## 2.5 Timeliness of response

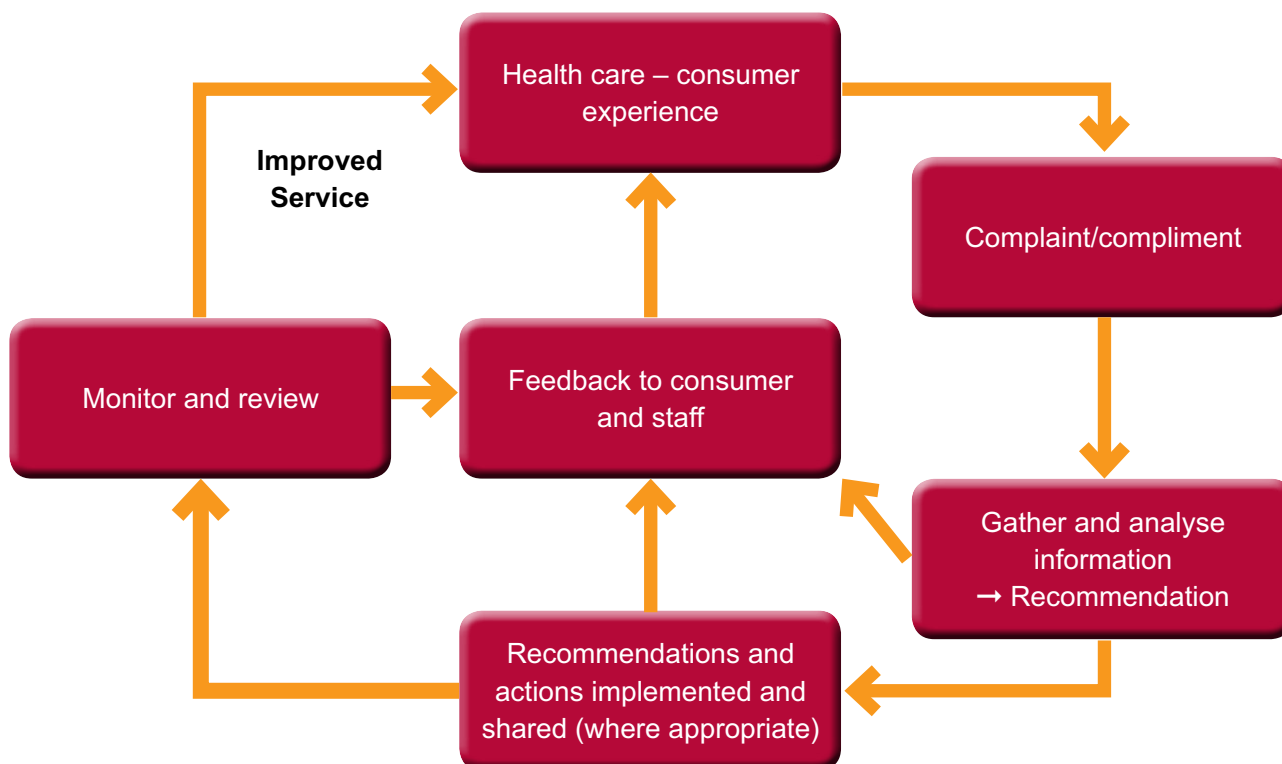
Hospitals/health services shall demonstrate commitment to the resolution of complaints in a timely manner by adherence to the following:

1. Acknowledge complaints within **five** working days of receipt of the initial complaint.
2. Inform the complainant of the approximate time that it will take to resolve the complaint.
3. Commence an investigation of complaints within **five** working days of receipt of the complaint.
4. Resolve complaints within **30** working days of receipt or as soon as practicable in the best interest of all parties.
5. Advise the complainant if there is a delay and providing updates on the progress of the investigation at **15** working day intervals.
6. If, despite the best efforts of the hospital/health service, a complaint is unable to be resolved and is *referred* to an external agency (see Section 4.2), it is considered closed/resolved for reporting purposes.
7. If a complaint is lodged via an external agency, the hospital/health service will endeavour to adhere to timeframes specified above. If the complaint is being managed by an external agency, the hospital/health service becomes a 'respondent' in the case. The external agency is likely to control the timeframes with input from the hospital/health service as appropriate.

## 2.6 Continuous service improvement

Hospitals/health services shall regularly evaluate the complaint management policy and practices. This includes:

- rapid and effective notification to senior management of all complaints with significant or severe risk, with an action plan and review process to show that action has been taken
- the staff members/clinicians involved in complaints being informed of, and included in the complaint management process
- 'closing the loop' by making sure that recommendations from reviewed complaints are implemented, reviewed and evaluated
- evaluating the policies and practices on complaints to decide effectiveness and make improvements
- monitoring whether complainants are satisfied with the complaint resolution process
- audits of the complaint management system against predetermined criteria
- involving consumers and staff in the design and evaluation of the complaint management system.

**Figure 1.** Continuous service improvement flowchart

## 2.7 Privacy and disclosure

It is recognised that consumers have a right to have complaints regarding their health care investigated and resolved in a fair and confidential manner. Hospitals/health services will establish procedures to make sure that relevant facts and decisions are communicated openly and the confidentiality of personal information is protected throughout the complaint management process (consistent with Operation Circular OP2050<sup>4</sup>). The hospital/health service will make sure:

- documented policies and procedures on confidentiality and disclosure are:
  - understood by staff
  - provided to consumers
- complainants are advised how their personal information is likely to be used at the time a complaint is first acknowledged
- complaint records are collected and stored separately from the complainants medical record – any information identifying the complainant is used only for the purpose of complaint resolution
- complainants, clinicians and staff involved in a complaint are provided with:
  - the known facts
  - a summary of the factors contributing to the complaint
  - information on action to be taken
  - how changes will be monitored.

**Note:** Any information or documents provided to and generated by the hospital/health service during the complaint management process could potentially be subject to the statutory requirements of the *Freedom of Information Act 1992*. Guidance with request for documents should be sought from the Legal and Legislative Services Directorate of the Department of Health or State Solicitor’s Office in the case of teaching hospitals.

### 3. Quality Improvement Principles

Hospitals/health services are required to provide a safe and quality health care service, which is consistently evaluated through continuous quality improvement processes to make sure that it meets consumer requirements.

The quality improvement principles are:

**Access** to hospitals/health services is provided on a needs basis and available resources. Decisions on access are made regardless of sex, marital status, pregnancy, family responsibility or family status, race, religious or political conviction, impairment, age or gender history (as set out in Part IX of the *Equal Opportunity Act 1984*).

Hospitals/health services are committed to the provision of readily accessible consumer health information.

**Efficiency and Effectiveness** of service provision. Hospitals/health services are committed to the rational use of resources and the attainment of stated outcomes.

**Reproducibility** – evidence-based clinical care that can be used in other similar settings.

**Safety** of consumers and staff with a commitment to risk management. This facilitates a proactive approach to maintain safety and prevent clinical incidents.

**Appropriate** care tailored to meet individual needs. Hospitals/health services are committed to the provision of clinical care identified as beneficial and relevant for the individual.

**Participation of Consumers/Providers/Employees** – this will make sure that hospitals/health services are aware of their needs and modify and develop services accordingly.

## 4. Complaint Management Process

The complaint management process allows the hospital/health service to use consumer feedback to increase consumer and staff satisfaction and make system improvements. Essential components to allow continuous quality improvement of hospitals/health services include:

- accountability by hospital/health service
- management of complaints
- Ministerial correspondence
- data collection and analysis
- risk management
- dealing with systemic and recurring problems.

### 4.1 Accountability by hospital/health service

Hospitals/health services shall strive to create a culture of accountability that includes:

- Management/senior staff having responsibility for effective complaint handling by:
  - ensuring staff are provided with appropriate complaint management training
  - developing, monitoring and reporting performance criteria for complaint handling
  - reviewing local complaint management processes on an annual basis, including information on actions taken in response to complaints
  - demonstrating a proactive approach to consumers and staff feedback.
- Each staff member accepting appropriate responsibility for safety, quality and complaints.

### 4.2 Management of complaints

The complaint management process operates within a framework of procedural fairness/natural justice and confidentiality. The following complaint management processes are to be established within each hospital/health service:

1. A complaint investigation procedure (see Figure 2 on page 17).
2. A central point of coordination to:
  - a) Register the complaint.
  - b) Manage the complaint process providing a timely response (see Section 2.5). The final written response to the complainant, within **30** working days of receipt of the complaint, shall include:
    - information relevant to the complaint
    - an explanation of the event(s)
    - adequate reasons for any decisions made
    - any changes made as a result of the complaint
    - an apology as appropriate
    - contact details for the hospital/health service's complaint coordinator
    - an acknowledgment thanking the consumer for their feedback.
3. Document in the complaint file a complainant's request/preference for a telephone, face-to-face or written response noting the date and time of this request.
4. If pending, provide feedback to the complainant at **15** working day intervals advising the status of the complaint investigation procedure and negotiate a timeframe for the final response.

5. Advise the complainant they have the right to take their concerns to the appropriate external agency (e.g. Office of Health Review, Health Consumers' Council) if they are dissatisfied with the outcome of the initial complaint.
6. If the complaint is referred to an external agency, complaint coordinators should cooperate with that agency as appropriate. Legal advice can be obtained from the Legal and Legislative Services Directorate of the Department of Health or State Solicitors Office for teaching hospitals.

### 4.3 Ministerial correspondence

If Ministerial Correspondence contains a complaint about the service, care or treatment provided by a hospital/health service, it should only be recorded as a complaint if the complainant has not previously lodged the same complaint with the Customer Liaison Officer.

This complaint should be recorded in exactly the same manner as a normal complaint. When reporting complaint data to the Office of Safety and Quality in Healthcare (OSQH) (see Section 11 and the Western Australian Health Complaint Management Toolkit) make a note stating that one (or more) of the complaints for the month was derived from Ministerial Correspondence.

The response time for complaints made via Ministerial Correspondence will be dictated by instructions from the Minister's office on a case-by-case basis and not by this policy (see Section 2.5). The response time for Ministerial Correspondence should be noted in data reported to the OSQH.

### 4.4 Data collection and analysis

An effective complaint management process requires appropriate systematic recording of complaints and their outcomes. Following is a list of factors to be considered by hospitals/health services when implementing a system for data collection and analysis:

- The number and type of complaints received.
- The type of services or practices about which complaints are made.
- Response time against defined parameters.
- Demographic details (e.g. name, age, gender).
- Demographic analysis (e.g. people, service, department, organisation).
- Referral source of the complaint.
- Resources consumed.
- Action planned or taken including remedies/determinants/results.
- Trend analysis of complaint issues.
- Outcomes and system changes introduced as a result of a complaint.

### 4.5 Risk management

Complaints can provide insight into system failure and identify areas in need of improvement. Complaint management can be viewed as an early warning system to identify opportunities for systemic improvement.

The early identification of individual complaints of a serious nature or with a potential for escalation are part of a hospital/health service's risk management program.

Additional information on risk management is available from the Department of Health's *Health Risk Management Policy and Framework*, *Health Risk Management General Procedures Manual* and *Clinical Risk Management Guidelines for Western Australian Health Services*.<sup>5,6</sup>

#### 4.6 Dealing with systemic and recurring problems

Hospitals/health services are required to classify and analyse complaints to assist the identification and regular reporting of systemic and recurring problems. This can be used to:

- demonstrate a commitment to using consumer feedback to change practice
- assess the performance of the service provided
- change organisational practices and procedures
- redesign care and services
- identify potential problems
- provide staff with feedback on changes in care and service delivery
- continually reassess consumer needs
- monitor if the outcomes and recommendations stemming from complaint data are implemented effectively.

To assist with this process all complaints are to be categorised according to the lists in the accompanying Western Australian Health Complaint Management Toolkit.

#### 4.7 Complaint investigation procedure

The investigation of a health care complaint will offer the opportunity to:

- determine what occurred, to whom and how
- identify how things might be or should be done better in the future.

The conduct of an investigation should include:

- gathering all relevant documentation (e.g. medical records, health professionals rosters, policies and procedures, product details)
- interviewing the complainant and/or significant others (possible on more than one occasion)
- interviewing staff members involved in the incident (possible on more than one occasion)
- conducting further research as required and analysing the available evidence
- generating options for resolution and proposing a course of action.

The following information may provide the key facts and where relevant should be included in the investigation report:

- Description of incident.
- Time of incident.
- Exact location of incident.
- Numbers, names and designations of staff members on duty at the time of the incident (e.g. clinicians, Patient Care Assistant [PCA], etc).
- Other business occurring concurrently (e.g. cardiac arrest or other emergencies).
- General workload information and consumer acuity levels in the clinical area.
- Level of experience of staff involved.

- Availability of support for staff involved at the time of the incident (e.g. extra staff, equipment, etc).
- What should have reasonably occurred, including references to supporting policies and procedures.
- What should not have occurred.
- Gathering of contributing factors and analysis.
- Recommendations to prevent recurrence.
- Options for dealing with consumer's complaint.
- Timeframe and strategies for:
  - implementation of recommendations
  - evaluation of effectiveness of changes.

A thorough investigation process ensures:

- all relevant information is gathered in an objective manner
- the investigator is able to assess information provided against the other available evidence
- procedural fairness/natural justice is applied to all parties
- an objective conclusion can be reached after examination of the facts
- opportunities for improvement can be identified
- the information can be used to respond to the complainant regarding the circumstances of event/incident (e.g. policy/procedure not followed, human error, etc).

**Note:** Not all complaints require an in-depth investigation. The level of investigation required will be determined by the relevant manager.

Refer to:

- *Western Australia Health Complaint Management Policy 2009* Figure 3: Flowchart for complaint investigation procedure.
- Western Australian Health Complaint Management Toolkit – Complaint Investigation Procedure Example Documentation.

## 4.8 Complaint management process and investigation flowcharts

The following flowcharts are provided to assist hospitals/health services to develop and implement complaint management procedures that are suitable for the local environment.

Figure 2. Complaint management process/procedure flowchart

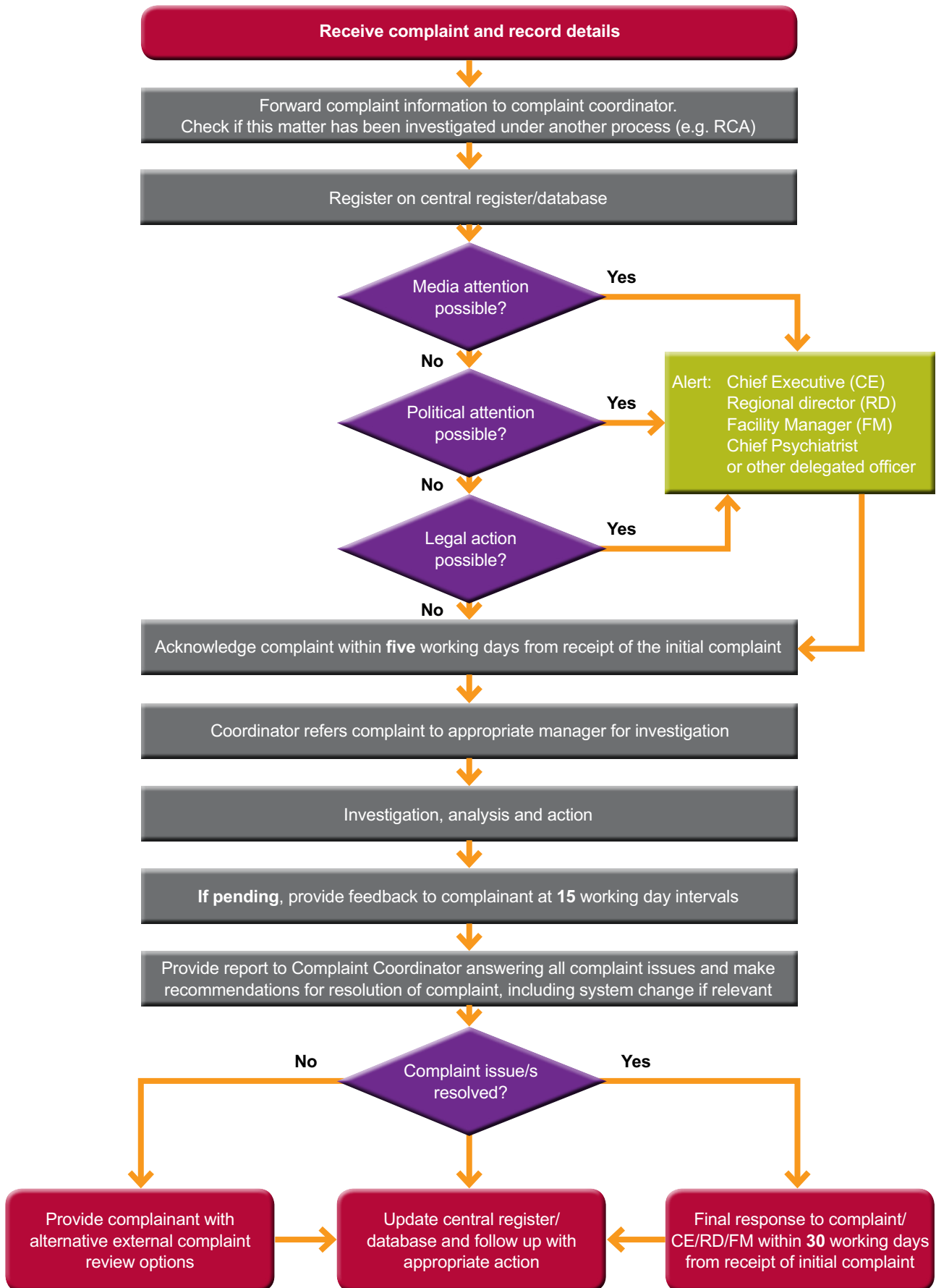
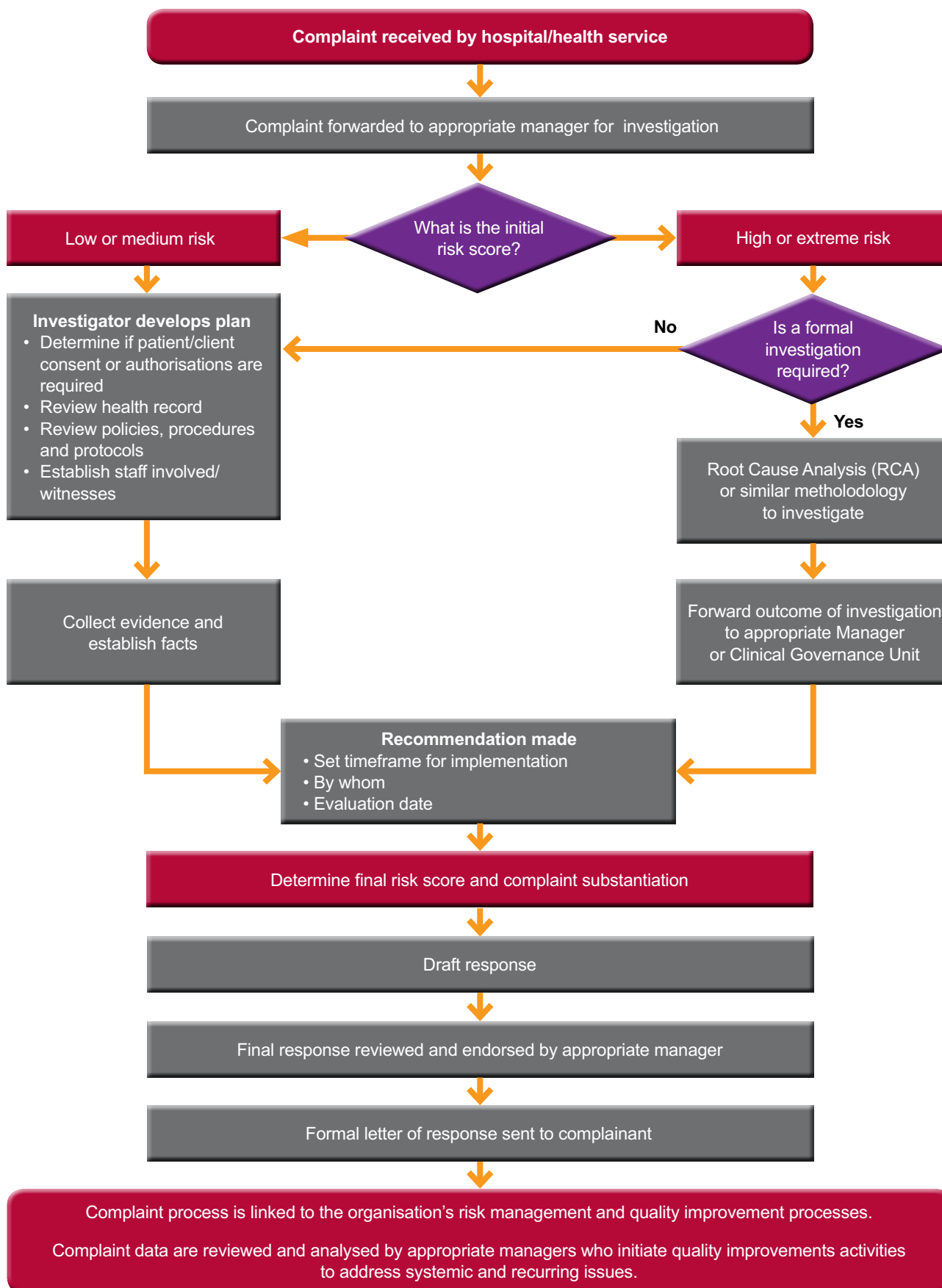


Figure 3. Complaint investigation procedure flowchart



## 5. Staff Complaints

Staff may use this complaint management process when complaining on behalf of the consumer. This should be done with the knowledge and consent of the consumer.

Staff complaints about other staff or any aspect of their work environment, are not addressed under this policy, should be managed in accordance with the *WA Health Employee Grievance Resolution Policy 2008*.<sup>7</sup>

## 6. Accidents and Clinical Incidents

Accidents and clinical incidents may become the subject of a complaint. Such incidents may need to be notified to several reporting systems or bodies that are outside the complaint management process (e.g. Open Disclosure).<sup>3,5,6</sup>

A proactive approach is encouraged when dealing with all accidents, clinical incidents and complaints. It should be noted that the resolution of a complaint may still be possible despite adverse clinical outcomes.

### 6.1 Potential/actual medico-legal claims – notice and handling

If the clinical incident results, or has the potential to result, in a medico-legal claim (against the hospital/health service and/or the clinicians involved) the hospital/health service<sup>c</sup> shall, within one working day, notify the case as follows:

- **For non-teaching hospitals:** report ALL actual and potential claims to the Legal and Legislative Services Directorate of the Department of Health (L&LS) who will notify RiskCover (and State Solicitors Office for incidents occurring prior to 1 July 1997) as necessary.
- **For teaching hospitals:** incidents occurring prior to 1 July 1997 must to be reported to the State Solicitor's Office (SSO). Incidents that occurred on or after 1 July 1997 must to be reported to RiskCover.

Health service staff who investigate and manage complaints must ensure that they do so in accordance with the RiskCover Fund Guidelines. This requires that staff **do not**, without first obtaining RiskCover's written approval:

- make admissions of liability
- make any payment or settlement in respect of any claim or potential claim.

### 6.2 Clinical incident management system

Hospital/health service staff should liaise with an appropriate Departmental Head/Director of Medical Services or their delegate, and recommend that the clinical incident is reported to/recorded in the WA Clinical Incident Management System (currently the Advanced Incident Management System or AIMS).

<sup>c</sup> All hospitals/health services should have an identified senior officer whose responsibilities include management of medico-legal claims. The Complaints Coordinator should ensure they liaise with this officer (if it's not the same person) in relation to any potential or actual claims arising from complaints.

A copy of the complaint management form may be attached to the AIMS incident form for the purpose of reporting the incident. Additional information documented about the incident on the AIMS form is protected by the statutory privilege of the AIMS system.

### 6.3 Sentinel events

If a complaint relates to a sentinel event (not previously identified and reported), hospital/health service staff must notify the local Chief Executive (CE)/Regional Director (RD)/Facility Manager (FM) or equivalent (or their delegate) of the sentinel event. The CE/RD/FM or equivalent (or their delegate) must ensure that a sentinel event notification form is completed and forwarded to the Director, Office of Safety and Quality in Healthcare within seven (7) working days of the incident occurring.<sup>8</sup>

Following notification to the local CE/RD/FM equivalent or their delegate, health service staff should liaise with an appropriate Departmental Head/Director of Medical Services or their delegate, to recommend that an AIMS reporting form is completed and forwarded to the appropriate officer.<sup>9</sup>

For more information regarding the Sentinel Event Program refer to the Office of Safety and Quality in Healthcare website at: [www.safetyandquality.health.wa.gov.au](http://www.safetyandquality.health.wa.gov.au)

#### 6.3.1 Reporting sentinel events to the Chief Psychiatrist

Under the *Mental Health Act 1996*, complaints relating to sentinel events in mental health services are required to be reported to the Chief Psychiatrist as a matter of first priority after the event occurring. This is in addition to filling in a sentinel event notification form.

Refer to Operational Circular OP 2061/06 for further information.

## 7. Storage of Complaint Records

All complaints will be recorded separately from the medical records of patients, with the medical record being strictly limited to clinical information.

Records of all complaints must be retained for a minimum of **seven** years by the hospital/health service in a central location. Longer periods apply in some circumstances and records staff must be familiar with these. Refer to the *State Records Act 2000*, *State Records Principles and Standards 2002* and the *Patient Information Retention and Disposal Schedule, Version 3*, (OD 0133/08) for further information.

## 8. Categorisation of Complaints

Consistent complaint categorisation, analysis, reporting and benchmarking is essential to make sure that complaint data collection is compatible across a range of facilities to identify:

- common factors in complaints about hospitals/health services
- opportunities for service improvement.

Appendix Three provides the definitions for the complaint categorisation list and the Western Australian Health Complaint Management Toolkit outlines suggested reporting fields to be collected by hospitals/health services.

## 9. Complaint Recording and Reporting

The process for recording and reporting complaints should include the following:

- Documentation of complaint data using suggested reporting fields (refer to the Western Australian Health Complaint Management Toolkit 2009) – additional fields may be added at the discretion of the hospital/health service to meet local needs.
- Categorisation of complaint data including severity and outcomes using the complaint categorisation list.
- Complaint data recorded electronically.
- Collection, collation and reporting of complaint data using the list and definitions.
- Reporting complaint data, investigation outcomes, analysis of trends and system changes to:
  - The Chief Executive/Regional Director/Facility Manager
  - Departmental/health service committees where appropriate
  - Clinical Advisory Committees of each hospital/health service.
- Communication of trends and outcomes to staff.
- Hospitals/health services are required to provide **monthly** and **quarterly** complaint data to the Office of Safety and Quality in Healthcare (OSQH). This data will be collated and forwarded to the Director General and the Chief Psychiatrist (quarterly) for review and discussion.

**Note:** Refer to:

- Western Australian Health Complaint Management Toolkit for suggested reporting fields and OSQH reporting format.
- Appendix 3 Complaint Categorisation List, Definition and Examples.
- Appendix 4 Additional Information for the Classification and Rating of Complaints.

## 10. Compliment Recording and Reporting

It is recognised that hospitals/health services receive compliments as well as complaints. Compliments provide an opportunity for hospitals/health services to utilise positive consumer feedback to offset the perceived negative aspects of health care. It is therefore recommended that hospitals/health services follow formal processes to record and report compliments and other forms of consumer feedback.

## 11. Evaluation

### 11.1 Review of hospital/health service complaint management processes

Evaluation of the complaint management policy and processes are to be undertaken by hospitals/health services every **three** years. The review is to include:

- an evaluation of the Policy and processes including a compliance audit of individual complaint files
- surveys of staff, consumers and complainants
- an assessment of the adequacy of the complaints management system.

Community Advisory Councils (CACs) and District Health Advisory Councils (DHACs) shall be involved in the evaluation of the complaint management process. The results of the evaluation of the complaint management process will be reported to the hospital/health service governance/quality committee and the CACs/DHACs.

### 11.2 Review of the *Western Australian Health Complaint Management Policy*

The *Western Australian Health Complaint Management Policy* shall be reviewed every **three** years in accordance with standard policy development procedure. This review will seek to ensure that complaint management processes are able to facilitate the provision of appropriate information leading to health system improvement.

## 12. Additional Information

### 12.1 Involuntary admission (mental health)

Involuntary patients are defined under Part 3 of the *Mental Health Act 1996*, and persons may be classified as 'involuntary' in accordance with section 26, which provides that:

“(1) A person should be an involuntary patient only if –

- (a) the person has a mental illness requiring treatment;
- (b) the treatment can be provided through detention in an authorised hospital or through a community treatment order and is required to be so provided in order to –
  - (i) protect the health or safety of that person or any other person;
  - (ii) protect the person from self-inflicted harm of a kind described in subsection (2); or
  - (iii) prevent the person doing serious damage to any property;
- (c) the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment; and
- (d) the treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.

- (2) The kinds of self-inflicted harm from which a person may be protected by making the person an involuntary patient are –
- (a) serious financial harm;
  - (b) lasting or irreparable harm to any important personal relationship resulting from damage to the reputation of the person among those with whom the person has such relationships; and
  - (c) serious damage to the reputation of the person.”<sup>10</sup>

## 12.2 Complaints by carers

The *Carers Recognition Act 2004* mandates that hospitals/health services comply with the *Western Australian Carers Charter*. Point four of the Charter states that ‘*Complaints made by carers in relation to services that impact on them and the role of carers must be given due attention and consideration*’.<sup>11</sup> See Appendix 1 for the definition of a carer.

## 12.3 Patient informed consent

Refer to the relevant Department of Health Guidelines and Operational Circular OD 1347/00 on informed consent. See the *Consent to Treatment Policy for WA Health Services* at: [www.safetyandquality.health.wa.gov.au](http://www.safetyandquality.health.wa.gov.au)

## 12.4 Freedom of information legislation

The *Freedom of Information Act 1992* is available at: [www.slp.wa.gov.au](http://www.slp.wa.gov.au)

Information regarding Freedom of Information in Western Australia can be obtained from: [www.foi.wa.gov.au](http://www.foi.wa.gov.au)

## Appendix 1: Definitions

**Apology** – An apology is defined in section 5AF of the Civil Liability Act 2002 and means “an expression of sorrow, regret or sympathy by a person that does not contain an acknowledgment of fault by that person.”

**Assault** – The following is an extract from section 222 of the *Criminal Code Act Compilation Act 1913*:

“A person who strikes, touches, moves, or otherwise applies force of any kind to the person of another, either directly or indirectly, without his consent, or with his consent if the consent is obtained by fraud, or who by any bodily act or gesture attempts or threatens to apply force of any kind to the person of another without his consent, under such circumstances that the person making the attempt or threat has actually or apparently a present ability to effect his purpose, is said to assault that other person, and the act is called an assault.”

**Carer** – Section 5 of the *Carers Recognition Act 2004* states the meaning of carer as:

- “(1) Except as provided in subsection (2), a person is a ‘Carer’ for the purposes of this Act if he or she is an individual who provides ongoing care or assistance to –
- (a) a person with a disability as defined in the *Disability Services Act 1993* section 3;
  - (b) a person who has a chronic illness, including a mental illness as defined in the *Mental Health Act 1996* section 3;
  - (c) a person who, because of frailty, requires assistance with carrying out everyday tasks; or
  - (d) a person of a prescribed class.
- (2) However a person is not a carer if he or she –
- (a) provides the care or assistance under a contract for services (other than an agreement entered into under the *Disability Services Act 1993* section 25) or a contract of service; or
  - (b) provides the care or assistance while doing community work as defined in the *Volunteers and Food and Other Donors (Protection from Liability) Act 2002* section 3(1).
- (3) A person is not a carer for the purposes of this Act only because:
- (a) the person is a spouse, de facto partner, parent or guardian of the person to whom the care or assistance is being provided; or
  - (b) the person provides care to a child under an arrangement with the chief executive officer of the department principally assisting the Minister administering the *Children and Community Services Act 2004* in the administration of that Act.”<sup>11</sup>

**Clinical incident** – an event or circumstance resulting from health care which could have, or did lead to unintended harm to a patient/consumer, loss or damage, and/or a complaint.

Clinical incidents include:

- **near misses** – incidents that may have, but did not cause harm
- **adverse events** – an incident in which harm resulted to a person. Harm includes death, disease, injury, suffering and/or disability.<sup>6</sup>

**Clinician** – For the purpose of this document, clinician refers to all health care professionals providing clinical care, including doctors, nurses, midwives and allied health professionals.

**Complainant** – A person (or organisation) that makes a complaint regarding any aspect of a service provided by a hospital/health service.

**Complaint** – An expression of dissatisfaction by or on behalf of an individual consumer regarding any aspect of a service provided by a hospital/health service. A complaint can be made verbally or in writing.

**Complaint category** – For complaint data collection to be compatible across a range of health services, nine complaint categories have been developed to assist in identifying common factors in complaints. See Appendix 4 for a list of complaint categories.

**Complaint issue** – Complaint categories are further subdivided into complaint issues, which aim to accurately identify and reflect the specific matters relating to each complaint. See Appendix 4 for a list of complaint issues in their respective complaint categories.

**Consumer** – In regard to this policy, consumer may include the following:

- Patients
- Carers
- Relatives
- Friends
- Visitors
- Health professionals external to the organisation
- Suppliers
- Other concerned individuals, agencies or groups

**Contact/concern** – Feedback from consumers regarding any aspect of service where:

- they state that they do not wish to lodge a formal complaint
- the issue can be resolved without going through the formal complaint process.

An expression of concern should be noted and any action taken documented as part of the quality improvement or risk management process appropriate to the circumstances. A contact/concern should not be logged in the complaint database.

**Disability** – As per section 3 *Disability Services Act 1993* “**disability** means a disability –

- (a) which is attributable to an intellectual, psychiatric, cognitive, neurological, sensory, or physical impairment or a combination of those impairments;
- (b) which is permanent or likely to be permanent;
- (c) which may or may not be of a chronic or episodic nature; and
- (d) which results in –
  - (i) a substantially reduced capacity of the person for communication, social interaction, learning or mobility; and
  - (ii) a need for continuing support services.”<sup>12</sup>

**Disclosure** – Providing consumers with important information regarding their clinical care or condition, which affects or has the potential to affect their wellbeing. This includes communicating information regarding the results of tests, treatments or interventions.

**Health service/provider** – Any person(s), hospital/health service providing a service to a consumer.

**Open disclosure** – The Australian Commission on Safety and Quality in Health Care’s *National Open Disclosure Standard (2003)* defines Open Disclosure as the ‘open discussion of incidents that result in harm to a patient while receiving health care.’<sup>13</sup>

The elements of open disclosure are an expression of regret, a factual explanation of what happened, the potential consequences of the incident, and the steps taken to manage the event and prevent recurrence. It is not an admission of liability or fault.

The *WA Open Disclosure Policy* was released in May 2009 and is available at:  
[www.safetyandquality.health.wa.gov.au](http://www.safetyandquality.health.wa.gov.au)

**Procedural fairness/natural justice** – Procedural fairness is concerned with the procedures used by a decision-maker, rather than the actual outcome reached. It requires that a fair and proper procedure is used when making a decision. A decision-maker who follows a fair procedure is more likely to reach a fair and correct decision.<sup>14</sup>

The term procedural fairness is thought to be preferable when referring to administrative decision-making because the term natural justice is associated with procedures used by courts of law. However, the terms have similar meaning and are commonly used interchangeably.<sup>14</sup>

**Sentinel event** – An event that leads to catastrophic patient outcomes. The Australian Commission for Safety and Quality in Health Care and WA Health have endorsed a national list of sentinel events:<sup>8</sup>

- Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.
- Suicide of a patient in an inpatient unit. (Under the *Mental Health Act 1996*, Mental Health Services are required to report to the Chief Psychiatrist episodes of unexpected death. See Operational Circular OP 1646/03 for further information).
- Retained instruments or other material after surgery requiring re-operation or further surgical procedure.
- Intravascular gas embolism resulting in death or neurological damage.
- Haemolytic blood transfusion reaction resulting from ABO incompatibility.
- Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.
- Maternal death or serious morbidity associated with labour or delivery.
- Infant discharged to wrong family or infant abduction.
- Other adverse event resulting in serious patient harm or death.

**UMRN** – Unit Medical Record Number.

**Vexatious complaints** – The purpose of these complaints are to harass, annoy, delay or cause detriment rather than genuinely intending to resolve the grievance. They also include complaints which are instituted or pursued without reasonable grounds.

## Appendix 2: Guidelines for Logging Mental Health Complaints

These Guidelines are provided to assist with the consistency of reporting mental health complaints.

1. Patients who are received into an Authorised Hospital under a Form 1 (section 29 *Mental Health Act 1996*) are detained persons and not technically involuntary patients as described by the *Mental Health Act 1996*, until formally admitted. For the purposes of complaint management, because they are restricted from leaving the facility, they will be logged as an 'Involuntary' patient (see the Western Australian Health Complaint Management Toolkit for an example Complaint Management Record Form).
2. As with general health complaints the category chosen should describe the issue/s of the complaint from the complainant's perspective, not the opinion of the person entering the information. This is particularly relevant for patients who are expressing what appear to be delusional beliefs. Guiding examples include:
  - 2.1 Patient states: *'I am being forced to take medication and I know they are purposely sedating me with poison because I know what they are up to.'* This is essentially a complaint about consent and should be logged under Category 3.4: Medication given without consent.
  - 2.2 Patient states: *'The Police and the Shire are all working together to have me in here (as an involuntary patient) because I know about their cover up of the paedophile ring'.* This is essentially a complaint about decision-making and could be logged under Category 3: Decision-Making.
3. The fact that a person is receiving care in a mental health facility and may be an involuntary patient under the *Mental Health Act 1996* does not mean that complaints should automatically be logged under Category 6.7: Failure to comply with the *Mental Health Act 1996*. Guiding examples include:
  - 3.1 The *Mental Health Act 1996*, at sections 111 and 164 gives the patient the right of a second opinion. The Category 4.12: Refusal to refer or assist to obtain a second opinion, would accurately describe the complaint.
  - 3.2 A patient has the right to access information under the *Mental Health Act 1996* section 160. The most appropriate category for a complaint about access to records is Category 6.10: Barriers to accessing personal health records.
  - 3.3 The *Mental Health Act 1996* section 206 is in respect of confidentiality. If a complaint is about a breach of personal information this should be logged under Category 6.5: Breach of confidentiality.
  - 3.4 Regulation 18 of the *Mental Health Regulations 1997* requires that a patient be given information about their rights (*Mental Health Act 1996* section 156). A complaint that rights were not given should be assigned to Category 6.7: Failure to comply with the *Mental Health Act 1996*, rather than say, Category 2.5: Inadequate Communication.
  - 3.5 A patient who complains that they have not been provided with information and/or assistance to contact the Mental Health Review Board or Council of Official Visitors should have their complaint categorised under Category 6.7: Failure to comply with the *Mental Health Act 1996*.
  - 3.6 Whilst electroconvulsive treatment (ECT) has special provisions under the *Mental Health Act 1996* it is still essentially a treatment and depending on the patient's complaint issue should be categorised as such, i.e. decision-making issue, treatment issue or second opinion issue.

If clarification is required for the logging of mental health complaints then you may seek advice from the Office of the Chief Psychiatrist, WA Department of Health on (08) 9222 4462.

## Appendix 3: Complaint Categorisation List, Definitions and Examples

Following is a comprehensive list of the nine complaint categories and their respective complaint issues. Included are:

- definitions of complaint issues, which are intended to assist complaint co-ordinators to recognise and record similar complaints issues in similar categories
- some examples of the type of complaints collected in the category under each complaint issue.

This is not intended to be a complete list. The list can be further customised within each major category as required.

### 1. Access

**Refers to availability of services in terms of location, waiting times and other constraints that limit the service**

1.1 Delay in admission or treatment; delays occurring after consumer is at the point of service (use 'waiting list' where appropriate):

- Delay occurring after client is at the point of service.
- Excessive waiting time for diagnostic testing.
- Delay in diagnostic testing leading to delay in commencement of treatment.

1.2 Waiting list delay:

- Unreasonable wait for elective surgery/procedure.
- Waiting time to gain appointment to an outpatient clinic.
- Lack of review if case becomes acute.
- Further postponement after a date has been set.
- Too many cancellations.
- Surgery cancelled at the last minute.

1.3 Non-attendance:

- Provider fails to keep an agreed appointment.
- Frequent cancellation of appointments.

1.4 Inadequate resources/lack of service.

- Inadequate:
  - human resources
  - equipment
  - facilities.
- Lack of service.

1.5 Refusal to provide services.

- A hospital/health service refuses to:
- admit a consumer
  - accept a consumer.

#### 1.6 Failure to provide advice about transport options when necessary:

- Failure to provide authorised ambulance transport.
- Delay/failure to provide inter-hospital/health service transport.
- Failure to provide assistance for family travel (lack of documentation for assistance to travel PATS, Airline, etc).

#### 1.7 Physical access/entry.

Impediments to entry to a hospital/health service.

Inadequate:

- ramps/space
- lighting
- signage
- walkways
- public transport accessibility
- access information
- access for people with disabilities.

#### 1.8 Parking issues.

Inadequate:

- short term parking
- set-down/pick-up parking
- visitor parking
- external provider parking
- parking for people with disabilities.

## 2. Communication

**Refers to the quality and quantity of information provided about treatment, risks and outcomes**

#### 2.1 Inadequate information about diagnostic testing, treatment options, alternative procedures and risks:

- Inadequate information about diagnostic preparation and tests (use 'failure to consult consumer' when the issue is one of decision-making rather than information provision).

#### 2.2 Inadequate information on services available – lack of discussion between hospital/health service and consumer.

#### 2.3 Misinformation or failure in communication (but not 'failure to consult'):

- Given inaccurate/wrong information.
- Given confusing/conflicting information.

#### 2.4 Inadequate or inaccurate records – personal information in a medical record held by a hospital/health service is incomplete or inaccurate.

#### 2.5 Inadequate written communication:

- No information brochure/leaflet available.
- No written confirmation of verbal instructions given.
- No information in language other than English.

#### 2.6 Inappropriate verbal/non-verbal communication:

- Irrelevant, untimely, misplaced comments or person speaking beyond their authority.
- Inappropriate body language, facial expression, voice tone or demeanour.

#### 2.7 Failure to listen to consumer and act on the information provided.

### 3. Decision-making

#### Refers to the consultation with the consumer in the decision-making process

3.1 Failure to consult consumer and involve them in the decision-making process.

3.2 Public/private choice:

- Classification as a public rather than private consumer, or vice versa.
- Failure of a hospital/health service to explain options for choice of status.
- Confusion between fee-for-service and public status.

3.3 Consent not informed.

Failure to provide sufficient information:

- so that the consumer can make an informed decision about treatment
- about treatment options
- about risks, contra-indications, rate of complications for the treatment/procedure.

3.4 Consent not obtained:

- Where consumer receives an additional treatment or surgical procedure for which they did not receive information and/or to which they did not consent.
- Failure to provide information pertinent to the removal of tissue or body parts for investigative purposes or at autopsy, or for the purposes of research.
- Medication given without consent.

3.5 Consent invalid.

Consent:

- was not voluntary
- did not cover the procedure performed
- was given by a consumer/person who had no legal capacity to consent
- older than three months without further discussion/review
- was withdrawn and not acknowledged or acted upon.

### 4. Quality of clinical care

#### Refers to the assessment, planning, implementation and evaluation of clinical care by any health care professional

4.1 Inadequate assessment:

- Condition or injury was:
  - overlooked
  - wrongly identified.
- Delay in assessment of new symptoms.
- Inadequate:
  - level of diagnosis
  - medical history taken
  - investigation of symptoms.

#### 4.2 Inadequate treatment/therapy:

- Negligent treatment – explicit allegation of legal liability.
- Inexperience for complexity of the procedure.
- Failure/delay to give emergency treatment.
- Inadequate:
  - standard of performance of treatment/procedure
  - level of observation
  - amount of therapy
  - or no assistance with activities of daily living
  - patient education
  - pressure area care.
- Wrong treatment.
- Incorrect choice of treatment has been made or offered.
- Delay in treatment.
- Failure in duty of care.
- Rough treatment.
- Equipment and/or supplies not available.

#### 4.3 Poor co-ordination of treatment:

- Conflicting decisions by different treating specialties.
- Poor communication between and within the treating teams.
- Too many changes of beds/wards.
- Moved or cared for outside of own specialty area.

#### 4.4 Failure to provide safe environment:

- Complaints of slips, trips and falls.
- Inadequate/inappropriate use of restraints.
- Inadequate assistance and/or observation.
- Assistance with ambulation not offered when required.
- Aids not offered or provided.
- Exposure to dangerous items/equipment/people.
- Assault – patient to patient.
- Sexual assault – patient to patient.
- Inappropriate sexual conduct – patient to patient.

#### 4.5 Pain issues:

- Inadequate:
  - pain control
  - analgesia given either before or after the treatment/procedure.
- Unnecessary pain inflicted during a treatment/procedure.
- Delay in:
  - receiving analgesia
  - summoning medical attention.

#### 4.6 Medication issues.

- Medication prescribing error:
  - wrong prescription, person, drug dose, site, time, route
  - medication prescribed despite documented allergy.
- Medication dispensing error:
  - wrong prescription, person, drug dose, site, time, route
  - drug not given or given multiple times
  - medication dispensed despite documented allergy.
- Loss of patient's own medication.

#### 4.7 Post surgery complications.

#### 4.8 Post procedure complications.

#### 4.9 Inadequate infection control:

- Poor hygiene practices.
- Equipment not cleaned/sterilised.

#### 4.9 Patient's test results not followed up.

Failure to:

- review test results
- act on test results
- refer abnormal test results to GP/specialist if patient discharged.

#### 4.10 Discharge or transfer arrangements:

- Premature discharge.
- Unsuitable or delayed discharge/transfer.
- Inadequate discharge planning – time, medication availability, changes of plans.
- Lack of continuity of care – no outpatient appointment, GP letter, no follow-up arranged.
- Patient discharged with unplanned cannula or suture in situ.

#### 4.12 Refusal to refer or assist to obtain a second opinion:

- Refusal to refer patient/client for specialist treatment.
- Inappropriate/inadequate referral.
- Delay in referring.

## 5. Costs

### Refers to issues about costs and fee structures

#### 5.1 Inadequate information about costs:

- Prior to treatment.
- Information was partial or misleading/confusing.

#### 5.2 Unsatisfactory billing practice:

- Item numbers used in a disadvantageous way.
- Extra fees for service, normally included in global fee.
- Unreasonable penalties for late payment.
- Refusal to offer a range of payment options.

- 5.3 Amount charged – the fee or account for the particular treatment, procedure, consultation or accommodation.
- 5.4 Over-servicing:
- Too frequent consultations.
  - Ordering unnecessary tests.
  - Recurrent bulk billing visits to hostels/nursing homes.
  - Repetition of tests already completed by GP.
- 5.5 Private health insurance and claim handling.
- 5.6 Lost property:
- Failure to acknowledge loss, replacement or reimbursement of property.
  - Unsatisfactory process for safekeeping of consumer property.
- 5.7 Responsibility for costs and resourcing – unsatisfactory facilitation of the reimbursement process.

## 6. Rights, respect and dignity

### Refers to the consumer's mandated or legislated human and health care rights

- 6.1 Consumer rights.  
Failure to:
- provide information about the existence of the Western Australian Public Patients' Hospital Charter
  - comply with the Western Australian Public Patients' Hospital Charter.
- 6.2 Inconsiderate service/lack of courtesy including:
- Lack of politeness/kindness.
  - Ignoring/negative attitude.
  - A patronising or overbearing manner.
- 6.3 Absence of caring – lack of regard or consideration of the consumer and their particular circumstances.
- 6.4 Failure to ensure privacy:
- Consumer's personal privacy not maintained.
  - Failure to offer appropriate clothing/cover.
  - Demeaning or humiliating care during treatment.
- 6.5 Breach of confidentiality:
- Provision of information to a third party without consent.
  - Careless communication and/or handling of consumer information/medical records.
- 6.6 Discrimination:
- Less favourable health treatment on one of the civil grounds in anti-discrimination law or covenant (e.g. the *Equal Opportunity Act 1984*).
  - Public consumer treated less favourably than private consumer.

- 6.7 Failure to comply with the requirements of the *Mental Health Act (1996)* – failure to fulfil statutory obligations regarding provision of information about rights, documentation and involuntary status.
- 6.8 Translating and interpreting service problems.  
Lack of:
- information about the consumer’s right to access an interpreter
  - arrangements for an interpreter to attend when required
  - availability of an interpreter.
- 6.9 Certificate or report problem:
- Failure to:
    - provide a correct certificate or report when requested
    - certify in accordance with the law
    - pass on information to an authorised person.
  - Claims that a hospital/health service has falsified a certificate.
- 6.10 Barriers to accessing personal health records.

## 7. Grievances

### **Refers to the individual’s rights to have timely and fair management of the complaint**

- 7.1 Response to a complaint:
- No response to a complaint.
  - Inadequate response to a complaint.
  - Unacceptable delay in response to a complaint.
  - Dissatisfaction with the outcome of a complaint.
- 7.2 Reprisal following a complaint – any action causing detriment to a consumer as a result of the complaint.

## 8. Corporate services

### **Corporate issues resulting in complaint**

- 8.1 Administrative actions of a hospital/health service.
- 8.2 Catering:
- Unsatisfactory provision of food services – access to food, quality, amount, variety, temperature.
  - Unsatisfactory selection of suitable choices for cultural preferences.
  - Failure to involve the consumer in decision of preferences that complement treatment.
  - Requested meals not provided.
- 8.3 Physical surroundings/environment:
- Inadequate provision of:
    - privacy in shared facilities (e.g. bathrooms, changing area)
    - space and facilities for consumer and their belongings
    - lighting
    - temperature control.
  - Poorly maintained or run down facilities.
  - Unacceptable noise.

#### 8.4 Security.

Inadequate security measures for consumer and visitors relating to:

- people or personal safety
- personal belongings.

8.5 Cleaning – inadequate provision and maintenance of a clean environment.

8.6 Fraud/illegal practice of a financial nature (applied to hospital/health service).

### 9. Professional conduct

**Refers to alleged unethical and alleged illegal practices.**

9.1 Inaccuracy of records:

- Failure to:
  - document
  - record information given by a consumer in medical records.
- Documented:
  - opinionated comments
  - non-substantiated conclusions.
- Illegibility of records.

9.2 Illegal practices (e.g. abortion, sterilisation or euthanasia).

9.3 Physical or mental impairment of a health care professional – care being offered by a health care professional who may be compromised outside the accepted definitions of physical or mental impairment/disability.

9.4 Sexual impropriety – behaviour that is sexually demeaning to a consumer including comments or gestures.

9.5 Sexual misconduct:

- Any touching of a sexual nature.
- Any sexual relationship with a consumer whether or not initiated or consented to by the consumer.

9.6 Aggression/assault – verbal or physical.

9.7 Unprofessional behaviour (e.g. loud noisy language, swearing, inappropriate comments or gestures).

### 10. Carers Charter

**Refers to complaints regarding the Carers Charter**

10.1 Failure to consider the needs of a carer.

10.2 Failure to consult a carer.

10.3 Failure to treat a carer with respect and dignity.

10.4 Unsatisfactory complaint handling – failure to address the carer's complaint.

## Appendix 4: Additional Information for the Classification and Rating of Complaints

### 1. Severity of the Complaint

#### Refers to the seriousness of the complaint and the potential for loss or damage

The identification, analysis and management of risks is a core requirement of *Treasurer's Instruction (TI) 825: Risk Management and Security*. The Department of Health's risk assessment matrix should be used to assist hospital/health services to evaluate the seriousness of a complaint and potential level of risk to the health service and to future consumers.

The relevant information including the matrix can be found in the Department of Health's *Clinical Risk Management Guidelines for the Western Australian Health System* available at: [www.safetyandquality.health.wa.gov.au](http://www.safetyandquality.health.wa.gov.au)

### 2. Consumer Objective

#### Refers to what the complainant feels should happen

- 2.1 Register their concern. The complainant wishes to bring the issue to the notice of the hospital/health service but may or may not want an ongoing involvement.
- 2.2 The complainant does not want a reply but still wants action.
- 2.3 Receive an explanation. The complainant wishes an investigation and explanation of why something occurred.
- 2.4 Obtain an apology. The complainant believes there has been wrongdoing and they are entitled to an apology from the:
  - hospital/health service
  - staff member involved.
- 2.5 Obtain a refund/compensation for:
  - costs incurred as a result of the incident
  - damage or loss (financial, material or personal).
- 2.6 Access to service. The complainant expects the service previously sought to be received.
- 2.7 Change in policy/practice/procedure(s).
- 2.8 The hospital/health service will accept and acknowledge its responsibility for the complaint. They will confirm that a staff member has been counselled about the behaviour that was the subject of a complaint and action taken.

### 3. Outcome/Resolution Mechanism for the Complaint Issue

**Refers to the outcome and/or resolution of the complaint issue/s for the complainant**

- 3.1 Concern registered.
- 3.2 Explanation provided.
- 3.3 Apology provided from the:
  - hospital/health service
  - staff member involved.
- 3.4 Costs refunded/compensation received.
- 3.5 Services provided.
- 3.6 Change in practice/procedure effected.
- 3.7 Policy change effected.
- 3.8 The hospital/health service will accept and acknowledge responsibility for the complaint:
  - Staff member/contractor/volunteer/ student counselled and/or offered performance support and development in accordance with hospital/health service policy.

### 4. Recommendation/Action Taken as a Result of this Complaint

This section demonstrates that a response was documented as a result of the complaint. If no further action was required a conscious decision was made about the recommendation or action that the hospital/health service would take:

- 4.1 Recommendations are made to the relevant hospital/health service manager(s).
- 4.2 Quality improvement activity, including risk management initiatives and system wide changes initiated.
- 4.3 Policy written or modified.
- 4.4 Procedure/practice modified.
- 4.5 Training/education of staff provided.
- 4.6 Staff member/contractor/volunteer/ student counselled and/or offered performance support and development in accordance with hospital/health service policy.
- 4.7 Duties changed.
- 4.8 No further action required.

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Videos: *First Impressions Count* (17:43) length. **A Little Kindness Helps** (11:20) length.

# Delivering a **Healthy WA**

