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

Complaints Management Guideline

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Contents

1. Introduction

Health consumer feedback is a valuable component of the quality improvement cycle, and the effective management of consumer/carer complaints is a key mechanism to obtain this feedback. Complaints provide a means to identify areas in need of improvement and uncover any real or potential system failures from a consumer/carer's perspective.

With an increasing focus on the provision of consumer-centred health care, complaints management is an important part of building effective partnerships with health consumers, carers and the community. Encouraging health consumers/carers to provide feedback, demonstrates the WA health system's commitment to continuous improvement and ensuring a safer and higher quality of health care for all consumers.

The complaint management process outlined in this guideline is not intended to apportion blame but strives to resolve the complaint, if possible, and identify any aspects of service delivery which require change to effect improvement where possible.

Ideally, a partnership between Health Service Providers* and consumers/carers will develop with the common aim of increasing the quality of health care services and improving the safety and experience of health care consumers in Western Australia (WA).

The National Safety and Quality Health Service Standards second edition[1] have requirements for consumer feedback which underpin this Guideline and the Complaint Management[2] Policy. An effective complaint management system is reliant on a number of elements[3] working together including:

- A culture that supports reporting of incidents and seeking feedback.
- Principles underpinning the practices that ensure complaints are dealt with in an equitable and objective manner.
- The skills and experience of the complaints handling officers and all staff supported by ongoing training as well as strong leadership.
- Standard processes that support efficiency in complaint handling, including the interface with other reporting systems or bodies outside the complaint management process.
- Analysis of feedback at all Health Service Provider levels to enable effective service improvement.

This guideline supports the Complaints Management Policy and is to be applied as best practice for Health Service Providers and Contracted Health Entities. Contracted Health Entities should follow any local reporting requirements to manage complaints as per local health service organisation guidelines. When the Contracted Health Entity has a contractual agreement applicable to complaints management, then the entity needs to apply those sections that are applicable to them within the Complaints Management Policy and Guidelines. As each agreement may differ, refer to the contract to confirm complaints management requirements. Contracted Health Entities should report complaints on a monthly basis to the PSSU using the Health Service Complaints Management Report Form, available by contacting PSSU@health.wa.gov.au.

* The term Health Service Provider refers to all WA health system Health Service Providers and any private health care facility that has a requirement to comply with the Complaints Management Policy. Any references to Health Service Providers throughout this document are to be taken to include that private health care facility.

2. Consumer feedback overview

Feedback from health consumers/carers can be described as one or more of the following:

- **Compliment** – An expression of satisfaction and/or gratitude by, or on behalf of, a consumer/carer regarding an aspect of a service delivered by a Health Service Provider.

- **Contact/concern** – An enquiry or feedback from a consumer/carer regarding any aspect of service where:
    a. The contact is inquisitorial in nature rather than an expression of dissatisfaction; and/or
    b. The consumer/carer states that they do not wish to lodge a complaint; and/or
    c. The issue(s) are minor and can be resolved immediately without going through the complaint process (e.g. the complainant is satisfied by immediate actions to resolve the issue). Immediate resolution negates the need for any follow up actions (i.e. if further action is required to resolve the complaint, it is not a contact/concern unless it satisfies criteria a or b).

- **Complaint** – An expression of dissatisfaction by, or on behalf of, an individual consumer/carer regarding any aspect of a service delivered by a Health Service Provider, where a response or resolution is explicitly or implicitly expected or legally required. A complaint can be lodged in writing or verbally. Where feedback is provided online including via social media and the feedback comprises a complaint, Health Service Providers should record this as a complaint. It is noted that all complaint management steps may not be possible in these types of complaints.

- **Anonymous complaint** – a complaint where the complainant for whatever reason chooses to withhold identifying details. It is acknowledged that anonymous complaints may not be able to be responded to, but Health Service Providers should never the less work to resolve these types of complaints via service improvement.

Consumers and their representatives make complaints for a variety of reasons. Primarily complaints are concerning communication, the quality of clinical care, access to services and being treated with respect and in accordance with the rights of consumers and carers. Many complainants are altruistic in that they identify the reason for making a complaint is to avoid other consumers/carers having a future similar experience.

2.1 Feedback from specific groups

Health Service Providers should have a variety of mechanisms in place to receive feedback from consumers and carers including mechanisms that encourage feedback from specific consumer groups such as children and young people, Aboriginal, Culturally and Linguistically Diverse (CaLD) people and persons with disability or mental health issues. These mechanisms should consider that these groups may have barriers to making a complaint that others may not encounter. It should also be noted that these groups may benefit from advocacy services and in some cases such as persons who are detained or referred under the Mental Health Act (2014) this may be a statutory requirement.

Health Services Providers are recommended to actively seek feedback from these groups to assist in measuring the appropriateness of services and addressing health disparities for these groups. One mechanism to enable this is for Heath Service Providers to collect and report demographic data when a complaint is made to identify these groups (refer to the Reporting section of this Guideline).

3. Recording and reporting of compliments, contacts or concerns

It is recognised that Health Service Providers receive compliments as well as complaints. Compliments offer Health Service Providers insight into a service's effectiveness, identify the service components that are most important to consumers and provides the opportunity to recognise staff efforts. It is therefore recommended that Health Service Providers follow formal processes to record and report compliments and other forms of consumer feedback such as contacts. It is recommended that feedback managed by front line staff be reported as per complaints reporting and monitored for emerging trends that indicate service improvement is required (e.g. identification of a recurring issue that should be addressed).

Internal monitoring and analysis of compliments, contacts and concerns is at the discretion of the Health Service Provider; however, it is recommended as it provides an indication of consumer engagement within the service. Contacts/concerns and compliments may be recorded in the central database (i.e. Datix Consumer Feedback Module). It is recommended that a contact/concern with a high to extreme risk profile be managed in accordance with complaints (i.e. Complaints Management Policy) and thoroughly documented, including its escalation to senior management.

4. Complaint Management Guiding Principles

The following principles underpin the management of complaints within the WA health system and the relationship with consumers throughout that process. These principles correlate with those outlined in the Australian Standard for the handling of complaints,[3] as well as guidelines from other agencies including the Australian Council for Safety and Quality in Health Care's Complaints Management Handbook for Health Care Services[4] and the Commonwealth Ombudsman's Better Practice Guide to Complaint Handling. [5] Refer to Appendix 2 for more information about the elements of each guiding principle.

Figure 1: Guiding principles of complaint management

Rights and responsibilities of consumers and carers

Health complainants have the right to be treated with respect and dignity, have their concerns treated as genuine and properly investigated, and to participate in decisions about the management of their complaint.

Likewise, complainants are expected to respect the role of Health Service Provider staff and their right to respond to a complaint.

Promotion, accessibility and transparency

Health Service Providers should encourage all consumers and carers to provide feedback, concerns and complaints and then action these in an open, receptive and transparent manner. The process for lodgement of complaints should be highly visible, easily accessible and understandable for all consumer groups. Consideration should be given to the promotion of complaints processes and accessibility to these processes for consumers groups with particular needs (e.g. children and young people, consumers with disabilities, carers).

Commitment to effective complaint management

Health Service Providers will demonstrate their commitment to the appropriate management of complaints by providing sufficient leadership, resources, training and support to staff in the receipt, recording, investigation, resolution and reporting of complaints.

Fairness and accountability

Each complaint should be addressed in an equitable, objective and unbiased manner, be treated as legitimate and investigated without prejudice applying natural justice.

Accountabilities for the management of complaints are established; and, complaints are monitored and escalated to the Health Service Provider's leadership team or external agencies when appropriate.

Responsiveness

Complaints should be acknowledged and addressed in a timely manner in accordance with the established timeframes within the Complaints Management Policy and the complaint's seriousness. Complainants are kept informed throughout the process.

Complaints management must be responsive to the needs of the consumer/carer and subject to ongoing review and improvement.

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. Health Service Providers will establish procedures to ensure that relevant facts and decisions are communicated openly and that the confidentiality of personal information is protected throughout the complaint management process.

Note that disclosure may be subject to legislative requirements and/or restrictions (e.g. documents generated throughout the complaint management process could be subject to a request under the *Freedom of Information Act 1992*).

Continuous service improvement

Consumer feedback is used to identify and initiate the implementation of local and service-wide practice improvements, including practices relating to the management of complaints.

5. Complaints Management Framework

The management of a complaint, including its resolution, should be managed by frontline staff in the first instance. When this is not appropriate and/or not possible, frontline staff should escalate the complaint to complaints management or senior staff in accordance with local processes. Should resolution not be possible at this stage, a complainant may be referred to an external agency such as the Health and Disability Services Complaints Office or the Ombudsman WA.

The framework below outlines the structure for the best practice management of complaints.

Figure 2: Complaints management framework

In addition, this Complaints Management Framework recognises that not all complaints warrant a full investigation and that not all complaints will be able to be resolved by a Health Service Provider despite a full investigation. The level of response will depend on several factors including: the complainant's level of participation in the complaint process; the Health Service Provider's capacity to manage a complaint, including implementing a resolution; the complexity of the event(s); and, the outcome(s) sought by the complainant.

6. Complaints management process

Health Service Providers should adopt best practice processes for the management of complaints, as outlined in this Guideline. A figure which depicts an overview of the complaints management process is provided above in Figure 2 and outlined in detail in Appendix 3.

6.1 Enabling collection of complaints

Health Service Providers should ensure that consumers and carers can easily access the complaints management process, including consumers who may require assistance or alternative approaches to lodge a complaint. This should recognise that one's culture and/or past experiences with authorities may be a barrier to lodging a complaint and that those who may be more likely to have problems with services are often the ones who need the most encouragement and support to raise their concerns.

Subsequently, Health Service Providers should utilise a variety of mechanisms to seek feedback about their services that are appropriate and include mechanisms that are tailored to specific consumer groups such as children and young people, Aboriginal people, persons who are CaLD, people with mental health issues and person's with a disability. [6] Practical information on making complaints processes accessible to specific groups is available in the Ombudsman WA's Guidelines: Making your complaint handling system accessible[6] and the Australian Government National Office for Child Safety: Compliant Handling Guideline Upholding the rights of children and young people. [7]

6.2 Anonymous complaints

Health Service Providers should support the lodgement and management of anonymous complaints as this is one mechanism to encourage complaints from vulnerable persons who may have concerns that retaliation may occur in response to their complaint. Subsequently, such complaints can provide vital information to guide service improvement. It is recognised that there are limitations to assessing, managing and responding to anonymous complaints; however Health Service Providers are to investigate and manage such complaints to the greatest extent possible. At a minimum Health Service Providers must record anonymous complaints.

6.3 Complaints made via social media

Health Service Providers maybe active users of social media platforms both moderated and unmoderated. Complaints received via social media maybe valid and where possible should be captured and managed potentially via the recording of an anonymous complaint. In the management of complaints received via social media the following considerations[8] should apply:

- Alignment of practices to local policies regarding the use of social media including the identification of genuine complaints
- Ensuring that staff have the appropriate skills and understand their obligations to manage social media content commensurate with their role
- Advising the complainant of escalation processes related to complaints management

6.4 Frontline complaints management

Receipt of complaints is the responsibility of all staff and Health Service Providers should promote customer service principles to all staff. Frontline staff should encourage consumers and carers to provide feedback, be able to resolve complaints at the point of care and may record feedback and complaints. This requires staff to be empowered to provide remedies commensurate with the complaint and their role. If a frontline staff member has an actual, potential or perceived conflict of interest or is unable to resolve the complaint or the complaint involves complex or serious issues and/or action(s) required is beyond the scope of the staff member, the complaint should be recorded and escalated in accordance with local processes (e.g. to complaints management staff or a more senior staff member).

It is recommended that Health Service Providers support frontline staff in their complaints management, including the provision of relevant education and training on consumer engagement, complaint management and consumer feedback activities to enable their effective management of complaints. [3] This education and training should endeavour to equip staff in the management of complainants with challenging conduct and should inform staff of available supports (e.g. escalation to a direct line manager). Education and training could be offered at induction sessions for new staff and/or through an online customer service and complaints management training package. Further, Health Service Providers may choose to offer consumer feedback forums, giving staff the opportunity to learn from consumers.

Information to assist with frontline complaints management can be accessed in the Complaints Management Toolkit. [9]

6.5 Acknowledgement of complaints

The acknowledgement of a complaint must be undertaken within five working days. It should include a discussion, and recording of, the following key pieces of information that will assist in the management of the complaint:

- Description of the event(s) which will confirm that what has been recorded is an accurate reflection of the complainant's description. More information from the complainant may be sought as required.
- The desired outcome/goal that the complainant seeks as a satisfactory resolution to the complaint.
- The complainant's request or preference for a particular mode of communication (e.g. telephone, face-to-face or written response and the requirement for interpreter services).
- The requirement for advocacy or support services such as an Aboriginal Liaison Officer.
- Other particulars that are mandatory reporting requirements as outlined in the Complaints Management policy and recommended reporting fields outlined in this Guideline.

It is reasonable for the staff member handling the complaint to refer back to the complainant if:

- The complaint is excessive in length and clarification is required to determine the complaint's key issues.
- The complaint makes general statements and does not explain the details of the actual event(s).
- The complaint is filled with offensive or abusive language (complainants may be requested to rephrase the complaint).
- The complainant's expectations need to be managed (e.g. demand for a certain outcome appears to be highly disproportionate to the incident and/or beyond the control of the Health Service Provider).

6.6 Assessment

Each complaint should be assessed based on available information to determine:

- Whether the complaint can be resolved immediately or whether an investigation needs to take place to ascertain other key pieces of information.
- The scope of any investigation that needs to take place and who is best placed to undertake the investigation including any issues that relate to another Health Service Provider
- Whether the complaint involves a child or young person and the need to develop a child safety investigation plan
- The issues that comprise the complaint, and whether they can be addressed together or must be addressed separately.
- If the complaint should be investigated collaboratively with any other organisation (see section 6.13 of this Guideline)
- Whether consumer authorisation is required prior to any release of information (e.g. if the complaint was lodged by a third-party person other than the consumer and access to a consumer's medical records is required to investigate the incident).
- Whether the complainant's expectations about the outcome are realistic and whether they need to be managed.
- The Seriousness Assessment Matrix (SAM) score) of the complaint which identifies the priority level for a response, both to the complainant and at a system level.
- The need for appropriate staff to meet with the complainant and the role this may take in achieving resolution goals
- Whether the incident needs to be reported through other incident management processes (e.g. clinical incident reporting and/or reporting of suspected breach of discipline[10]). Refer to Section 9 and 10). NOTE: All suspected breaches of discipline (including misconduct) must be reported to the relevant area (See Section 9).
- Whether the incident is part of an emerging trend that needs to be addressed at a system level.

6.7 Collection of demographic information

It is recommended that Health Service Providers collect demographic information on the consumer and the complainant (should the consumer not be the complainant) to aid in assessing how well services are meeting the needs of specific groups and to identify necessary service improvements and to comply with statutory complaints reporting processes. [11] In addition to age and gender[†], the following information should be sought:

- Aboriginal and/or Torres Strait Islander status
- If an interpreter is required
- Country of birth
- Preferred language
- Main language other than English spoken at home
- If a disability is identified and if so, the type of disability(ies) (e.g. intellectual, mobility impairment).

6.8 Complaint issue categorisation

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

[†] Noting that non gender specific responses are permitted

issues, complaint trends and common factors in complaints. This data can then be utilised to identify opportunities for service improvement.

Refer to Appendix 4 for complaint categorisation list definitions and reporting fields to be collected by Health Service Providers.

6.9 Initial Seriousness Assessment and Risk management

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

The Seriousness Assessment Matrix (SAM) provides a framework for assessing the seriousness associated with the event(s) that are the subject of the complaint (refer to Appendix 5 for further information on SAM). An initial SAM score should be assigned by the person lodging the complaint to each complaint which is merely based upon the complaint itself (i.e. excluding any investigation or other information external/in addition to the complaint). Rating the severity of the complaint will assist in determining:

- Who needs to be notified of the complaint.
- The priority for the Health Service Provider's response and the mode of response.
- Who will need to be involved in the investigation and response.
- Timeframes and extent of necessary action(s) to minimise the risk of recurrence.

The early identification of individual complaints of a serious nature or with a potential for escalation are part of a Health Service Provider's risk management program. Assessing the seriousness of a complaint at this stage seeks to highlight complaints associated with significant safety, political, legal or financial risks to the service or its consumers that require the attention of the Health Service Provider's senior management. Health Service Providers should ensure there are appropriate review processes in place for complaints with significant risks, including the review and sign-off of complaint responses by senior management.

When a complaint has been identified to be a moderate, high or extreme risk, Health Service Providers should determine if the risk has been managed in accordance with policy and local requirements.

Additional information on risk management is available from the WA Health Risk Management Policy[12], the WA Health Clinical Risk Management Guidelines[13] and the Western Australia Government Risk Management Guidelines.[14]

6.10 Investigation

The investigation of a complaint relating to a health service will offer the opportunity to determine what occurred to whom and how; and, identify how things might be or should be, done better in the future. Its purpose is to establish the facts, reach appropriate conclusions and based on available evidence determine a suitable response. For further detailed guidance on complaint investigation utilise the Complaints Management Toolkit or access the Ombudsman WA Investigation of Complaints. [15]

Any matters than involve a suspected breach of discipline (including misconduct) must be reported to the relevant area before any investigation occurs, to ensure the matter is assessed and investigated appropriately (See Section 9).

Not all complaints require an in-depth investigation. The level of investigation required will be determined by the relevant staff member (e.g. Complaints Manager) and based on an objective review of the information available, including the complaint's initial SAM score. It is recommended

that an investigation commence within five working days of receipt of the complaint (the date of referral to the investigator should be taken as the commencement date). If this is not reasonable due to operational constraints (e.g. staff member on leave), then the date of commencement and reason for delay should be documented appropriately.

The conduct of an investigation should, where appropriate, include:

- Gathering all relevant documentation (e.g. medical records, health professional rosters, policies and procedures, product details).
- Interviewing/meeting with the complainant and/or significant others (possibly on more than one occasion and potentially with support from an advocate).
- Interviewing staff members involved in the event(s) (possibly on more than one occasion).
- Interviewing staff members with relevant expertise.
- Analysing the information for its completeness, reliability, relevance and impartiality.
- Conducting further research as required (based on analysis).
- 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:

WHAT	• Description of the event(s) • What should have, and should not have, occurred? (include reference to supporting information such as policies, procedures or expert opinion) • What events are agreed upon or in dispute?
WHO	• How many staff were involved or witnessed the event(s)? • What are their roles and experience levels? • What are their biases or conflicts of interest? (if biases or conflicts of interest are identified).
WHERE	• Location of the incident • Can this incident be isolated to a particular area?
WHEN	• Time(s) of the incident • Has this happened before?
WHY	• Other business occurring concurrently (e.g. emergencies) • General workload information • Availability of support for staff involved at the time of the incident • Consumer acuity levels in the clinical area • Other contributing factors and analysis of their impact.
HOW (RESOLUTION)	• Options for resolving the complaint.
HOW (SERVICE IMPROVEMENT)	• Recommendations/actions to prevent or minimise recurrence • Timeframes and strategies for implementation of recommendations • Evaluation of the implemented strategies to assess their effectiveness.

A thorough investigation process must be undertaken in an objective manner and apply procedural fairness/natural justice to all parties. [16] This will ensure:

- The investigator is able to gather information and assess the information against the other available evidence.
- An objective conclusion can be reached after examination of the facts.
- Determination of a complaint's confirmed SAM score (recognising that this may differ from the initial SAM score).
- Opportunities for improvement can be identified.

- The information can be used to respond to the complainant regarding the circumstances of the event/incident (e.g. policy/procedure was not followed, human error etc.).

Factors that affect the Health Service Provider's capacity to conduct a thorough investigation may include:

- A delay in obtaining consumer authorisation for the release of information
- Staff turnover
- Limited accessibility of medical records
- Staff having no/limited memory of the event(s)
- Incident involved the use of policies, procedures or practices that have been superseded and may be unknown.

Where for whatever reason the resolution of a complaint is delayed the complainant should be advised every 15 working days from the 30th working day of the receipt of the complaint. If the complaint is unable to be resolved in three months it should be escalated to the relevant senior executive.

For further information on complaint investigations, refer to the Complaints Management Toolkit.[9]

6.11 Confirmed seriousness assessment

Health Service Providers are required to determine a complaint's confirmed SAM score, which reflects the complaint and any investigation findings. Based upon the confirmed SAM score, Health Service Providers should determine whether or not an identified risk has been reported in ERMS (if not previously assessed based on the complaint's initial SAM score). This will ensure existing risks are assessed for controls adequacy and new risks are identified, recorded and controls and treatment action plans put in place to minimise the consequences and likelihood of recurrence.

It is important to note that the confirmed SAM score is merely a reflection of the complaint's seriousness rating post investigation and does not include consideration of any strategies that have been implemented in response to the complaint. Any strategies implemented should be evaluated as part of a HSPs risk management processes; however, this evaluation is not reflected within the confirmed SAM score.

6.12 Complaint resolution

Once an investigation is complete and all information considered, an appropriate resolution mechanism(s) (e.g. provide an explanation) and necessary action(s) in response to the complaint should be identified and implemented. Refer to Appendix 6 for further information on resolution mechanisms and recommendations/actions taken.

6.13 Response to complainant

The response to the complainant should include:

- Information relevant to the complaint (the event(s)).
- An explanation of the event(s).
- Adequate reasons for any decisions that were made.
- Any changes made as a result of the complaint.
- An apology/expression of regret for the person's experience and, where appropriate, for the event(s).
- Contact details for the Health Service Provider's senior Complaints Handling Officer (or appropriate staff member).

- An acknowledgement thanking the complainant for their feedback.
- Notice of the complainant's right to escalate the complaint to an external agency and the external agency's contact details.

If the complainant has indicated that their preferred mode of response is not in writing a written summary of the complaint response should be added to the complaint record.

It is important that the response to the complainant advises if they find the Heath Service resolution inadequate of the complainant's right to reply to raise a grievance complaint or to take their concerns to an appropriate external agency, such as the Health and Disability Services Complaints Office or the Ombudsman WA. If the complaint is referred to an external agency (either by the Health Service Provider or the complainant), Health Service Provider staff should cooperate with that agency as required and as appropriate. In the case of mental health consumers this should include the Mental Health Advocacy Service.

If the response to a complainant is pending, regular updates should be provided and a timeframe for the final response should be negotiated with the complainant. Flexibility and special arrangements are encouraged to be adopted for responding to specific consumer groups (e.g. Aboriginal, CaLD, persons with a disability, people with mental health issues, children and young people, LGBTI people) when appropriate. [3, 6] It is recommended that these arrangements be guided by consumer input.

6.14 Complaints involving more than one organisation

Should a complaint involve more than one organisation (within or external to a Health Service Provider) staff should collaborate to ensure that the complaint investigation and communication with the complainant is well coordinated. [3] Communication between organisations should:

- recognise confidentiality requirements[17] (e.g. authorisation to share information)
- consider agreeing a single point of contact (lead agency) for the complainant
- endeavour to work collaboratively through any identified complaint issues in a timely manner to facilitate complaint resolution and communication to the complainant in an appropriate timeframe.
- provide where possible a single coordinated response to the complainant

7. Service Improvement

Health Service Providers are required to provide a safe and quality health service, which is consistently evaluated through continuous quality improvement processes to make sure that it meets consumer requirements. It is recognised that multiple consumer feedback sources exist.

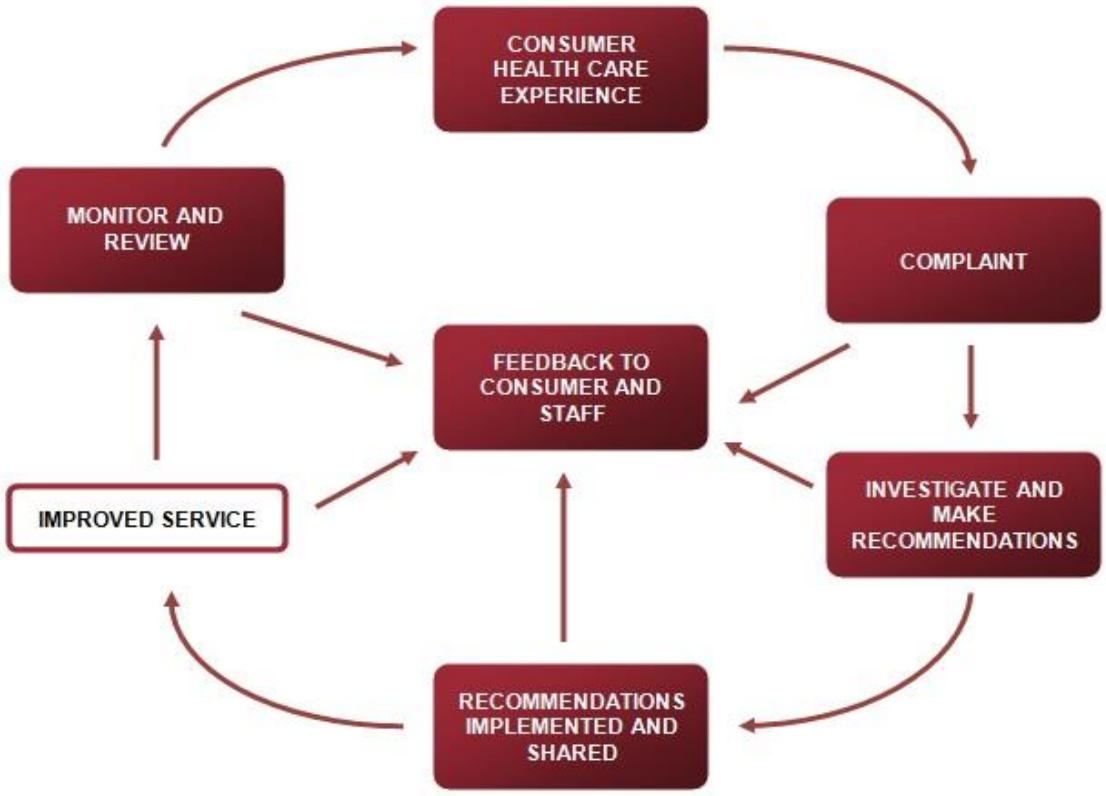
Under the Complaints Management policy, Health Service Providers are required to classify and analyse complaints to assist in the identification and regular reporting of systemic and recurring problems. Health Service Providers should use information from complaints to:

- Identify real and potential complaint trends.
- Recognise common complaint/concern issues for specific consumer groups (e.g. Aboriginal, CaLD, persons with a disability, people with mental health issues, children and young people, LGBTI people[18]), and use this information to determine targeted strategies to improve engagement and service delivery for these groups.
- Initiate an investigation into current organisational practices and procedures with a view to make any necessary changes.
- Continually reassess consumer needs.

- Redesign care and services.
- Provide staff and consumers with feedback on changes in care and service delivery.
- Monitor if the outcomes and recommendations stemming from complaint data are implemented effectively.

The below figure depicts the quality improvement cycle in relation to complaints management.

Figure 3: Continuous service improvement cycle



7.1 Review of complaint management processes

Service improvement activity should include the Health Service Provider's routine evaluation of local complaint management policies and processes. The review should include:

- Consumer/carer engagement.
- An evaluation of policies and processes including a compliance audit of individual complaint files.
- Surveys of staff, consumers and complainants including the use of satisfaction or service evaluation surveys (refer to the Complaints Management Toolkit[9]).
- An assessment of the adequacy of the complaints management system.
- Providing feedback to consumers/carers and staff to close the loop in the consumer feedback process and to promote consumer feedback and consumer engagement best practice principles.

In addition to these review activities, Health Service Providers are encouraged to conduct regular comprehensive audits of their complaints management process, to identify areas which are excelling and which are areas for improvement and from this develop action plans. Refer to the WA Self Audit Tool for Complaints Management[19] for more information and to obtain an audit tool.

8. Complaints Data Reporting

Health Service Providers are required to report complaints data in accordance with local and legislative requirements.

8.1 Reporting within the Health Service Provider

Health Service Provider staff should analyse and monitor local complaint issue trends or issues that require a quality improvement activity. It is recommended that these trends or issues are shared with management to assist in the implementation and evaluation of appropriate quality improvement activities. Any complaint or contact/concern that attracts a high to extreme SAM score should be reported to senior management as soon as practicable.

Health Service Providers are encouraged to report on complaints data to consumers and throughout all levels of the organisation, including frontline staff. It is recommended that these reports:

- Provide an overview of consumer feedback data and data quality.
- Highlight themes, issues and consumer feedback activity occurring within the organisation.
- Include data on specific groups (e.g. Aboriginal, CaLD, persons with a disability). [20, 21]
- Share service improvements implemented in response to consumer feedback and, if known, the success of these initiatives.
- Are publicly published to support accountability and transparency.

8.2 Provision of data to the Health and Disability Services Complaints Office

The *Health and Disability Services (Complaints) Act 1995*[22] and the Health and Disability Services (Complaints) Regulations 2010[11] legislate Health Service Providers' annual provision of information relating to complaints received and action taken to the Health and Disability Services Complaints Office using the format prescribed by their Office.

Health Service Providers are required to ensure that complaints data are an accurate and contemporaneous account of annual complaints management activity at the time of extraction. The timeframe and format for provision of this information will be dictated by instructions from the Health and Disability Services Complaints Office.

9. Complaints that may concern misconduct

Complaints that may concern a breach of discipline, professional misconduct or unsatisfactory professional performance as outlined in parts 10 and 11 in the Health Services Act must be managed in accordance with the relevant policies noting the importance of procedural fairness.

Issues concerning staff conduct may be detected in reporting systems such as that for the management of complaints. A breach of discipline by an employee is committed when an employee:

- disobeys or contravenes a lawful order; or
- contravenes:

    - any provision of the HSA applicable to the employee; or
    - any public sector standard or code of ethics; or
    - a policy framework; or
- commits an act of misconduct; or
- is negligent or careless in the performance of the employee's functions; or
- commits an act of victimisation within the meaning of the *Public Disclosure Act 2003* section 15. [23]

An act of misconduct means acts or behaviours that are unacceptable to the Employing Authority and may include, but is not limited to:

- Disobeying or disregarding a lawful order or reasonable direction
- Contravening the HSA or a policy framework
- Contravening any legislative requirement, Public Sector Standard in Human Resource Management, Code of Ethics, WA Health Code of Conduct
- Dishonesty, theft or fraud
- Physical violence, unwanted or inappropriate physical contact
- Bullying
- Deliberate or serious damage to property
- Negligence or carelessness in the performance of work duties or functions
- Incapacity or impairment to perform work due to consumption of alcohol or drugs
- Misuse of computing facilities to download or view inappropriate material
- Unexplained absences
- Discrimination or harassment
- Making a false or frivolous complaint

The *Corruption Crime and Misconduct Act* 2003 defines misconduct and requires that serious misconduct be reported to the Corruption and Crime Commission (CCC) and minor misconduct be reported to the Public Sector Commission (PSC).

The relevant Health Service Provider integrity area or System-wide Integrity Services unit at the Department of Health should be consulted if there is any doubt about whether the substance of a complaint qualifies as misconduct. All misconduct must be managed and reported in accordance with the Notifiable and Reportable Conduct Policy. [24]

In determining whether a breach of discipline or misconduct may have occurred, staff should seek professional advice (e.g. integrity services, management, governance, human resource or clinical expertise), and all suspected breaches of discipline must be reported to the relevant area responsible for dealing with these matters (i.e. human resources, Integrity units). If the decision is made that a breach of discipline has not occurred, a detailed summary of the decision and reasoning must be recorded.

Any complaint that raises these issues[‡] must be reported in accordance with the WA health system policies Notifying Misconduct Policy[18] and Reporting of Criminal Conduct and Professional Misconduct Policy[19] and local processes.

Where a decision is made that a breach of discipline has occurred the complainant should receive a resolution response in accordance with Section 6.12 of this Guideline, advising them of the process that will be used to investigate and manage their complaint and the complaint record should be closed.

[‡] Issues identified from 'Appendix 4: Complaint categorisation list, definitions and examples'. List may not be exhaustive.

10. Accidents and clinical incidents

Accidents and clinical incidents may become the subject of a complaint and may need to be notified to several reporting systems or bodies that are outside the complaint management process. A proactive approach is encouraged when dealing with all incidents, clinical incidents and complaints. It should be noted that the resolution of a complaint may still be possible despite adverse clinical outcomes.

10.1 Clinical incident management system

Complaints Handling Officers should liaise with an appropriate senior staff member and recommend that the clinical incident is reported through the approved[§] clinical incident management system. Staff who receive the complaint and can report via the clinical incident management system, should do so as soon as practicable and in line with the Clinical Incident Management Policy. [25]

A copy of the complaint management form may be attached to the Clinical Incident Management (CIM) form for the purpose of clarifying details of the incident. Where a complaint involves a clinical incident, it is recommended that these records are linked for monitoring and reporting purposes.

10.2 Severity Assessment Code (SAC) 1 and Sentinel events

If a complaint relates to a SAC1 clinical incident[**] that has not previously been reported, staff must notify the appropriate senior staff member of the clinical incident. The senior staff member must ensure that a SAC1 notification form is completed and forwarded to the Patient Safety Surveillance Unit within seven working days of the incident occurring, in accordance with the Clinical Incident Management Policy. [20]

10.3 Reporting SAC1 events to the Chief Psychiatrist

Under the *Mental Health Act 2014*, complaints relating to SAC1 clinical incidents 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 the completion of a SAC1 notification to the Patient Safety Surveillance Unit as required by the Clinical Incident Management Policy.

10.4 Open disclosure of incidents

In accordance with the Australian Open Disclosure Framework[26] an appropriate level of open disclosure to the patient, their family and carers should be actioned as soon as practicable. They must also have processes in place to ensure support for the teams or individual staff involved in a clinical incident is provided.

Circumstances to consider open disclosure for a consumer may include but are not limited to:

- A defined clinical incident as per the Clinical Incident Management Policy.
- Events when there is a significant clinical effect on the consumer and that is perceptible to either the consumer or the health care team.
- Events that necessitates a change in the consumer's care.
- Events with a known risk of serious future health consequences, even if the likelihood of that risk is extremely small.

[§] For more detail on approved CIMS, the CIM Guideline provides further information

[**] SAC1 includes all clinical incidents that have or could have (near miss), caused serious harm or death; and which are attributed to health service provision (or lack thereof) rather than the patient's underlying condition or illness.

- Events that requires a Health Service Provider staff to provide treatment or undertake a procedure without the consumer's consent.

11. Child Safe Complaints Process

In February 2019 the Council of Australian Governments endorsed the National Principles for Child Safe Organisations. National Principle 6 states that organisations should have processes to respond to complaints and concerns that are child focused and uphold the rights of children and young people. [7] Health Services Providers that deliver care to children and young people must have child focused complaints systems. Throughout the complaint management process the following aspects need to be taken into consideration:

- Respecting the child or young person's views.
- Adopting a trauma- informed approach.
- Ensuring that staff are confident in managing disclosures.
- Responding appropriately to complaints involving children and young people with harmful sexual behaviours.

12. Obtaining legal advice

A complaint that involves misconduct, an accident or clinical incident may result, or have the potential to result, in a medico-legal claim (against the Health Service Provider and/or the clinician(s) involved). The Health Service Provider should, as soon as practicable, notify the case to their relevant medico-legal department. Health Service Provider staff who investigate and manage complaints must ensure that they do so in accordance with RiskCover requirements.

If the Health Service Provider seeks legal advice in relation to a complaint, and Complaints Handling Officers or other relevant staff are not able to progress the complaint any further, the referral to legal officers is to be treated as an outcome of the complaint management process (for example, if legal services is engaged in relation to a claim for compensation). For reporting purposes, the complaint should be considered closed if there are no residual complaint issues that require resolution. The final response to the complainant must advise the complainant about the referral, the process that will follow, and an appropriate contact person to discuss the matter.

If legal advice is being sought to provide supporting information for the response, the complaint should remain an open case for the purposes of reporting until the response is provided to the complainant. For example, if legal advice is sought for a response that includes an admission of liability.

13. Managing challenging and unreasonable complainant conduct

All complainants have the right to have their concerns dealt with in a timely and fair manner, and to be informed about the outcome(s) of their complaint. This includes complainants with challenging or unreasonable conduct. Although the complainant may act in an unreasonable or challenging manner, the complaint may have merit and should be managed accordingly. In such situations it is important to focus on the complaint rather than the conduct of the person and to manage the complainant's expectations. [27]

Health Service Providers should support Complaints Handling Officers and all staff in the management of challenging behaviour by providing relevant training, resources and professional development opportunities.

Complaints Handling Officers should utilise all available advocacy services to assist in dealing with the complainant.

It is recognised that a small percentage of complainants may be genuinely difficult to deal with. The Western Australian Ombudsman identifies unreasonable complainants as:

- Habitual or obsessive complainants including:
    - Complainants who cannot let go of the complaint or be satisfied despite the service's best efforts to resolve the issue.
    - Complainants that make unreasonable demands on the service's resources (which may compromise the level of service provided to other consumers).
- Rude, angry and harassing complainants.
- Aggressive complainants.

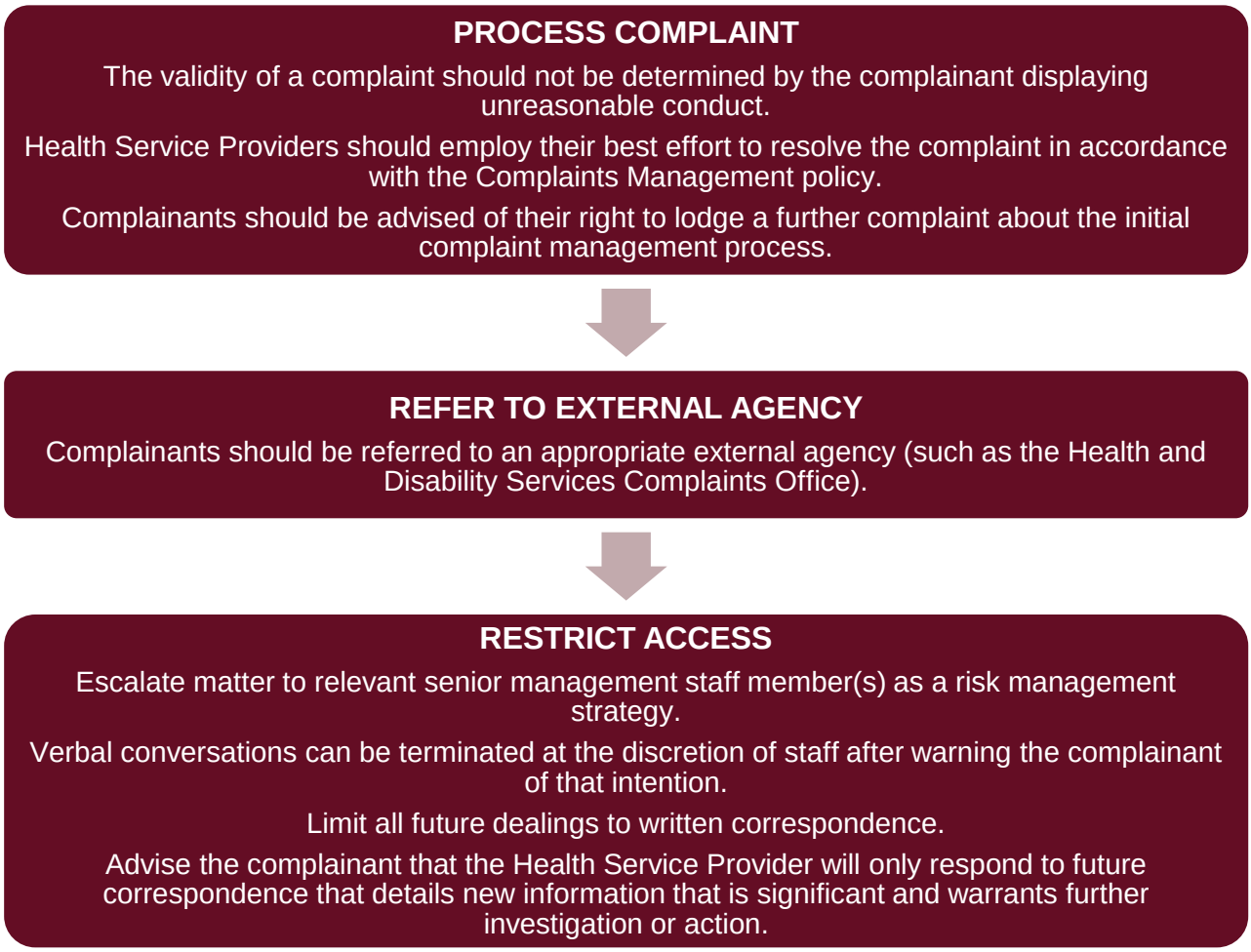
In cases where a complainant displays persistent unreasonable conduct that is not alleviated despite the Health Service Provider's best efforts to resolve the matter, a decision to restrict the provision of complaint services to the complainant may be made as a last resort measure. A restricted access to service refers only to those services provided through the Health Service Provider's complaints management processes, and not the provision of health services.

13.1 Restricting access

In making the decision to restrict, withhold or withdraw the complainant's access to the complaint management process, the following factors should be taken into consideration:

- All efforts to resolve the complaint and explain the outcome to the complainant have been made including the utilisation of available advocacy services.
- The Health Service Provider's internal review and appeal processes should be exhausted.
- The decision to restrict access to the complaint management process should not impinge on the complainant's ability to access health services.
- The resources that are diverted away from critical and/or required service activity in ongoing attempts to resolve the complaint.
- Complaints Handling Officers and other relevant staff should be compassionate to the complainant's situation, particularly if the incident in question was of a serious nature.
- In the case of multiple complaints over time each complaint should have been assessed on its own merit.
- Complaints Handling Officers and other relevant staff should be sensitive to the possibility that the complainant's medical condition may be a contributing factor in their behaviour.

Figure 5: Escalation model for the management of complainants that display unreasonable conduct



The decision to restrict access must be approved by a member of the Health Service Provider's senior leadership team. Written correspondence informing the complainant of restricted access must contain a comprehensive summary of events and a thorough explanation for the decision, and be signed by the relevant senior leadership staff member. Refer to the Complaints Management Toolkit[9] for example correspondence to vexatious complaints.

Detailed records should be kept about all correspondence and decisions in relation to restricting access.

For further guidance about handling unreasonable conduct, refer to the WA Ombudsman's Managing unreasonable complainant conduct: Practice Manual. [27]

Appendix 1: Definitions

Apology	An expression of sorrow, regret or sympathy that does not contain an acknowledgement of fault.
Carer	Someone who provides unpaid assistance and support to a family member or friend who have disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue, or who are frail and require assistance with carrying out everyday tasks.
Clinical incident	An event or circumstance resulting from health service provision (or lack thereof) which could have or did lead to unintended or unnecessary physical or psychological harm to a patient. Clinical incidents include: • **Near miss:** an incident that may have, but did not cause harm, either by chance or through timely intervention. • **Sentinel events:** a subset of serious clinical incidents that has caused or could have caused serious harm or death of a patient. It refers to preventable occurrences involving physical or psychological injury, or risk thereof.
Clinician	For the purpose of this Policy, 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 delivered by a Health Service Provider. The complainant may not be the person who was involved in the health cate episode in which case they are considered a Third Party.
Complaint	An expression of dissatisfaction by or on behalf of an individual consumer/carer regarding any aspect of a service delivered by a Health Service Provider, where a response or resolution is explicitly or implicitly expected or legally required. A complaint can be made verbally or in writing. • **Anonymous complaint:** a complaint where the complainant for whatever reason chooses to withhold identifying details. It is acknowledged that anonymous complaints may not be able to be responded to, but Health Service Providers should never the less work to resolve these types of complaints via service improvement.
Complaint category	Ten complaint categories exist to assist in identifying common factors in complaints and to ensure consistent reporting.
Complaint issue	A complaint category is further subdivided into complaint issues, which aim to accurately identify and reflect the specific matters relating to each complaint.
Complaints Handling Officer	An officer employed by a Health Service Provider who undertakes the dedicated functions of receipt, investigation or reporting of complaints; and/or fulfils a consumer liaison role (e.g. Customer Liaison Officer, Consumer Liaison Officer, Complaints Coordinator or any equivalent role).
Consumer	Any person receiving health care from a Health Service Provider either as an inpatient, outpatient or in a community setting. A consumer may also

	include carers, relatives or friends of a person receiving services from a Health Service Provider, health professionals external to the organisation or other concerned individuals, agencies or groups.
Contact/concern	Feedback from consumers/carers regarding any aspect of service where: • They state that they do not wish to lodge a complaint; and • The issue can be resolved without going through the complaint management 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.
Disability	In accordance with the *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; and b) Which is permanent or likely to be permanent; and 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.
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, and communicating information to carers regarding decisions that may impact them.
Grievance	A grievance issue is identified when the complainant has already lodged a complaint and is unsatisfied with the response to their initial complaint. This could include issues that the complainant perceives such as: • no response to the complaint • unacceptable delays to the response • an inadequate response from the health service • dissatisfaction with the outcome of the complaint • retaliation or negative outcomes as a result of making a complaint
Incident	Any event that has occurred throughout a consumer's health care experience that has resulted in the consumer expressing either satisfaction or dissatisfaction with the service (may or may not be expressed through the lodgement of a compliment or complaint).
Open disclosure	The open discussion of an incident that results in harm (or might result in future harm) to a consumer while receiving health care.
Third Party	This person may submit feedback including a complaint but will not have been the person who received health care. In this circumstance the consumer must give permission for confidential information to be made available to the third-party complainant unless the law permits disclosure.
Trauma informed approach	This involves being sensitive to lived experiences and noting that certain triggers may lead to re traumatisation and revictimization[7]

Appendix 2: Guiding Principles

Rights and responsibilities of consumers

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.
- Include support people of their choosing in the management of their complaint.
- Have information about their complaint filed separately from their medical record.
- Have personal information remain confidential within the complaint management process, unless otherwise agreed or required by 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.
- Be provided with assistance in the complaint management process if they request it.
- Feel that their access to, and treatment by, the Health Service Provider has not been compromised because they have made a complaint.

Consumers are expected to:

- Provide relevant information to staff regarding their complaint.
- Respect the role of staff and their right to respond to a complaint.
- Treat all 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 staff as soon as possible.

Promotion, accessibility and transparency of the complaint management process

Health Service Providers should encourage all consumers/carers to provide feedback, concerns and complaints by following these standard guidelines:

- Receive and accept complaints and provide opportunities to give feedback about their service.
- Acknowledge the consumer's right to complain by publicising and promoting information on how consumers and carers can lodge a complaint.
- Promote feedback by offering a variety of ways for consumers and carers to raise concerns and lodge complaints, including methods that are appropriate to specific groups.
- Encourage complainants to bring a support person to any meetings with staff.
- Provide information to consumers, carers and staff in a format that they can understand and give further explanation or assistance when requested.
- Confirm the receipt of a verbal complaint and provide a summary to the complainant in an appropriate format (e.g. written, via a translator).
- Operate a complaint management process that recognises the importance of openness, accountability, service improvement and the provision of just outcomes.
- Provide anonymity of complainants, where possible.

- Where a complaint is submitted anonymously, it is processed and managed in the same way as ordinary complaints with the exception of correspondence requirements.
- Assess all complaints against risk assessment criteria to determine the level of risk and appropriate response.
- Assess all complaints to decide the most appropriate complaint resolution process, taking into account the seriousness, complexity of the complaint and the wishes of the complainant.
- Provide assistance to staff on completing a report in response to a complaint and accessing counselling/debriefing services as necessary.
- Maintain thorough and consistent documentation of the complaint management process.
- Ensure that people with disabilities have the same opportunities as other people to make complaints.

Organisational commitment to effective complaint management

Health Service Providers should demonstrate their commitment to appropriate management of complaints regarding health care by:

- Providing sufficient resources to make sure all complaints are adequately received, managed, investigated and reported.
- Assigning the responsibility for effective complaint management to all staff.
- Developing, implementing and evaluating a defined complaint management process.
- Managing the complaint resolution process within required time frames.
- Making clearly defined information systems and ongoing training and educational resources available to enable all staff to receive and manage complaints.
- Providing support processes for staff in dealing with complaints.

Fairness and accountability

The complaint management process will ensure that:

- Complainants can withdraw their involvement with a complaint at any stage.
- The type and depth of the investigation is appropriate to each complaint, is complete and demonstrates accountability by the Health Service Provider.
- Complainants receive support during the complaint management process and expect no retribution as a consequence of lodging a complaint. 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 medical records.
- Complaint documentation is located and stored in a central location with restricted access.
- The Health Service Provider records all complaints to enable review of individual cases, identification of trends and risks, and 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 to be managed, with all such actions being documented thoroughly and clearly communicated to complainants.

Health Service Providers should strive to create a culture of accountability that includes:

- Management and 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 consumer and staff feedback.
- Each staff member accepting appropriate responsibility for safety and quality, including complaints.

Timeliness of response

Health Service Providers should demonstrate commitment to the resolution of complaints in a timely manner by:

- Acknowledging the complaint within five working days of receipt of the initial complaint.
- Informing the complainant of the approximate time that it will take to resolve the complaint.
- Commencing an investigation of the complaint within five working days of receipt of the complaint.
- Resolving complaints within 30 working days of receipt, or as soon as practicable, in the best interest of all parties.
- Advising the complainant if there is a delay and providing updates on the progress of the investigation at 15 working day intervals.

Privacy and disclosure

The Health Service Provider will ensure that:

- Documented policies and procedures on confidentiality and disclosure are understood by staff and provided to consumers and carers.
- 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 medical records – any information identifying the complainant is used only for the purpose of complaint resolution.
- Complainants 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 and how changes will be monitored.

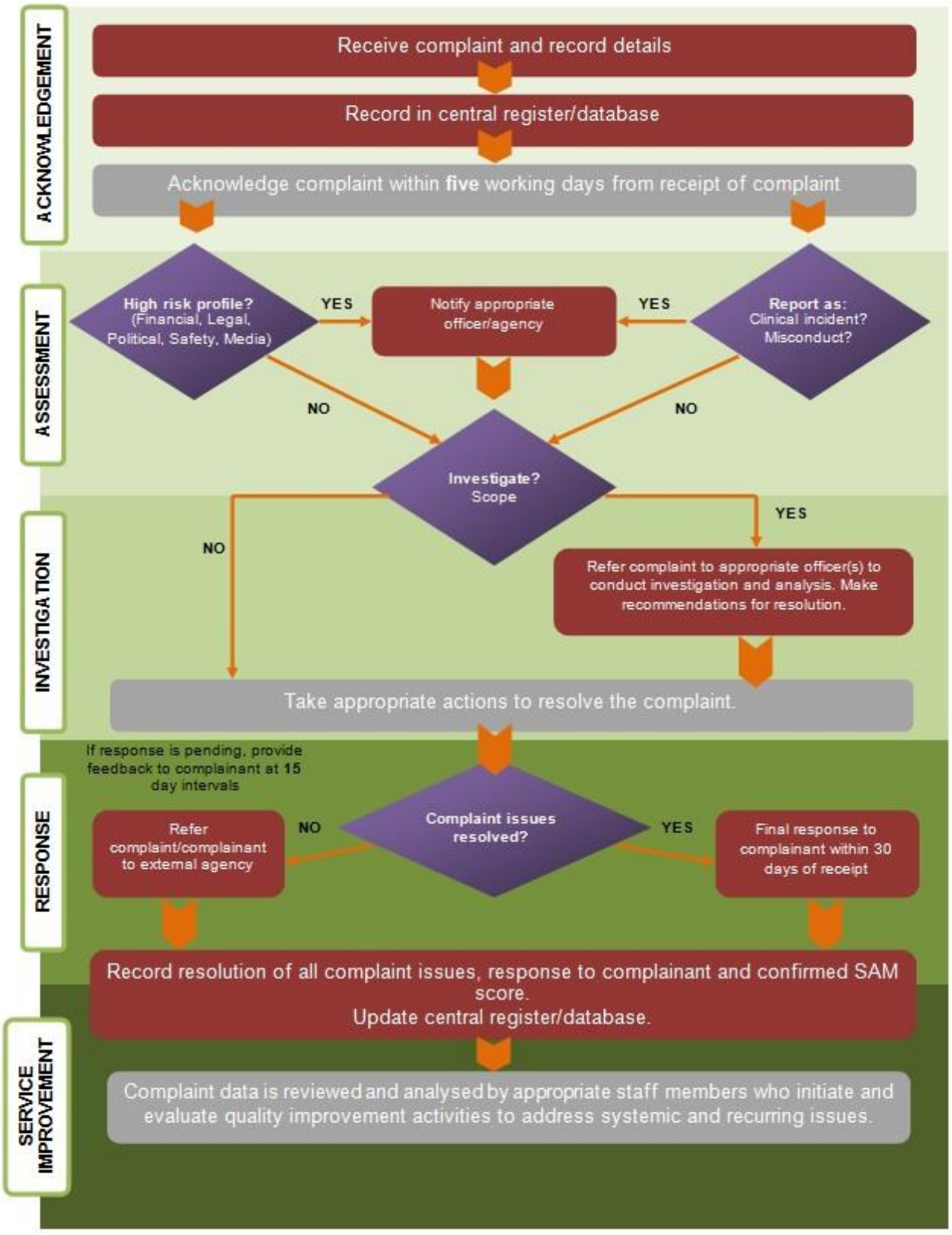
Continuous service improvement

Health Service Providers should regularly evaluate policies and practices relating to complaint management, which should include:

- Rapid and effective notification to senior staff of all complaints with significant or severe risk, with an action plan and review process to show that action has been taken.
- Ensuring relevant risks are recorded in the Enterprise Risk Management System and appropriate controls are in place to minimise the likelihood of event recurrence.
- Staff members implicated in complaints should be informed of, and included in the complaint management process.
- ‘Closing the loop’ by making sure that recommendations from complaints are implemented, reviewed and evaluated.
- Evaluating the policies and practices for complaints management to determine their effectiveness and make improvements.
- Monitoring whether complainants are satisfied or dissatisfied with the complaint resolution process.
- Auditing the complaint management system against predetermined criteria.
- Involving consumers and carers in the implementation and review of quality improvement activity where appropriate.

- Involving consumers, carers and staff in the design and evaluation of the complaint management process.

Appendix 3: Complaint Management Process Overview



Appendix 4: Complaint categorisation list, definitions and examples

This list provides a description of the ten broad complaint categories and their respective complaint issues; and, includes definitions of complaint issues, which are intended to assist complaint coordinators to recognise and record similar complaints issues in similar categories.

	TIER 1	TIER 2	TIER 3
A1.1	Access	Delay in admission/treatment	After client is at the point of service
A1.2			Excessive waiting time for diagnostic testing
A1.3			Delay in diagnostic testing leading to delay in treatment
A2.1		Waiting list delay	Unreasonable wait for elective surgery/procedure
A2.2			Waiting time to gain appointment to an outpatient clinic
A2.3			Lack of review if case becomes acute
A2.4			Further postponement after a date has been set
A2.5			Too many cancellations
A2.6			Surgery cancelled at the last minute
A3.1		Staff member or contractor unavailable	Provider fails to keep an agreed appointment
A3.2			Frequent cancellation of appointments
A4.1		Inadequate resources/lack of service	Inadequate human resources/equipment/facilities
A4.2			Lack of service
A5.1		Refusal to provide services	Refusal to admit a consumer
A5.2			Refusal to treat/accept a consumer
A6.1		Failure to provide advice about transport options when necessary	Failure to provide authorised ambulance transport
A6.2			Delay/failure to provide inter-hospital health service transport
A6.3			Failure to provide assistance for travel
A7.1		Physical access/entry	Impediment to entry to a hospital or health service
A7.2			Inadequate measures for safe and equitable access
A8.1		Parking issues	Inadequate short term parking
A8.2			Inadequate set-down/pick-up parking
A8.3			Inadequate visitor parking

	TIER 1	TIER 2	TIER 3
A8.4			Inadequate external provider parking
A8.5			Inadequate disabled parking
B1.1	Communication	Inadequate medical information provided	Inadequate information about diagnostic testing
B1.2			Inadequate information about treatment options
B1.3			Inadequate information about alternative procedures
B1.4			Inadequate information about risks
B2.1		Inadequate information about services available	Location of service not suitable
B2.2			Lack of discussion between health service and consumer
B3.1		Misinformation/failure in communication (not failure to consult)	Given inaccurate/wrong information
B3.2			Given confusing/conflicting information
B3.3			Delayed information
B4.1		Inadequate/inaccurate personal information in a medical record	Incomplete personal information in a medical record
B4.2			Inaccurate personal information in a medical record
B5.1		Inadequate written communication	No brochure/leaflet available
B5.2			No written confirmation of verbal instructions given
B5.3			No information in language other than English
B6.1		Inappropriate verbal/non-verbal communication	Careless comments or person speaking beyond their authority
B6.2			Inappropriate demeanour/non-verbal communication
B7.1		Failure to listen to consumer/representative/carer/family	No opportunity provided
B7.2			Dismissed attempts by consumer
B7.3			No appropriate staff member available
C1.1	Decision making	Failure to consult and involve in decision-making process	Failure to consult consumer
C1.2			Failure to consult consumer representative
C2.1		Choice regarding treatment as public/private patient	Classification as a public not private consumer, or vice versa
C2.2			Failure to explain options for choice of status
C2.3			Confusion between fee-for-service and public status
C3.1		Consent not informed	Inadequate information to enable informed decision
C3.2			Inadequate information about treatment options
C3.3			Inadequate information about risk/complications

	TIER 1	TIER 2	TIER 3
C4.1		Consent not obtained	Additional treatment/surgical procedure provided
C4.2			Removal of tissue/body part
C4.3			Medication administration
C5.1		Consent invalid	Not voluntary
C5.2			Did not cover procedure performed
C5.3			Given by person without legal capacity to consent
C5.4			Treatment no longer appropriate due to change in patient's circumstances
C5.5			Withdrawn and not acknowledged or acted upon
D1.1	Quality of clinical care	Inadequate assessment	Condition or injury was overlooked or wrongly identified
D1.2			Delay in assessment of new symptoms
D1.3			Inadequate level of diagnosis
D1.4			Inadequate medical history taken
D1.5			Inadequate investigation of symptoms
D1.6			Inadequate tool used for assessment
D2.1		Inadequate treatment/therapy	Negligent treatment
D2.2			Inexperience for complexity of the procedure
D2.3			Failure/delay to give emergency treatment
D2.4			Inadequate standard of performance of treatment/procedure
D2.5			Inadequate level of observation
D2.6			Inadequate amount of therapy
D2.7			Inadequate assistance with activities of daily living
D2.8			Inadequate patient education
D2.9			Inadequate pressure area care
D2.10			Wrong treatment
D2.11			Incorrect choice of treatment made/offered
D2.12			Delay in treatment
D2.13			Failure in duty of care
D2.14			Rough treatment
D2.15			Equipment and/or supplies not available
D3.1		Poor coordination of treatment	Conflicting decisions by different treating specialties

	TIER 1	TIER 2	TIER 3
D3.2			Poor communication between and within the treating teams
D3.3			Too many changes of beds/wards and/or treating practitioners
D3.4			Moved or cared for outside of own specialty area
D4.1		Failure to provide safe environment	Complaints of slips/trips/falls
D4.2			Inadequate/inappropriate use of restraints
D4.3			Inadequate assistance and/or observation
D4.4			Assistance with ambulation not offered when required
D4.5			Aids not offered or provided
D4.6			Exposure to dangerous items/equipment/people
D4.7			Assault – consumer to consumer
D4.8			Sexual assault - consumer to consumer
D4.9			Inappropriate sexual conduct - consumer to consumer
D5.1		Pain issues	Inadequate pain control
D5.2			Inadequate analgesia given before/after treatment/procedure
D5.3			Unnecessary pain inflicted during a treatment/procedure
D5.4			Delay in receiving analgesia or summoning medical attention
D6.1		Medication issues	Prescribing error (prescription/person/dose/site/time/route)
D6.2			Medication prescribed despite documented allergy/contraindication
D6.3			Dispensing error (prescription/person/dose/site/time/route)
D6.4			Drug not given or given multiple times
D6.5			Medication dispensed despite documented allergy
D6.6			Loss of patient's own medication
D7.0		Post-surgery complications	Post-surgery complications
D8.0		Post procedure complications	Post procedure complications
D9.1		Inadequate infection control	Poor hygiene practices
D9.2			Equipment not cleaned/sterilised
D9.3			Patients potentially exposed to other infectious diseases
D10.1		Patient's test results not followed up	Failure to review test results
D10.2			Failure to act on test results
D10.3			Failure to refer abnormal test results if patient discharged

	TIER 1	TIER 2	TIER 3
D11.1		Discharge or transfer arrangements	Premature discharge
D11.2			Unsuitable/delayed discharge/transfer
D11.3			Inadequate discharge planning
D11.4			Lack of continuity of care/follow-up
D11.5			Patient discharged with unplanned cannula/suture in situ
D11.6			Discharge summary incomplete, incorrect, not forwarded/provided
D12.1		Refusal to refer or assist to obtain a second opinion	Refusal to refer patient/client for specialist treatment
D12.2			Inappropriate/inadequate referral
D12.3			Delay in referring
E1.1	Costs	Inadequate information about costs	Prior to treatment/service
E1.2			Information was partial or misleading/confusing
E2.1		Unsatisfactory billing process	Item numbers used in a disadvantageous way
E2.2			Extra fees for service, normally included in global fee
E2.3			Unreasonable penalties for late payment
E2.4			Refusal to offer a range of payment options
E3.1		Amount charged	Fee/account for a particular treatment
E3.2			Fee/account for a particular procedure
E3.3			Fee/account for a particular consultation
E3.4			Fee/account for accommodation
E3.5			Parking charges
E4.1		Over-servicing	Too frequent consultations
E4.2			Ordering unnecessary tests
E4.3			Recurrent bulk billing visits to hostels/nursing homes
E4.4			Repetition to tests already completed by GP
E5.1		Private health insurance and claim handling	Private health insurance and claim handling
E6.1		Lost property	Failure to acknowledge loss/replacement/reimbursement
E6.2			Unsatisfactory process for safekeeping of consumer property
E6.3			Loss/damage of personal property
E7.1		Responsibility for costs and resourcing	Unsatisfactory facilitation of the reimbursed process
F1.1	Rights, respect and dignity	Consumer rights (Australian Charter of Healthcare Rights)	Failure to provide information about existence of the Charter

	TIER 1	TIER 2	TIER 3
F1.2			Failure to comply with the Charter
F2.1		Inconsiderate service/lack of courtesy	Lack of politeness/kindness
F2.2			Ignoring/negative attitude
F2.3			A patronising/overbearing manner
F2.4			Unhelpful manner
F3.1		Absence of compassion	Absence of compassion
F4.1		Failure to ensure privacy	Consumer's personal privacy not maintained
F4.2			Failure to offer appropriate clothing/cover
F4.3			Demeaning/humiliating care during treatment
F5.1		Breach of confidentiality	Provision of information to a third party without consent
F5.2			Careless communication and/or handling of medical records
F6.1		Discrimination leading to less favourable health treatment	On one of the civil grounds in anti-discrimination law or covenant
F6.2			Public consumer treated less favourably than private consumer
F7.1		Failure to fulfil Mental Health legislation requirements	Failure in provision of information about rights
F7.2			Failure in documentation of involuntary status
F8.1		Translating and interpreting services problems	Lack of information about the right to access an interpreter
F8.2			Lack of arrangements for an interpreter to attend when required
F8.3			Lack of availability of an interpreter
F8.4			Unsatisfactory quality of interpreter's service
F9.1		Certificate or report problem	Failure to provide a correct certificate/report when requested
F9.2			Failure to certify in accordance with the law
F9.3			Failure to pass on information to an authorised person
F9.4			Claims of falsification of a certificate
F10.0		Denying/restricting access to personal health records	Denying/restricting access to personal health records
G1.1	Grievances	Response to a complaint	No response
G1.2			Inadequate response
G1.3			Unacceptable delay in response
G1.4			Dissatisfaction with the outcome
G2.0		Retaliation/negative outcomes as a result of making a complaint	Retaliation/negative outcomes as a result of making a complaint
H1.0	Corporate services	Administrative actions of a hospital/health service	Administrative actions of a hospital/health service

	TIER 1	TIER 2	TIER 3
H2.1		Records management	Unsatisfactory storage of a medical record
H2.2			Unsatisfactory disposal of a medical record
H2.3			Loss of medical record
H2.4			Inappropriate storage of complaint record
H3.1		Catering	Unsatisfactory quality/amount/variety/temperature of food
H3.2			Unsatisfactory provision of culturally appropriate food choices
H3.3			Failure to provide suitable therapeutic diet
H3.4			Lack of consultation of consumer preferences in therapeutic diet
H3.5			Requested meals not provided
H4.1		Physical surroundings/environment	Inadequate privacy in shared facilities
H4.2			Inadequate space/facilities for consumer and their belongings
H4.3			Inadequate lighting
H4.4			Inadequate temperature control
H4.5			Poorly maintained/run down facilities
H4.6			Unacceptable noise
H4.7			Failure to enforce no smoking in designated areas
H4.8			Lack of entertainment facilities
H5.1		Security	Inadequate security measures regarding people or personal safety
H5.2			Inadequate security measures regarding personal belongings
H6.1		Cleaning/maintenance	Inadequate provision of a clean environment
H6.2			Inadequate maintenance of environment
I1.1	Professional conduct	Inaccuracy of records	Failure to document/record information given by a consumer
I1.2			Documented opinionated comments/non-substantiated conclusions
I1.3			Illegibility of records
I2.0		Illegal practices	Illegal practices
I3.0		Physical/mental impairment of health professional	Physical/mental impairment of health professional
I4.0		Sexual impropriety	Sexual impropriety
I5.1		Sexual misconduct	Any touching of a sexual nature
I5.2			Any sexual relationship with a consumer

	TIER 1	TIER 2	TIER 3
I6.0		Aggression/assault	Aggression/assault
I7.0		Unprofessional behaviour	Unprofessional behaviour
I8.0		Fraud/illegal practice of financial nature	Fraud/illegal practice of financial nature
J1.0	Carers Charter	Failure to consider the needs of a carer	Failure to consider the needs of a carer
J2.0		Failure to consult a carer	Failure to consult a carer
J3.0		Failure to treat a carer with respect and dignity	Failure to treat a carer with respect and dignity
J4.0		Unsatisfactory complaint handling of carer's complaint	Unsatisfactory complaint handling of carer's complaint

Appendix 5: Seriousness Assessment Matrix

		Seriousness of event				
		INSIGNIFICANT	MINOR	MODERATE	MAJOR	EXTREME
Likelihood of event recurrence	FREQUENT (almost certain)	3	3	2	1	1
	PROBABLE (likely)	3	3	2	1	1
	OCCASIONAL (possible)	4	3	2	2	1
	UNCOMMON (unlikely)	4	4	3	2	1
	REMOTE (rare)	4	4	3	3	1

Risk rating	Risk classification
1	Extreme risk
2	High risk
3	Moderate risk
4	Low risk

PROBABILITY CATEGORIES	DEFINITION
Frequent (almost certain)	Expected to occur again, either immediately or within a short period (likely to occur most weeks or months)
Probable (likely)	Will probably occur in most circumstances (several times per year)
Occasional (possible)	Probably will recur, might occur (may happen every one to two years)
Uncommon (unlikely)	Possibly will recur (could occur in two to five years)
Remote (rare)	Unlikely to recur – may occur only in exceptional circumstances (may happen every five to 30 years)

Seriousness Assessment Matrix (SAM) Guide

EXTREME	MAJOR	MODERATE	MINOR	INSIGNIFICANT
Consumer: Issues regarding SAC1 events, long-term damage, grossly sub-standard care or involving a death that requires investigation.	**Consumer:** Significant issues of standards, quality of care, or denial of rights. Clear quality assurance or risk management implications or issues causing lasting detriment that require investigation. Where a consumer has required surgical intervention or has suffered disfigurement or major permanent loss of function as a result of the event.	**Consumer:** Issues that may require investigation. Legitimate consumer concern, especially about communication or practice management, but not causing lasting major detriment. The consumer may have a permanent lessening of bodily functioning, increased length of stay, required an additional operation or procedure as a result of the event and/or suffered psychological distress.	**Consumer:** No impact on or risk to the provision of health care or the organisation. Feedback/complaint could be easily resolved at the frontline. Significant lapses in customer service (where no injury sustained). Consumer may have required a temporary increased level of care due to the event.	**Consumer:** Trivial, vexatious or misconceived complaint. No injury to consumer or impact on their length of stay or level of care required.
Visitors: Death of a visitor(s) or significant permanent disability of a visitor(s).	**Visitors:** Hospitalisation of a visitor(s).	**Visitors:** Medical expenses incurred or treatment of a visitor(s), but not requiring hospitalisation.	**Visitors:** Evaluation and treatment with negligible expenses.	**Visitors:** No treatment required or treatment refused.
Reputation: Highly probable legal action and likely to result in Ministerial censure. Maximum multiple high-level exposure. Loss of credibility and public/key stakeholder support.	**Reputation:** Threat of legal action and Ministerial notification and involvement. Headline profile. Repeated exposure. At fault or unresolved complexities impacting public or key groups.	**Reputation:** Potential for legal action. Repeated non-headline exposure. Slow resolution. Ministerial enquiry/briefing.	**Reputation:** Non-headline exposure. Clear fault. Settled quickly by health service response. Negligible impact.	**Reputation:** Non-headline exposure. Not at fault. Settled quickly. No impact.
Professional conduct: Serious and wilful breach. Criminal negligence or act. Litigation or prosecution with significant penalty. Possible grounds for dismissal. Ministerial censure. Criminal misconduct.	**Professional conduct:** Deliberate breach or gross negligence. Significant harm. Formal investigation. Disciplinary action. Ministerial involvement. Serious misconduct.	**Professional conduct:** Negligent breach. Lack of good faith evident. Performance review required. Material harm caused. Misconduct established.	**Professional conduct:** Breach resulting in minor harm and investigation. Evidence of good faith arguable.	**Professional conduct:** Innocent procedural breach. Evidence of good faith by degree of care/diligence. Little impact.
Services: Complete loss of service or output, serious threat to customer service relationships, or permanent harm to reputation of the service.	**Services:** Significant loss of service or output, threat to customer service relationships, or long-term harm to reputation of the service.	**Services:** Disruption to users due to agency problems. Potential to impact on service provision/delivery.	**Services:** Reduced efficiency or disruption to agency working.	**Services:** No loss of service.
Financial: Critical financial loss more than $20M.	**Financial:** Major financial loss from $3M to $20M.	**Financial:** Moderate financial loss from $100,000 to $3M.	**Financial:** Minor financial loss from $5,000 to less than $100,000.	**Financial:** No, or minor, financial loss less than $5,000.
Environmental: Extensive very long term or permanent, significant, unacceptable damage to, or contamination of significant resource or area of environment. Very long term or permanent denial of access or exposure.	**Environmental:** High level but recoverable, unacceptable damage or contamination of significant resource or area of environment. Significant intervention, permanent cessation of harmful activity. Long term suspended access, presence or use of resource.	**Environmental:** Moderate impact. Medium level intervention indicated to bring about recovery. Short to medium term restriction of access or exposure.	**Environmental:** Low level impact. Quick recovery with minimal intervention. Minimal disruption to access or exposure.	**Environmental:** Negligible impact. Spontaneous recovery by natural processes. No disruption to access or exposure.

Appendix 6: Classification of Complaint Outcomes, Resolution and Recommendations

Consumer objective

Refers to what actions the complainant feels should be taken in response to their complaint, or what outcomes should be achieved. This could include one or more of the following:

1. Registration of concern
    - Complainant wishes to bring the issue to the notice of the Health Service Provider but may, or may not, want ongoing involvement
    - Complainant does not want a response but still wants to initiate action
2. Receipt of an explanation
    - Complainant wishes to initiate an investigation and explanation of why something has occurred
3. Resolve adverse outcome (non-clinical, non-financial outcome)
    - Complainant seeks remedial action to rectify an adverse outcome (e.g. return of lost property)
4. Receipt of an apology
    - Complainant believes there has been wrongdoing and they are entitled to an apology from the Health Service Provider and/or staff member(s) involved
5. Obtain a refund/compensation
    - Costs incurred as a result of the incident
    - Damage or loss (financial, material or personal)
6. Obtain access to a service
    - Complainant expects the service previously sought to be received
7. Initiate a change in policy or practice
8. Health Service Provider to accept responsibility
    - Health Service Provider accepts and acknowledges its responsibility for the complaint. The Health Service Provider confirms that a staff member(s) has been counselled about the behaviour that was the subject of a complaint and action taken.

Resolution mechanism for the complaint issue

This refers to the actions taken to resolve a complaint issue(s). There may be multiple resolution mechanisms in response to a single complaint.

1. Concern registered
2. Explanation provided
3. Apology provided from the facility or staff member(s) involved
4. Costs refunded or reduced
5. Compensation received
6. Services provided
7. Change in practice/procedure effected
8. Change in policy effected
9. Organisation accepts and acknowledges responsibility for the complaint – employee is counselled and/or offered performance support and development in accordance with local policy
10. Complaint has been withdrawn.

Recommendations/action taken as a result of this complaint

The following list provides examples of actions that can be taken in response to the complaint:

- Recommendations are made to a relevant manager
- Quality improvement activity, including risk management initiatives and system-wide changes initiated
- Policy written or modified
- Procedure/practice modified
- Training/education of staff provided
- Staff member or affiliate counselled and/or offered performance support and development in accordance with local policy
- Duties have been modified
- No further action required.

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These references were correct at time of publication; refer to updated versions when available.

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