Sutton County Hospital District
Lillian M. Hudspeth Memorial Hospital
Sonora Medical Clinic
Sutton County Emergency Medical Service

STANDARD POLICY AND PROCEDURE

TITLE: Patient Complaint and Grievance Process

EFFECTIVE DATE: 02/26/2024

REVIEWED: 11/01/2024

REVISED:

STATEMENT OF PURPOSE:
This policy will provide a formal procedure allowing patients and/or family members to register complaints and grievances regarding the care and treatment provided by hospital district personnel and to ensure that investigation and follow-up is accomplished. The successful implementation of this process will further advance the district's goal of quality patient-centered care.

POLICY:
It is the policy of the Sutton County Hospital District to follow a systematic process for addressing patient complaints and grievances in a timely manner, consistent with federal and state regulations.

PROCEDURE:
Patients and their families will be informed upon admission of their right to express concerns regarding care and treatment as well as the procedure for doing so. A handout entitled "Expressing Concerns About Your Care" will be made available to all patients receiving care throughout the system.

TEXT:
Complaints:

- Hospital district employees receiving concerns or complaints from a patient or family member of a patient will attempt to resolve the issue(s) themselves. If a solution cannot be reached, other staff, (such as supervisors, managers/directors, or the hospital administrator) will be immediately notified to assist the patient in addressing his/her complaint.
- Complaints should be documented on a Quality Improvement Report.
- Patients who are uncomfortable sharing their concerns or complaints with hospital employees involved in their care may contact a hospital supervisor or Administration

directly. Appropriate departmental staff should be contacted to facilitate a timely resolution of the matter.

- A complaint is considered resolved when the patient is satisfied with the actions taken on his/her behalf. Staff should clearly document in the Quality Improvement Report the actions taken to address the complaint and the patient's satisfaction with the response.
- If a verbal patient care complaint cannot be resolved at the time of the complaint by staff present;
    - is postponed for later resolution;
    - is referred to other staff;
    - requires later investigation and/or further action for resolution;

  such verbal complaint is classified as a grievance and a written response is required. These matters shall be referred to the appropriate manager or director through the initiation of a Quality Improvement Report.

Grievances:

- A patient grievance is a written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient's representative, regarding the patient's care, abuse or neglect issues related to the hospital district's compliance with the CMS Hospital Conditions of Participation (CoP), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489. All verbal and written complaints regarding abuse, neglect, patient harm or hospital compliance with CMS requirements are considered a grievance.
- A written complaint (including an email or fax) is always a grievance, whether from a patient or representative. Whenever the patient or the patient's representative requests their complaint to be handled as a formal complaint or grievance or when the patient requests a written response from the hospital, then the complaint is also considered a grievance.
- Patient complaints that become grievances also include situations where a patient or a patient's representative telephones the hospital with a complaint regarding their patient care after being discharged.
- Grievances, whether written or verbal, are to be forwarded to the Quality Director or CNO and the appropriate service line (i.e. Nursing, Radiology etc.) for review and investigation. Additional distribution will be as follows:
    - Grievances that relate to physician services will be forwarded to the CEO for investigation.
        - Concerns regarding quality of patient care or premature discharge will be referred timely to the appropriate department or individuals.

Patients filing a verbal or written grievance will receive a written response from the hospital district. The time frame for investigation and response will vary depending on the nature and complexity of the grievance, the number of departments involved, and the length of time that has

elapsed since the date of the event upon with the grievance is based. On average, a timeframe of 7 days for the provision of the response would not be considered inappropriate.

If the grievance will not be resolved or of the investigation will not be completed within 7 days, the patient or the patient's representative will be informed in writing that the hospital is still working to resolve the grievance and the final response will follow in 21 days. Grievances are to be resolved as soon as possible.

- Grievances that place the patient in immediate danger must be addressed immediately.
- Billing issues are not usually considered grievances. However a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CRFR 489 is considered a grievance.

A written response to the patient is to include:

1. The name of the hospital district contact person;
2. The steps taken on behalf of the patient to investigate the grievance;
3. The results of the grievance process; and
4. The date of completion.

The response does not need to include an exhaustive explanation of every action taken to investigate or resolve the grievance but must provide adequate information to address each item.

The hospital district may use additional strategies to resolve a grievance, such as meeting with the patient and his/her family, negotiation/mediation, or other methods it finds effective. However, the district must still provide a written response to the grievance.

A grievance is considered resolved when the patient is satisfied with the actions taken on their behalf, There may be situations when appropriate and reasonable actions have been taken on the patient's behalf in order to resolve the grievance and the patient or the patient's representative remains unsatisfied with the district's actions. In these situations, the district may consider the grievance closed but must maintain documentation of its efforts to resolve the grievance.

The information obtained through the grievance process contributes to the ongoing objective of each facility to improve patient satisfaction and the quality of patient care. The data obtained from the process will be incorporated into the trended information and reported to the committee charged with oversight of the Quality and Improvement/Process Improvement activities of the district.

A Grievance Checklist (included in this policy) is a tool to assist in the grievance process. This form is available on the public forms drive.

State Licensure Agency

Patients and/or family members have the right to file a complaint with the state licensure agency regardless of whether they have attempted to resolve the matter first with the hospital. Complaints and grievances can be reported to:

Texas Department of State Health Services
Patient Quality Care Unit
Complaint Hot Line 1-888-973-0022
Fax: 512-834-6653

REFERENCES:

Centers for Medicare and Medicaid Services (CMS), Revisions to Interpretive Guidelines for Centers for Medicare & Medicaid Services Hospital Conditions of Participation 42 CFR§§482.12, 482.13, 482.27, and 482.2[online].