NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS) POLICY AND PROCEDURE

SUBJECT:	MANAGIN	G CONSUMER (GRIEVANCES	AND OTHER	FEEDBACK
NUMBER:	NN-RI-15				Page 1 of 5
ORIGINAL [DATE: 01/23	/91			
REVIEW/RE	VISE DATE:	04/22/92, 07/28	/93, 07/05/95,	07/10/97, 03/	22/01, 05/01/03,

APPROVAL	Cody L. Phinney	Agency Director				
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# I. PURPOSE

04/01/04, 10/28/04, 10/04/07, 8/19/10, 9/23/13, 1/16/14

To ensure prompt resolution of consumer/family grievances and complaints, and to consider suggestions and compliments as part of the quality improvement process.

## II. POLICY

NNAMHS shall provide an effective means for handling consumer/family grievances and for responding to suggestions and/or compliments.

# III. REFERENCES

1. 42 C.F.R. 482.13 (a)(2) Centers for Medicare and Medicaid Services (CMS), Hospital Conditions of Participation (COPs), Patient Rights.

- 2. 45 C.F.R., Part 160, 162, & 164 HIPPA Regulations.
- 3. 42 C.F.R., Part 489 Provider Agreements and Supplier Approval.
- 4. NNAMHS Policy NN-RI-14 Non-Discrimination Policy.
- 5. HealthInsight: http://www.healthinsight.org.

#### IV. DEFINITIONS

- 1. Consumer Complaint: A time-limited, immediate issue or concern which can be addressed without extensive investigation, and is resolved within 24 hours of notification; or, a post-hospital verbal complaint (usually a telephone call) that could have been resolved the same day had staff been made aware of the complaint and is resolved by staff after receiving the complaint.
- 2. Consumer Grievance: A written or verbal complaint (when the verbal complaint is not resolved within 24 hours by staff present) by a consumer or the consumer's family regarding the consumer's care, abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation or a Medicare beneficiary billing complaint.
  - a. All written letters, emails or faxes from consumers or their families are considered a grievance, whether from an inpatient, outpatient, or discharged consumer.
  - b. If a verbal consumer care complaint cannot be resolved at the time of the complaint, or within 24 hours by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation and/or requires further actions for resolution, then the complaint is a grievance.
  - c. Billing issues are not usually considered grievances for the purpose of these requirements. However, a Medicare beneficiary billing complaint about consumer rights is considered a grievance. Billing issues can become grievances if the consumer or their family states they will not pay because of care or treatment issues.

- d. All verbal or written complaints regarding abuse, neglect, consumer harm, or hospital compliance with CMS regulations are considered a grievance.
- e. Whenever the consumer or the consumer's family requests their complaint be handled as a formal complaint, or when the consumer requests a response, then the complaint is a grievance.
- 3. Resolved Complaint: A complaint is considered resolved when the consumer is satisfied with the actions taken on their behalf.
- 4. Staff Present: Any staff immediately available or who can reasonably quickly be at the consumer's location to assist with resolution (e.g., nursing, administration, nursing supervisors, physicians).
- Complaint Form: For the purposes of this policy the NNAMHS Compliments,Concerns, Suggestions Form will be called the Complaint form.

## V. PROCEDURE

- The Local Governing Body designates the Client Action Team as the committee responsible for the effective operation of the grievance process and for the review and resolution of grievances.
- 2. Consumers and their family are informed of the process by which they can express any concern upon admission to services.
  - a. The information is in the patient handbooks and posted in the hospital lobby and on both inpatient units.
  - b. The information includes the phone number used to reach the Performance Improvement Coordinator to file a complaint with NNAMHS.
  - c. The information includes the phone number used to contact the Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance, where a complaint can be filed even if a complaint has not been filed with NNAMHS.

- d. Medicare beneficiaries are notified of their right to file a complaint or request a review by the Quality Improvement Organization, Health Insight at 1-800-748-6773.
- e. Consumers are given information on where to file an external complaint with the Office of Civil Rights (OCR) if they feel they have been discriminated against or their health information privacy has been violated.
- 3. When a complaint is made every effort to resolve the issue will be made at the time of the complaint by staff involved with the consumer's care.
- If the complaint cannot be resolved, staff will instruct the consumer to complete a complaint form, or assist them in completing the form and notify their supervisor.
- 5. Depending on the situation, the supervisor, manager, Director of Nursing or Social Services, Performance Improvement Coordinator, Agency Director, or other staff will continue to pursue resolution, or investigate further on behalf of the consumer.
- 6. If the grievance is significant in nature, such as neglect or abuse or a violation of rights, the Agency Director will be notified immediately.
- 7. Once a grievance has been filed every effort will be made to complete the investigation within 72 hours unless there are extenuating circumstances. Documentation of each step is documented on the complaint form, or can be attached to the complaint form.
- 8. A written response will be provided to the consumer (or complainant) within seven (7) days of the grievance being received. The response will include:
  - a. The name of the contact person.
  - The steps taken to investigate the grievance on behalf of the consumer.
  - c. The results of the grievance process.
  - d. The date of completion of the investigation.

- e. The process to follow if the consumer is not satisfied with the response.
- 9. If more than 7 days is required to resolve a grievance, an interim acknowledgement letter will be sent to the consumer explaining that an investigation is underway.
- 10. Unless a grievance involves complex issues, extensive investigation, and the contributions of numerous individuals, all grievances shall be resolved within 30 days.
- 11. If a supervisor or manager completed a complaint form for the sole purpose of documenting a resolution of a complaint, a written response to the consumer is not necessary.
- 12. There may occasionally be situations where NNAMHS has taken all appropriate actions and the consumer or family remains dissatisfied. Per CMS COPs NNAMHS may consider the grievance resolved for the purposes of this requirement.
- 13. The procedures herein are intended to provide guidelines for the complaint/grievance process. They may be modified as necessary to ensure prompt and responsive action by the most appropriate staff in any given situation.
- 14. All complaints and grievances are tracked by the Performance Improvement Coordinator and reported monthly at the Client Action Team meeting and quarterly to Accreditation Leadership.
- 15. Compliments and suggestions can be written on the same form and are sent to the Performance Improvement Department.
- 16. Compliments and suggestions are tracked by the Performance Improvement Department.
- 17. Compliments and suggestions are forwarded to department managers and applicable staff.