Rancho Los Amigos National Rehabilitation Center

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT: PATIENT COMPLAINTS

Policy No.: B514
Supersedes: April 08, 2019
Revision Date: August 31, 2022

PURPOSE:

To establish a policy and procedure to identify, investigate, and resolve patient complaints and grievances in a timely manner at Rancho Los Amigos National Rehabilitation Center (Rancho). Complaints and grievances will be used for evaluation and improvement of quality of care/services and for peer review purposes, where appropriate. Findings under peer review purposes are considered privileged and confidential information under the California Evidence Code, Section 1157.

DEFINITION:

Workforce Member: Employees, contract staff, affiliates, volunteers, trainees, students, and other persons whose conduct, in the performance of work for DHS, is under its direct control, whether or not they receive compensation from the County.

Complaint: A verbal expression of concern or dissatisfaction made by a patient, or the patient's authorized representative, that can be resolved at the time of the complaint by staff present.

Grievance: A grievance is a written or verbal complaint made by the patient or patient's authorized representative, including but not limited to the following:

- Patient's care
- Abuse
- Neglect
- Compliance with CMS Hospital Conditions of Participation or Medicare beneficiary billing complaint
- A written (email, fax, or handwritten) complaint received from the patient or patient's authorized representative is always considered a grievance.
- Any verbal complaint that cannot be resolved at the time of the complaint, is postponed for later resolution, is referred to another staff for later resolution, or requires investigation
- Any complaint for which the patient requests a written response is also considered a grievance.

POLICY:

Rancho Los Amigos National Rehabilitation Center is committed to providing high quality and patient-centered care. Complaints and grievances received from patients and/or their authorized representatives shall be investigated and responded to in a prompt and courteous manner.
Patients and their authorized representatives are encouraged to provide feedback regarding care received at Rancho and have the right to file a complaint or grievance with their health care provider, health plan, and regulatory or accreditation agencies without being subject to coercion, discrimination, reprisal, or unreasonable interruption in care.

PROCEDURE:

1. Patients or patient's authorized representatives are informed of Rancho's grievance process through "Patient Rights" posters within the facility, the Patient Handbook, and the Guiding Principles of Care.

2. Any patient, who perceives he/she/they has been denied an essential service, believes a procedure or treatment has been improperly administered or omitted, or feels that care has been given in an insensitive or disrespectful manner, may file a complaint or grievance.

3. Any employee who is approached with a complaint should attempt to resolve the issue. If this cannot be done successfully or immediately, the complaint should be referred to the first line supervisor/Nurse Manager of the person or department against whom the complaint is made.

4. The complaint may be elevated up the chain of command for resolution, as needed.

5. If the patient/authorized representative is not satisfied with the resolution/action taken, they should be directed to the Patient Advocate's Office.

6. The Patient Complaint (PCF) Form (attachment) will be provided to any patient or patient's legal representative who wishes to file a formal written complaint. The forms may be requested from the nurse or the Patient Advocate. The person receiving the complaint may assist the complainant in completing the form.

Note: If the complaint/concern alleges harm or potential harm to the patient or the individual making the complaint, as applicable, the person receiving the complaint will notify the patient's provider, nursing administration/resource office, and area administrator and complete a Safety Intelligence online event notification report prior to end of shift.

7. When the Patient Advocate Office is contacted directly by the patient/authorized representative, the Patient Advocate will:
   a. Enter the complaint in the Safety Intelligence online Complaints Module.
   b. Send an action consult to the unit/department supervisor(s) or workforce member(s) responsible for investigating the complaint. If response to consult is not received within 7 days, the complaint will be elevated via chain of command.
   c. Send an action consult to Regulatory/Accreditation Director if the complaint involves allegation of abuse by workforce member or allegation of protected health information breach or HIPAA violation.
   d. Consult with CSW for complaints requiring a meeting with the patient/next of kin and clinical team.
   e. Notify the patient/authorized representative of the findings/results of the complaint investigation within 30 days, unless further information is required to complete the investigation beyond 30 days. Provide an update to the complainant as needed.
   f. Provide a claim form (attachment) as needed and notify Risk Management at X57900.

8. In cases involving State Accountability patients (Medi-Cal), there must be a finding of fact and resolution within 30 days of receipt of the grievance. In those cases where the grievance cannot be resolved, there must be entry of notations to that effect in the record. The notations must include the reasons why the grievance could not be resolved and the individual responsible for that decision. Any complainant wishing to appeal the resolution of a complaint may do so, in writing to: State Department of Health Services, Medi-Cal Operations Division, Contract Officer, P.O. Box 942732, 714 P Street, Sacramento, CA 95814.

9. Cases involving complaints regarding the provision of language interpretation or translation services to patients/families with limited English proficiency shall be referred to the Patient

Advocates Office. The Patient Advocate will facilitate a resolution to the complaint and advise the complainant that they have the right to file a formal complaint with the facility or with the Department of Health and Human Services, Office for Civil Rights, 50 United Nations Plaza, San Francisco, CA 94102.

10. The Patient Advocate will log and monitor resolution of all patient complaints. This information is compiled, tracked and is available for review upon request from the Chief Operations Officer, Chief Nursing Officer, Risk Management, Area Administrators and Service Councils for performance improvement initiatives.

11. Patient complaints and their resolutions must be maintained in a file for a period of four (4) years, if a possibility of litigation exists, the file is maintained for a period of five (5) years. Files will be maintained in the Patient Advocates Office.

AUTHORITY:

Federal Register
Title XXII of the California Administrative Code
Joint Commission on Accreditation of Healthcare Organizations, Patient Rights and Organization Ethics.

OTHER PATIENT RELATED POLICIES:

Policy-DHS 322.100 Patient Complaint and Grievance Management
Policy - Patient Rights and Responsibilities
Policy - Patient Rights to Informed Participation in Decisions Regarding Care
Policy - Considerate and Respectful Care of Patients
Policy - Policy for Addressing Patient Rights and Ethical Issues
Policy - Problematic Patient Behavior
Policy - Reporting of Patient Abuse and Neglect by Staff

Attachment I	Patient Complaint Form
Attachment II	Claim Form

SV:GS:jm
CD:CB
VR:CB

Revisions: 04/06/2006, 01/21/2007, 04/22/2016, 04/08/19, 7/08/22

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER

Patient Complaint/Concern Form
Forma De Quejas Para Pacientes

SECTION I: **TO BE COMPLETED BY PATIENT OR STAFF (Para Ser Completado Por El Paciente o Por El Personal De Rancho Los Amigos)**

Patient Name/:_____ Today's Date/Fecha**:**_____Rancho#:_____
Nombre del Paciente

Patient Telephone/Telefono #: Home/Casa:**(_____)**_____ Work/Trabajo: **(_____)**_____
Area Code Area Code

COMPLAINT/QUEJA:

SECTION II: **TO BE COMPLETED BY STAFF (Para Ser Completado Por El Personal De Rancho)**

Date of occurrence:_____ Time of occurrence:_____ Unit/Location:_____
Service:_____ Department:_____

Who brought the concern to staff's attention:

Patient ( ) Relative ( ) Friend ( )
Staff ( ) Other Patient ( ) Other ( )_____

Complaint referred: In person ( ) Telephone ( ) Letter ( )

Name of employee documenting complaint:_____
Copy to Area Administrator: yes ( ) Name:_____ Date:_____
Copy to Patient Advocate: yes ( ) Name:_____ Date:_____

COMPLETE RESOLUTION ON REVERSE SIDE OF THIS FORM

IF THIS COMPLAINT/CONCERN INDICATES EVIDENCE OF HARM OR POTENTIAL HARM TO THE PATIENT OR INDIVIDUAL MAKING THE COMPLAINT, AN EVENT NOTIFICATION REPORT MUST BE COMPLETED.

RESOLUTION/ACTION TAKEN

Name of employee completing resolution section: _____

Date: _____

Problem Resolved **Yes ( )** **No ( )**

Patient appears satisfied **Yes ( )** **No ( )**

THIS FORM IS TO BE FORWARDED TO THE PATIENT ADVOCATE OFFICE WITHIN 24 HOURS OF COMPLETION (HB 105).

This document is used for Medical Staff Quality Improvement and Peer Review

CLAIMS FOR DAMAGES TO PERSON OR PROPERTY

TIME STAMP
OFFICE USE ONLY

COUNTY OF LOS ANGELES

INSTRUCTIONS:

1. Read claim thoroughly.
2. Fill out claim as indicated; attach additional information if necessary.
3. Return this original signed claim and any attachments supporting your claim. This form must be signed.

DELIVER OR U.S. MAIL TO:
EXECUTIVE OFFICER, BOARD OF SUPERVISORS, ATTENTION: CLAIMS
500 WEST TEMPLE STREET, ROOM 383,
KENNETH HAHN HALL OF ADMINISTRATION, LOS ANGELES, CA 90012
(213) 974-1440

1. ☐ Mr. ☐ Ms. ☐ Mrs. LAST NAME | FIRST NAME | M.I.

2. ADDRESS OF CLAIMANT

CITY | STATE | ZIP CODE

HOME PHONE ( ) | ALTERNATE PHONE ( )

3. CLAIMANT'S BIRTHDATE:

4. CLAIMANT'S SOCIAL SECURITY NUMBER

5. ADDRESS TO WHICH CORRESPONDENCE SHOULD BE SENT

STREET | CITY, STATE | ZIP CODE

6. DATE AND TIME OF INCIDENT

7. WHERE DID DAMAGE OR INJURY OCCUR?

STREET | CITY, STATE | ZIP CODE

8. DESCRIBE IN DETAIL HOW DAMAGE OR INJURY OCCURRED AND LIST DAMAGES (attach copies of receipts or repair estimates):

9. WERE POLICE OR PARAMEDICS CALLED? YES ☐ NO ☐

(IF YES) AGENCY'S NAME _____ REPORT # _____

CHECK IF LIMITED CIVIL CASE ☐

TOTAL DAMAGES TO DATE | TOTAL ESTIMATED PROPECTIVE DAMAGES

$_____ | $_____

10. WHY DO YOU CLAIM COUNTY IS RESPONSIBLE?

11. NAMES OF ANY COUNTY EMPLOYEES (AND THEIR DEPARTMENTS) INVOLVED IN INJURY OR DAMAGE (IF APPLICABLE):

NAME | DEPARTMENT

NAME | DEPARTMENT

12. WITNESS(ES) TO DAMAGES OR INJURY: LIST ALL PERSONS AND ADDRESSES OF PERSONS KNOWN TO HAVE INFORMATION:

NAME | PHONE ( )

ADDRESS

NAME | PHONE ( )

ADDRESS

13. IF PHYSICIAN(S) WERE VISTED DUE TO INJURY, PROVIDE NAME, ADDRESS, PHONE NUMBER, AND DATE OF FIRST VISIT FOR EACH:

DATE OF FIRST VISIT | PHYSICIAN'S NAME | PHONE ( )

STREET | CITY, STATE | ZIP CODE

DATE OF FIRST VISIT | PHYSICIAN'S NAME | PHONE ( )

STREET | CITY, STATE | ZIP CODE

THIS CLAIM MUST BE *SIGNED*

NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY (PENAL CODE SECTION 72)

CLAIMS FOR DEATH, INJURY TO PERSON OR TO PERSONAL PROPERTY MUST BE FILED NOT LATER THAN 6 MONTHS AFTER THE OCCURRENCE. (GOVERNMENT CODE SECTION 911.2)

ALL OTHER CLAIMS FOR DAMAGES MUST BE FILED NOT LATER THAN ONE YEAR AFTER THE OCCURRENCE. (GOVERNMENT CODE SECTION 911.2)

14. PRINT OR TYPE NAME | DATE

15. SIGNATURE OF CLAIMANT OR PERSON FILING ON HIS/HER BEHALF GIVING RELATIONSHIP TO CLAIMANT | DATE