

<b>State of New York</b> <b>OFFICE OF MENTAL HEALTH</b> <hr style="width: 20%; margin: 10px auto;"/> <b>OMH</b> <b>OFFICIAL POLICY MANUAL</b>	<b>Date Issued</b> 10-01-01	<b>T. L.</b> 01-09	<b>Section #</b> QA-500
	<b>Section</b> Patient Care		
	<b>Directive</b> Patient Complaint Resolution Process		

A. **Policy Statement:**

It is the policy of the Office of Mental Health to fully respect a patient's right to register complaints about any aspect of his or her care or treatment, and to ensure that such complaints are addressed by the treating facility in a timely manner.

The issues patients may raise about their care and environment can range from fairly minor concerns that can be quickly and easily resolved in the course of a facility's normal daily operations to more serious matters that need to be addressed through a formal patient complaint resolution process. While many times it is preferable for patient complaints to routinely be resolved informally on a day to day basis with the patient's primary therapist, in some cases, it is not possible to immediately resolve the issues raised in a complaint and the registering of a more formal complaint is desirable or necessary.

This policy directive sets forth the principles for the development of a responsive review process to facilitate prompt and fair resolution of patient complaints. While individual facilities may tailor their own complaint resolution policies to best meet their unique needs, this policy directive sets forth a basic floor of requirements that must be included in all such individual facility policies and is not intended to inhibit the use of additional helpful approaches in handling patient grievances. In this regard, facilities may wish to supplement this policy with the use of additional tools to resolve patient complaints, such as meeting with the patient and his or her family, or other methods it finds effective.

This policy directive, which is effective immediately, is applicable to all state-operated psychiatric facilities and programs.

B. **Relevant Statutes and Standards:**

42 C.F.R. §482.13  
42 C.F.R. §489.27  
JCAHO Hospital Accreditation Standards RI 1.3.4  
Mental Hygiene Law §33.02  
NYS OMH Prepaid Mental Health Plan - Quality Assurance Complaint Resolution Process

C. **Definitions:** For purposes of this policy directive:

1. *Complaint* means any formal written or verbal grievance that is filed by a patient when a patient issue cannot be resolved promptly by the staff present<sup>1</sup>.

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<sup>1</sup> Events which have or may have an adverse effect on the life, health, or welfare of a patient and/or another person are classified as *incidents*. For those events, the procedures of OMH Policy QA-510 shall apply. Also note that this policy directive does not apply to the administrative review procedures arising out of a patient's right to make informed decisions regarding his or her care, which are addressed elsewhere in 14 NYCRR Parts 27 and 527, as applicable.

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2. *Minor* means an individual under eighteen years of age.

3. *Patient* means and includes:

a) for adults: each individual for whom a clinical record is maintained or possessed by a facility or program and, if applicable, his or her legally appointed guardian; and

b) for minors: each individual for whom a clinical record is maintained or possessed by a facility or program and his or her parent, unless clinically counterindicated, or legal guardian.

**D. Body of the Directive:**

1. Each facility which provides treatment services must establish a process for prompt resolution of all patient complaints and must ensure that each patient is informed as to whom to contact to file a complaint and appeal a complaint determination<sup>2</sup>.

2. The Facility Director must review and approve, and shall be responsible for, the effective operation of the complaint resolution process.

3. Governing principles. At a minimum, the following governing principles must be included in a facility's complaint resolution process:

a) Patients should have reasonable expectations of care and services and facilities must address these expectations in a timely, reasonable, and consistent manner.

b) Patients have the right to make complaints about any aspect of their care and treatment.

c) The right to make complaints may not be limited by the facility as a means of punishment or for the convenience of staff.

d) The complaint resolution process shall assure patient confidentiality.

e) Whenever possible, complaints should be resolved by beginning with direct care staff and progressing through administrative levels as necessary.

4. Complaint resolution process. The following provisions must be included in a facility's complaint resolution process:

a) Notification procedures

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<sup>2</sup> Patients who are enrolled in PMHP shall be subject to the procedures set forth in the PMHP Quality Assurance Complaint Resolution Process.

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1) The process shall include provisions designed to assure that each patient receives written information about the complaint resolution process upon his or her admission to a program and again upon his or her request. With the patient's consent, such information shall also be provided to the patient's family member or significant other.

i) Each patient must be advised that he or she has the right to file a complaint with the Bureau of Quality Management in Central Office, regardless of whether or not he or she chooses to use the facility complaint resolution process.

ii) Inpatients who are Medicare beneficiaries must be advised of their right to file complaints about quality and concerns about premature discharge to the Independent Peer Review Organization (IPRO)<sup>3</sup>.

2) Such information shall clearly explain the facility's complaint resolution procedure and identify who a patient should contact if he or she wishes to access the complaint resolution process and file a complaint. Information regarding access to the Office of Mental Health Customer Service line(1-800-597-8481) shall also be provided.

3) Each patient should also be advised of his or her ability to appeal the facility's determination with regard to a complaint and shall be informed how to do so in accordance with D)4)e) of this policy directive.

4) As required by Section 33.02 of the Mental Hygiene Law, a notice of rights shall be posted in each ward or living area of each facility, which shall include the address and telephone number of the facility director, a designee responsible for receiving questions or complaints, the Board of Visitors, Mental Hygiene Legal Services, and the Commission on Quality of Care for the Mentally Disabled.

b) Form of complaints. Procedures must permit and address the processing of complaints made in either verbal or written form.

c) Time frames. The complaint resolution process must specify that, upon receipt of a complaint by a patient, the facility's decision with regard to the complaint shall be provided to the patient in writing within ten business days of such receipt<sup>4</sup>,

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<sup>3</sup>Note that a facility is not required to automatically refer each Medicare beneficiary's complaint to IPRO; however, the facility must inform the beneficiary of this right and comply with his or her request if the beneficiary asks for IPRO review.

<sup>4</sup>The expectation is that each facility will have a process to implement a relatively minor change in a more timely manner than a written response. For example, a change in bedding, housekeeping of a

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provided, however, that complaints related to the safety of patients or others shall receive immediate action<sup>5</sup> In unusual circumstances wherein an investigation into a complaint will require more than ten business days to complete, the facility shall advise the patient in writing of same within ten business days of receipt of the complaint and shall specify in such writing when the facility's decision will be forthcoming.

d) Written decision. For all filed complaints, the Facility Director, or his or her designee<sup>6</sup>, must review and timely render a determination in a written decision<sup>7</sup> that shall be communicated to the patient in a language and manner the patient understands. The written decision shall include:

- 1) the name of the facility contact person regarding the complaint;
- 2) a summary of the steps taken on behalf of the patient to investigate the complaint;
- 3) the results of the complaint resolution process; and
- 4) the date of completion.

e) Appeal of decisions.

- 1) Each facility shall develop a process to be followed if a patient wishes to appeal a complaint determination. This process may include a second level of review within the facility. Appeals shall be processed in a timely fashion and decisions shall be provided to patients in written form.
- 2) If a patient's complaint resolution attempts are unsuccessful at the facility level, the patient shall be informed that he or she may contact the

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room, or serving more preferred food/beverages may be made relatively quickly without a written facility response.

<sup>5</sup>For example, complaints about situations that endanger the patient, such as neglect or abuse, must be reviewed immediately, given the seriousness of the allegations and the potential for harm. Furthermore, cases in which the safety of patients or others is at issue qualify as incidents and must be processed as such in accordance with OMH Policy QA-510.

<sup>6</sup>A Facility Director may elect to establish a Complaint or Grievance Committee, to whom it may delegate the responsibility of reviewing and resolving complaints.

<sup>7</sup>While facility determinations of filed complaints must always be provided to a patient in writing, prefacing or supplementing the written response with a verbal, face-to-face contact, with written documentation of such contact, should also be utilized whenever feasible to facilitate meaningful resolution of complaints.

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Bureau of Quality Management in Central Office for further review. In addition, the facility may remind the patient of the availability of Peer Advocates or other appropriate resources for additional assistance in resolving complaints.

5. Recordkeeping and Reporting.
  - a) Each facility must establish a process for recording and monitoring all complaints received. Such process shall include a description of how, and the date upon which, each complaint was resolved. The process shall also identify whether or not the patient was satisfied with the outcome of the process, wherever possible.
  - b) Each facility must aggregate its complaint data and analyze it as part of its performance improvement program, identifying systemic trends or patterns, as possible.
  - c) Each facility must include such analysis of its aggregate complaint data in its annual report to the Governing Body.
  
6. Staff Education & Training. Each facility will make available education and training relating to the implementation of this policy directive to all staff having direct patient care responsibilities.