Subject: Patient Relations and Complaints Process	Doc ID #: ADM-PR-VI-01
Manual: Administration	Printed copy is not a controlled document. Electronic document is the most current version. Accessible formats available upon request
Category: Public Relations	Page: 1 of 6
Reviewed by: CEO	Next review date: September 6, 2028
Approved by: CEO	Approved Date: September 6, 2025

1. PURPOSE:

Red Lake Margaret Cochenour Memorial Hospital's (RLMCMH) goal is to provide excellent care. Our Patient Relations and Complaints Policy provides Patients and Care Partners with a mechanism to bring forward concerns, suggestions, and comments to support excellence in every care experience.

RLMCMH's values, vision, and mission drive us to address concerns and complaints with a patient-focused, just culture approach, making local and systemic improvements in a climate of accountability.

2. POLICY STATEMENT:

RLMCMH is committed to continuously improving service quality. We welcome our Patients' and Care Partners' feedback.

Our complaints resolution process will provide Patients and Care Partners with a clearly defined and accessible point, to make it easy for concerns to be raised. All comments, suggestions and complaints will be reviewed and recommendations for improvement made where appropriate.

Accessible formats for feedback will be made available upon request.

3. PRINCIPLES

- The Director of Quality, Risk, and Support Services leads the complaint process.
- The review of complaints/compliments may include managers/team leaders, physicians, staff and senior management at the discretion of the CEO and/or Director of Quality, Risk, and Support Services.
- The Director of Quality, Risk, and Support Services logs and tracks the complaints and maintains files.
- All patients will be made aware of their right to voice concerns and shall have information on how to use the complaints procedure. This information shall be shared

via posters, pamphlets, patient information binders and a link on the public internet site which includes a direct email address to the CEO.
- The Patient's care shall not be adversely affected by having made a complaint.
- Patient complaints will be tracked and trended and used to improve systems and service.
- Aggregate data will be reported to the Quality Committee of the Board, Medical Advisory Committee (MAC) and Senior Leadership Team (SLT) by the Director of Quality, Risk, and Support Services.

Verbal Complaints to Front-line Staff:

- All staff have a role in addressing patient concerns as soon as they become aware of these concerns. Whenever possible, staff should make every effort to resolve the complaint at point-of-service by endeavoring to meet the needs of the patient within the limits of the professional's ethics, appropriateness of care and the policy and procedures of the organization.
- Staff may seek assistance or involve their manager/service leader/after-hours administrator on-call in addressing a concern as needed.
- If the complainant prefers to voice their concern to someone not involved in the service area or if the complainant is not satisfied with the response, he or she should be directed to contact the CEO, CNE, or the Director of Quality, Risk, and Support Services.

INITIAL ACKNOWLEDGEMENT:

- Verbal complaints that are not resolved at the point-of-service and all written complaints should be directed to the CEO. The CEO will either respond to the complainant or direct the complaint to the Director of Quality, Risk, and Support Services for resolution. Acknowledgement to the complainant shall occur within two business days.
- The CEO, Director of Quality, Risk, and Support Services or CNE will receive and document the complaint in our incident reporting system (RL) and verify its accuracy and completeness with the complainant.
- The CEO or CNE will forward information to the Director of Quality, Risk, and Support Services for logging/tracking purposes.

INITIAL CONTACT:

- The preferred mechanism for resolving complaints is through discussion with the Patient/Care Partner.
- Empathy and clear, complete explanations may satisfy the complainant. In the normal course of delivering patient care, there may be areas in which there is a perception of or actual room for improvement. An apology that RLMCMH was unable to meet their expectation of service and assurances that attempts will be made to improve service delivery in the future may also be appropriate.

If the issue is not resolved during this initial contact, the CEO/CNE or Director of Quality, Risk, and Support Services will:

- Offer to arrange a meeting with the Patient/Care Partner and relevant stakeholders to discuss their concerns
- Seek clarification of the issues
- Describe the process for investigation, including timelines
- Obtain consent to investigate: if the complainant is someone other than the patient, the investigator must obtain permission from the patient or their substitute decision maker to begin an investigation
- Ask the complainant what resolution they would like to see.

Complaints Involving a Physician:

When a complaint involves the care provided by a Physician, the CEO shall be informed. The Chief of Staff will assist in the review of the complaint and is responsible to:

- Ensure the Physician has reviewed the matter
- Provide input or assist in the resolution of sensitive issues
- Assist in the development of a final response to the patient/family
- Participate in a meeting with the patient/family as required for resolution of the issue
- Follow RLMCMH's professional bylaws, and appropriate regulations/legislation

Complaints Involving Staff or Hospital Services:

When necessary, a Manager shall assist the Director of Quality, Risk, and Support Services in conducting the review of the complaint in their relevant service area.

When a complaint involves a Staff member, it is the responsibility of the Manager to:

- Ensure all Staff named in the complaint are informed in a timely, sensitive and supportive manner, including review of the contents of the complaint letter/verbal summary
- Review the circumstances of the complaint with the Staff involved
- Provide the results of the review to the CEO/Director of Quality, Risk, and Support Services in the standard time frame
- Make recommendations for improvement when indicated

When a complaint involves a manager, it is the responsibility of the CNE/CEO to conduct the review of the complaint and make recommendations for improvement when indicated.

When a complaint involves the CNE, it is the responsibility of the CEO to conduct the review of the complaint and make recommendations for improvement when indicated.

When a complaint involves the CEO, the Chair and/or Vice Chair will consult with the Board to conduct a review of the complaint and make recommendations for improvement when

indicated. The Board Chair and/or Vice Chair will work with the Director of Quality, Risk, and Support Services Management to ensure due process is followed.

DOCUMENTATION:

When a complaint is made:

- Document all discussion with people in relation to the complaint handling including telephone calls.
- Document the issues objectively in clear unambiguous language.
- Document the information in chronological order, recording date and time of entry.
- Documentation will be filed in the office of the Director of Quality, Risk, and Support Services, and, as appropriate, in the RL system.

RESPONSE:

Personal discussions such as face-to-face or telephone calls are the best approach to respond to concerns or complaints. An additional written response may be appropriate when there are complex or contentious issues to document.

Letters of response related to Hospital Staff or services:

- Letters will be written by CEO/CNE/Director of Quality, Risk, and Support Services in collaboration with the Manager of the service area.
- The letter will be signed by the CEO.
- A copy of the final response will be forwarded to the Manager.
- Managers will share the contents of the response with the staff named in the complaint.

Letter of response related to CEO:

- Letters will be written by the Board Chair and/or Vice Chair in consultation with legal counsel.
- A copy of the final response will be forwarded to the CEO.

Letters of response in Physician complaints:

- Letters will be formulated by the CEO/Director of Quality, Risk, and Support Services in collaboration with the Chief of Staff:
- The letter will be signed by the Chief of Staff.
- A copy of the final response will be forwarded to the Physician involved.
- A copy of the letter will be kept in a locked file in the office of the Director of Quality, Risk, and Support Services

The final response may include:

- Information relevant to complaint
- Explanation of the events

- Reasons for decision
- A description of changes that have resulted from the complaint
- An apology whenever appropriate
- Thanks to the complainant for their feedback.

Response to Complaints involving service providers under contract to Home and Community Care:

The CEO shall:

a. Immediately report the complaint to the Ontario Health at Home (OHH);

b. Provide a written record of the complaint to the OHH as soon as practicable.

c. Inform Ontario Health at Home of the Service Provider's response to the complaint; and

d. If requested by OHH, provide written status updates to OHH on any investigation commenced by the Service Provider.

PROCESS IMPROVEMENT PROJECTS

The Manager of the service area is responsible for initiating any process improvement plan that results from the complaint and investigation. The process improvement plan will be reported to the Director of Quality, Risk, and Support Services for inclusion in the report to the Quality Committee of the Board and Medical Advisory Committee (MAC).

HIGH RISK: Adverse events

If a complaint reveals a case of possible negligence, significant risk to patient safety or the likelihood of legal action then the complaint shall be deemed to be an adverse event. Investigation will be immediately paused and a decision made with regard to investigation under a Quality of Care review as regulated under Quality of Care Information Protection Act (QCIPA). The Patient or Care Partner who initiated the complaint shall be advised that the Quality of Care Committee is investigating the adverse incident.

TARGETED TIMELINES:

The CEO/CNE will respond to complaints within the following time parameters, subject to change should the circumstances require:

- Verbal/written acknowledgement of complaint to the complainant: two (2) business day, or as per complainant availability

- Completion of investigation: 28 calendar days
- Response to complainant: 30 calendar days or as per complainant availability

QUALITY MONITORING AND REPORTING

- A consolidated report will be forwarded to the Quality Committee of the Board, MAC, Senior Leadership Team and the Nursing department on a quarterly basis by the Director of Quality, Risk, and Support Services.
- The report will identify key themes and will include initiatives undertaken to improve quality of care and service.
- The information will inform the development of the annual Quality Improvement Plan (QIP) under the Excellent Care for All Act.

4. RESOURCES AND REFERENCES:

Toronto East General, 'Complaint and Recovery Process'
Credit Valley Hospital, 'Patient Feedback Program' 2005
Bloorview Kids Rehab, 'Issue Resolution Process'
Humber River Regional Hospital, 'Compliments and Concerns Process' (2007)
Massachusetts General Hospital, 'Developing a Patient Advocacy Program'
Northwestern Medical Center, 'Complaint Process'
University Health Network, 'Clinical – Patient Compliments & Complaints' 2006 York Central Hospital, 'Patient Concerns Resolution Process', 2007
Markham Stouffville Hospital, 'Complaints/Compliments Process', 2004
Dryden Regional Health Centre, 'Complaints Resolution and Compliments Policy'
Excellent Care for All Act