Complaints Management System

Complaints Officer User Manual

NCGLT

January 2023

Contents

Introduction to Complaints on the Complaints Management System

This manual goes through the steps of how a **Complaints Officer** should record a formal Complaint on the Complaints Management System.

A formal complaint is made up of a number of different parts. These are stored and tracked on the Complaints Management System in two different places.

1. Occurrences [Complaint & Complainant details]
2. Incidents [Issue(s)]
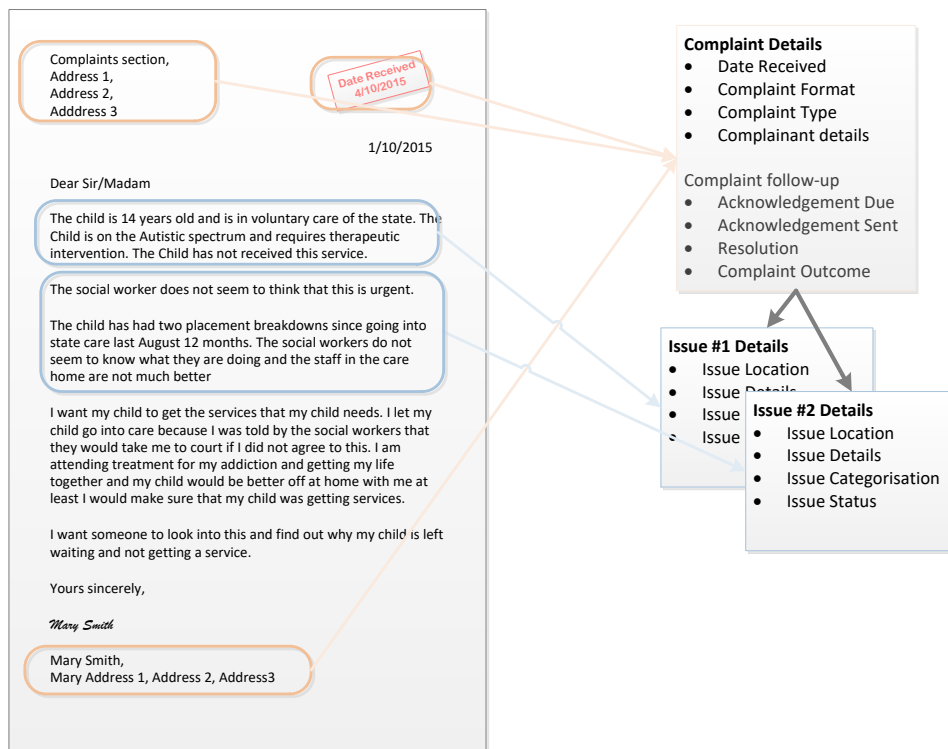
Complaint: There are standard details on the letter that are stored at the complaint level. This includes

- **When** did we receive the complaint?
- **Who** is it from?
- **How** did it arrive?

Once the complaint is saved there are additional details that are stored as part of the complaint, and will be accessed as the complaint moves through it life-cycle.

- When do we **need to acknowledge** the complaint?
- When did we **actually acknowledge** the complaint?
- When do we **need to respond** to the complaint?
- What was the **overall resolution and outcome** of the complaint?

Issue: each complaint will contain one or more separate issues. These are the individual issues that are listed within the letter and may involve investigation by different members of the organisation. These separate investigations have different life cycles to be tracked, and we can't respond to the overall complaint until each issue has been resolved.

- Where was the issue **located**?
- Who is **responsible** for the issue?
- How do we **categorise** the issue?

Finally there is a third entity called a **recommendation**. These are used after the investigation to record any recommendations that have been made in relation to each issue in the complaint.

Logging In

1. Open https://www.riskonnectclearsight.eu/Enterprise/login.cmdx??c=NIMS Chrome/MS Edge now the preferred NIMS browsers. Do not use Internet Explorer.

Welcome to Enterprise/ClearSight login

Please enter your user information.

Client ID   NIMS

User ID

Password

Forgot your password?

LOG IN TO NIMS

2. Enter your *User ID* & *Password* and click **LOG IN**
   My NIMS Dashboard

Note: You will have received your username and password by email from DoNotReply@ntma.ie
If you forget your password, or it expires, select "Forgot your password?"

If you do not have a username and password you can request one by filling out the NIMS (CMS) User Set Up Request Form: Complaints Management System which can be found here:
https://www.hse.ie/eng/about/qavd/complaints/ncglt/toolkit/cmstoolkit/forms.html

This should be returned completed to **cmstraining@hse.ie**

Dashboard

Select FC – Formal Complaints under Dashboard dropdown arrow options for panels specific to complaints.
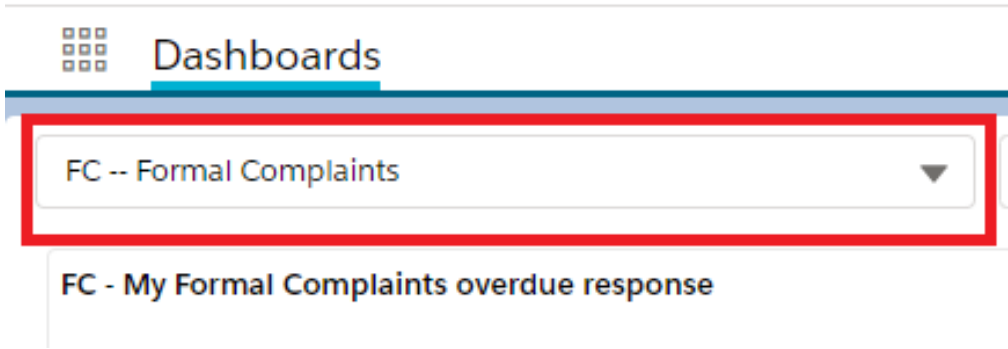
Dashboards that appear are unique to each Complaint Officer/User Account. By default **Dashboards** show the following:

- FC - My Formal Complaints overdue response
- FC - All open Complaint Recommendations
- FC - My open Complaint Issues
- FC - My Formal Complaints awaiting acknowledgement
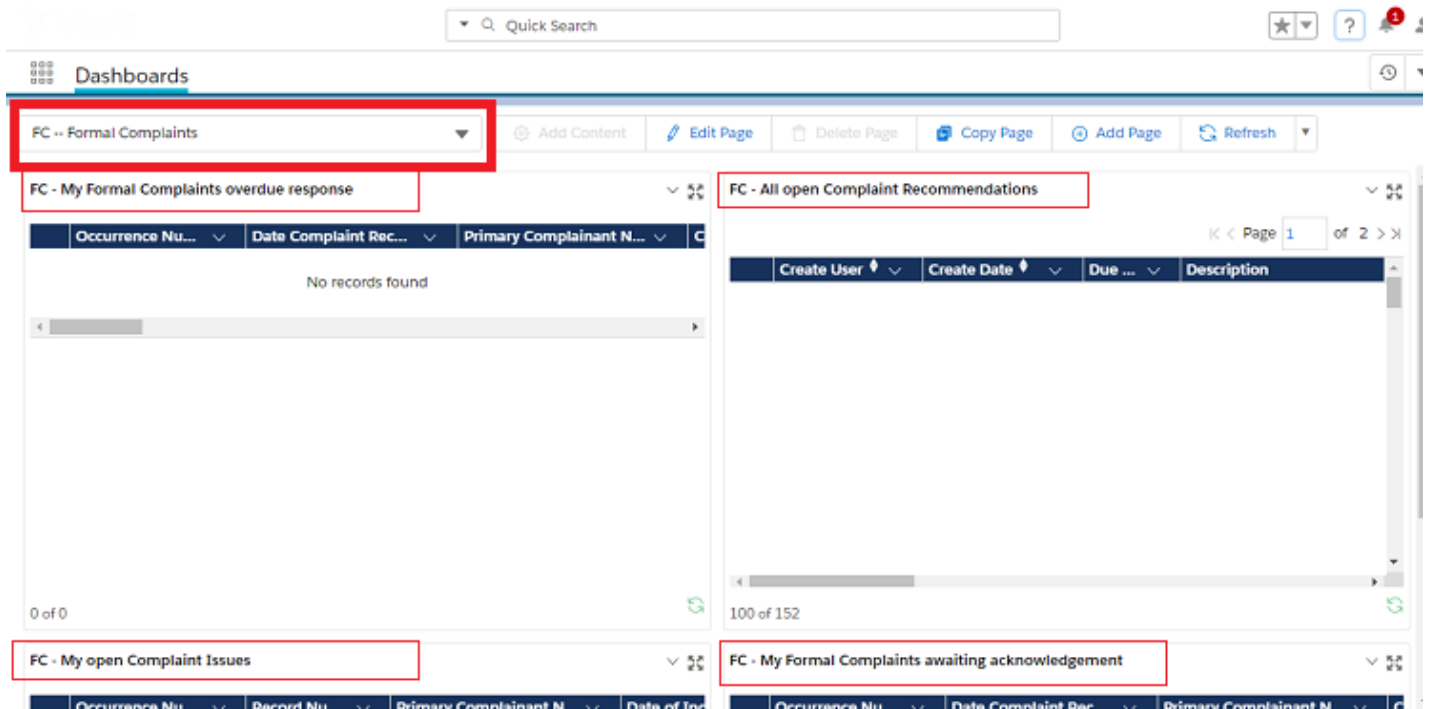
These can be extended for Complaints Managers and Review Officers on request.

Terminology

The HSE's Complaints Management System uses the same platform as NIMS and shares some of its terminology

1. A **complaint** is referred to as an '**Occurrence**'

2. An **issue** within a complaint is referred to as an '**Incident**'

3. A **recommendation** is referred to as a '**Task**'

Complaints Management System:
Quick 1-Page Guide to Logging Complaints (Stage 2)

Recommendation: Print this page and keep at hand.

NOTE: Login in at https://www.riskonnectclearsight.eu/Enterprise/login.cmdx??c=NIMS using Chrome or MS Edge browser. Select Incident Manager in App Launcher icon buttons top left of screen, click on Occurrences

Step 1: Log complaint in Occurrences:

1. Click *+ New* "**Create a new Occurrence**". Coverage = Formal Complaint
2. Enter Date complaint received, location and complainant details in **Complaint General Details.**
3. **Save** Occurrence - you can now see the Claims/Incidents option. Note the Occurrence Number.
4. Upload Complaints Letter/Fax/Email/Form etc. in **File.**

Step 2: Update Complaint Record

1. Open Occurrence - **Complaint Follow-up** page**.**
2. Day 5: Update **Date Acknowledgement Sent.**

Step 3: Log issues of Complaint in Claims/Incidents (MANDATORY)

1. Select **New Incident.**
2. Enter details of individual issues in **Claims/Incidents**. Select Complaints Officer, Date of Incident, Location, Did this happen Onsite/Offsite, Brief Summary details, Pathway, HCAT and Categories, Division/Service/SubService.
3. **Save** Incident.
4. Repeat for each issue/incident in complaint.
    NOTE: A complaint MUST have at least ONE associated issue.

Step 4: Update Issue/Complaint Record

1. Day 30: In **Occurrences - Claims/Incidents - Complaints Issue** change all Issue Status to **Closed.**
2. Double click Issue in Claims/Incidents to open issue.
3. Set Issue Status to closed and enter Issue Complete Date and Issue Resolution.
4. Upload Issue Investigation Report File if applicable.
5. Repeat for each issue/incident in complaint if applicable.

OR

3. Day 30: Update **Number of Delayed Letters** in **Occurrence – Complaint Follow-up**
4. And repeat **Step 4**; **1- 4** above once investigation of issue is complete.

Step 5: Log Complaint Issue recommendations made in Tasks (Mandatory).

1. When Complaint Investigation complete, update for any Recommendations: **Occurrence - Claims/Incidents page: open the Incident** (Complaint Issue). Click Tasks and Select **New - Formal Complaint Issue Recommendation.**
2. Enter **Recommendation details** and update when implemented.
3. **Save** Task.
4. Repeat for each issue/incident in complaint where Recommendations made.

Step 6: Close the Complaint.

1. Open Occurrence - **Complaint Follow-up** page.
2. Set **Complaint Status** to Closed. Enter **Date Complaint Closed** and **Close details- Outcome, Resolution, Date Response Sent.**
3. **Save** Occurrence.

NB: Ensure all issues are 'Closed' (Step 4) before closing the Complaint. Email CMSTraining@hse.ie for assistance

Step 1: Create Record of Complaint

In the Complaints Management System a Complaint is referred to as an Occurrence.

In *Incident Manager app*, on the left-hand menu click **Occurrences.**

A list of Occurrences is displayed (double-click on a record to open an existing Occurrence).
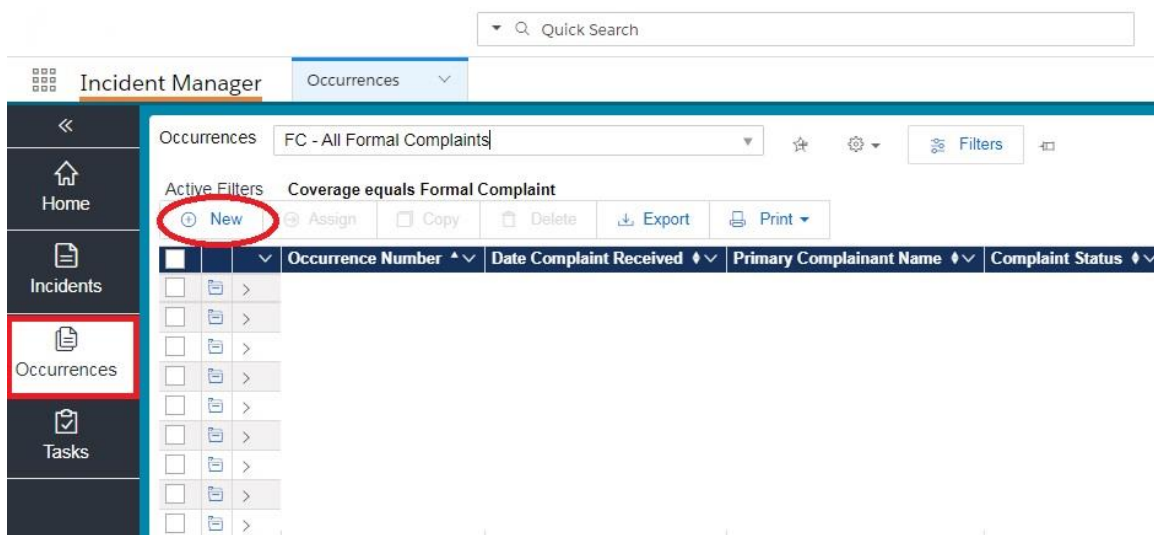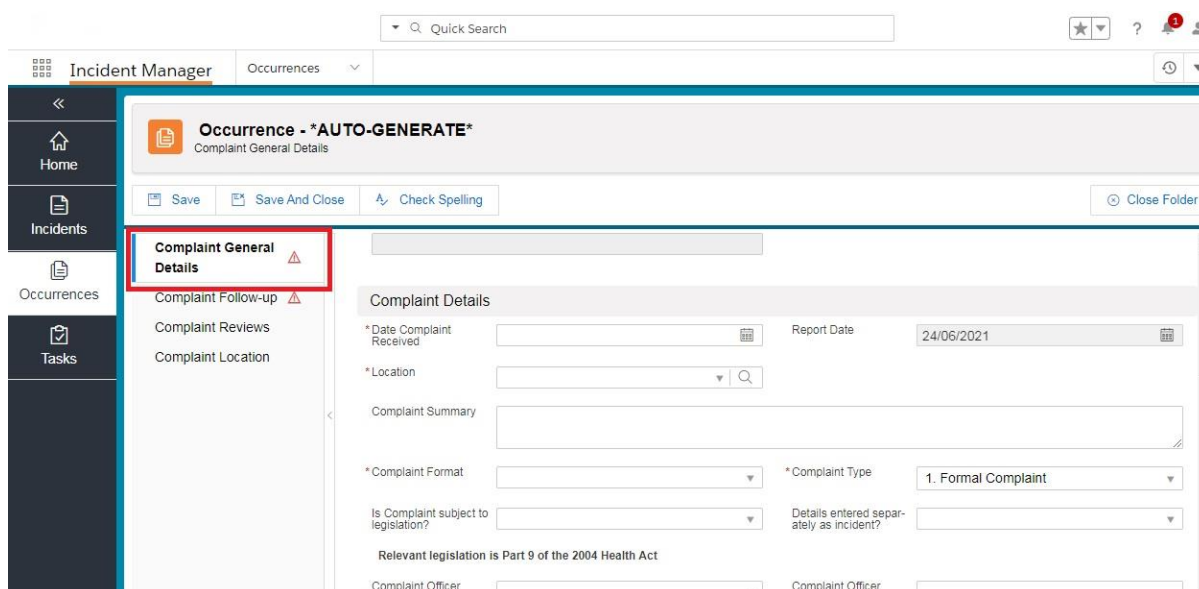

1. Click the button **New Occurrence**.
2. You are prompted to select the *Coverage*
3. Select 'Formal Complaint' and click **OK –**
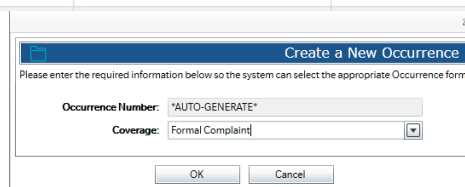

Blank 'Complaint General Details' Occurrence screen appears**:**

4. Enter the complaint details (at minimum):

a. *Date Complaint received.*
b. *Report Date* (defaults to today).
c. *Location - **How to lookup a location.***

- Use the lookup: if you click on the magnifying glass🔍 the search screen appears. Within this there are two different options, either the **Grid** view OR **Tree-View**.
  ALWAYS use Tree-View.
- Click on **Tree** and you can look through the Healthcare location hierarchy to find the correct location.
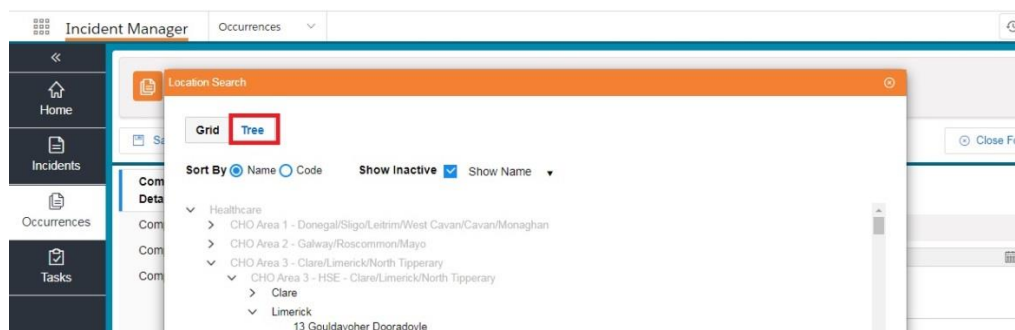
d. *Complaint Summary* to include a concise list of issues raised, anonymised (no staff/service user names)
e. *Complaint Format*

Complaint Format	Comment
E-mail	Emails to your local complaints email account and/or ysys@hse.ie
Face-to-face	
Fax	
Letter	
Other Written	
Telephone	
Website	

f. *Complaint Type- Formal Complaint*

Complaint Types	Comment
1.Formal Complaint	Stage 2 in *Your Service Your Say* complaints process
2.Locally resolved Complaint	
3.Comment/Suggestion	
4.Postive Feedback	
5.Public Representation	
6.Parliamentary Question	
7.Review existing complaint	

g. Either *Service user name* OR *Complainant name if not the same person.*
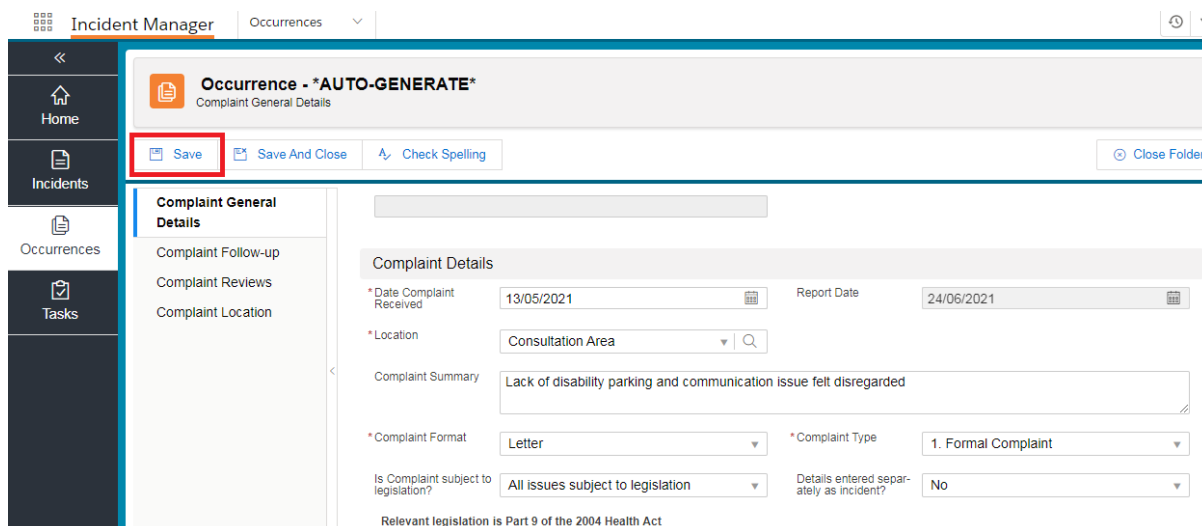
5.   After you have entered all available details, click **Save Occurrence**.

> **Note**: Once you click Save additional pages become available, including Claims/Incidents.

6.   You will now see additional options:

           i.   Claims/Incidents

          ii.   Notes

        iii.   Audits

        iv.   Tasks

         v.   Attachments

        vi.   Occurrence Timeline

      vii.   Audits
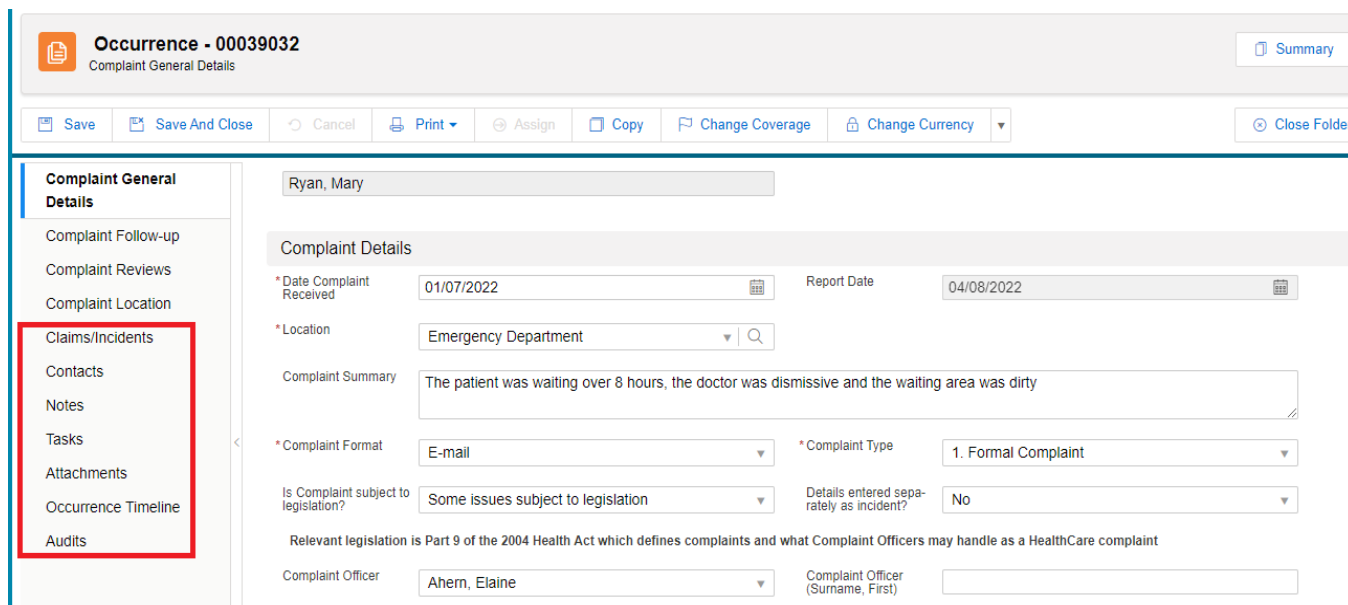
Step 2: Create Record of Issues (MANDATORY)

This shows all the issues within a complaint.

1.   Click on **Claims/Incidents** on the **small** left-hand menu.

2.   The list of saved issues appears. In a new complaint *No records found* appears until an Incident record is created.

Click **Create** *Create new claims/incidents within this occurrence* then **New Incident**.

You are asked to confirm the incident is 'Formal Complaint' coverage.

3.   Click **OK**.
a blank Incident screen appears:

Auto-populated Fields

a.   On creating the Issue, if *Complaint Officer* remains blank, the system fills this as the current user.
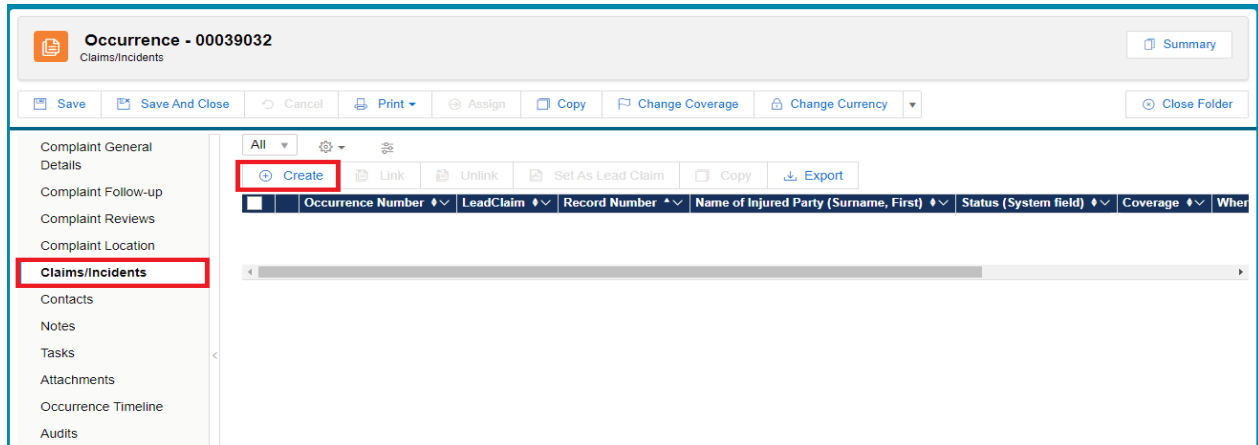b.   *Date Formal Complaint Received* as per date recorded to Complaint General Details page.
c.   *Issue Status* is "Open" and *Did this happen* is set to Onsite.

Dependant Fields *These are fields where changing the first one will change the available values in the second)*

d.   Issue Category → Issue Sub Category Type → Issue Sub Category (details in Appendix 3).
e.   Pathway → Pathway Description.
f.   Division → Service → Sub Service.

4.   Enter at least the minimum details to save the Complaint Issue record:

a. *Date of Incident*

b. *Issue location- Where (Hierarchy)*

c. *Issue Details – Summary of the Incident brief anonymised*

d. *Pathway*

e. *Categorise the issue using the various options (Issue Category, Issue Category Type, Issue Category Sub-type).*

f. *Division Details with service and sub service specified.*

For guidance on determining HCAT Severity Rating and HCAT Harm Rating- see Appendix 2.

Mandatory fields are highlighted below

5. Click **Save And Close**.

   The issue is saved and appears as the first issue.

Double-click on Incident record in Claims/Incidents to open the complaint issue. Sample complaint with identified issues can be viewed in Appendix 1.

6. Repeat Steps 1-5 to save additional issues. Example incidents list view:

Note: By default the first issue is deemed the **'lead claim'**. This is not relevant to Complaints, but cannot be hidden.

Step 3: Update Record of Complaint

Complaint Follow-up screen

Mandatory Fields

- *Complaint Status* (default is Open)

Auto-populated Fields

- On creating the Occurrence, if *Date Acknowledgement Due* is blank, the system fills this as *Date Complaint Received* + 7 days (5 week days).
- On creating the Occurrence, if *Date Response Due* is blank, the system fills this as **Date Complaint Received + 42 days (30 week days).**
- On creating the Occurrence, if *Complaint Officer* is blank, the system fills this as the current user.
- On creating the Occurrence, the Complaint status is "Open"
- *Number of Incidents*. This is auto-calculated based on number of complaint issues logged.
- On changing the *Complaint Status* to "Closed", if *Complaint Close Date* is blank, it is set to today. The *weekdays to close (incl bank holiday)* is filled. This is a count of the number of weekdays between the *Complaint Received Date* and the *Complaint Closed Date*. It is NOT aware of bank holidays.

Note: All Complaint Issues must first be Closed (All mandatory fields completed and Status set to Closed in each Issue) before closing the overall complaint on Complaint Follow-up page. See Step 6- Close Record of Issues.

*Where the complaint investigation requires more than the 30 working days timeframe and a delay letter issues to the complainant, *Update to Complaint* Date field is available for use. *Date Response Due* will not re-calculate but user may update to reflect the further 20 working days timeframe. Updates for any other delay letters issued can be saved and Date Response Due amended and saved.

Step 4: Update Record of Issues

You can select the issue to update from Claims/Incidents. Double click to open.

You can make any changes in the non auto-populated fields, including changing the complaints officer assigned this incident (issue).

Note: Names available on the drop-down menu *Complaint Officer* relate to users with NIMS or CMS access. The dashboard panels will be populated for the Complaint Officer selected on the drop-down menu if accessing CMS Formal Complaints.

Note: FC Recommendation added? Yes must to be chosen in drop-down menu in order to close Issue - **Mandatory**

Step 5: Create Record of Recommendations (Mandatory)

Recommendation details must be added to the COMPLAINTS MANAGEMENT SYSTEM using the Tasks page within each Incident (Issue).

Note: *Details* relates to the Issue brief summary. *Details of the complaint officer's findings* relates to the Recommendation made by the complaint officer.

It is Mandatory to complete all fields within the Recommendation/Task page.

Creating a Recommendation (Task)

1. Open the Incident (issue) by double-clicking the record in Claims/Incidents.

2. Click on **Tasks**. [Task = Recommendation]

3.   Click on the **New Task** button.

You are asked to select a Task type.

4.   Select "Formal Complaint Issue Recommendation" and click **OK**.
     A blank Complaint Recommendation screen appears.

5.   Enter all available details as each field is now mandatory and click **Save And Close**.

6.   Once saved, notes can be added to the Issue Recommendation.

Step 6: Close Record of Issues

NOTE: Each issue recorded must be closed before closing the complaint record.

1.   Go to Claims/Incidents in the Occurrence pages menu.

2.   Double click on an Incident Record (Issue) to open and complete the close details (below). See Appendix 2 for Guide to Determining HCAT Severity and Harm Rating.

3.   Set Issue Status to Closed and **Save And Close** the record.

4.   FC Recommendation added? **Yes** has to be chosen in order to close the Issue – reminder to add Recommendation/Task to Issue - **Mandatory**

Step 7: Close Record of Complaint

1. Check each Incident/Issue is closed and a selection has been made from the 'Issue Resolution' field. Save Task details record for any Complaint Issue where *Resolution* = Recommendations made
2. To close a complaint go to the **Complaint Follow-up** screen and
a. Change the *Complaint Status* to 'Closed'.
b. Add a *Complaint Outcome*.

Complaint Outcome	Comment
Not Upheld	NO ISSUES UPHELD
Partially Upheld	USED FOR MULTI-ISSUE COMPLAINT WITH SOME ISSUES UPHELD AND SOME NOT UPHELD
Upheld	ALL ISSUES UPHELD

3. Show how the complaint was resolved

Complaint Resolution	
Anonymous Complaint	
Documentation Update	USE RECOMMENDATIONS MADE
No Action	
No Recommendation	
Not Substantiated	
Process Update	USE RECOMMENDATIONS MADE
Recommendations Made	
Resolved Locally	
Resolved through Mediation	
Retraining	USE RECOMMENDATIONS MADE
Transfer to Risk Register	USE RECOMMENDATIONS MADE
Vexatious Complaint	
Withdrawn	

4. Click **Save And Close**.

Mandatory Fields

- *Status* (defaults to Open)

Auto-populated Fields

- *none*

Step 8: Internal Review

Currently there is no way for a Complaints Manager to assign a review to a Review Officer through the system. The Review Officer will have access to all complaints in their location and will be given the relevant Occurrence Number. Details regarding the Review Officer should be added to notes and the Review Investigation Report should be uploaded to Files.

After a complaint is closed it may be reviewed. Select "Complaints Review" in "Occurrence" to record the details that can be captured for the reviews.

There are currently no rules on the system regarding the filling of any of these fields. i.e. you can fill any of these fields at any time.

These have no effect on the *Complaint Status*. i.e. the Stage 2 complaint remains closed while a Stage 3 review is happening.

Note:	

The **Save** button ![Save] will save the current details and leave the screen open.

The **Save and Close** button ![Save And Close] will save the current details <u>and</u> close the current screen.

Attachments: Files and Notes

Files screen

Files can be attached at both Occurrence and Issue level. E.g., this allows scanned copies of the complaint to be loaded into the Complaints Management System. Other examples of files that can be uploaded are:

- Complaint Investigation Final Report
- Action Plans for Implementing Recommendations
- Associated emails
- Review Report

Adding Files:

1. Open **Attachments** in the Occurrence page menu panel.

2. Click the 📎 **Upload File** button, you are prompted to select file(s).
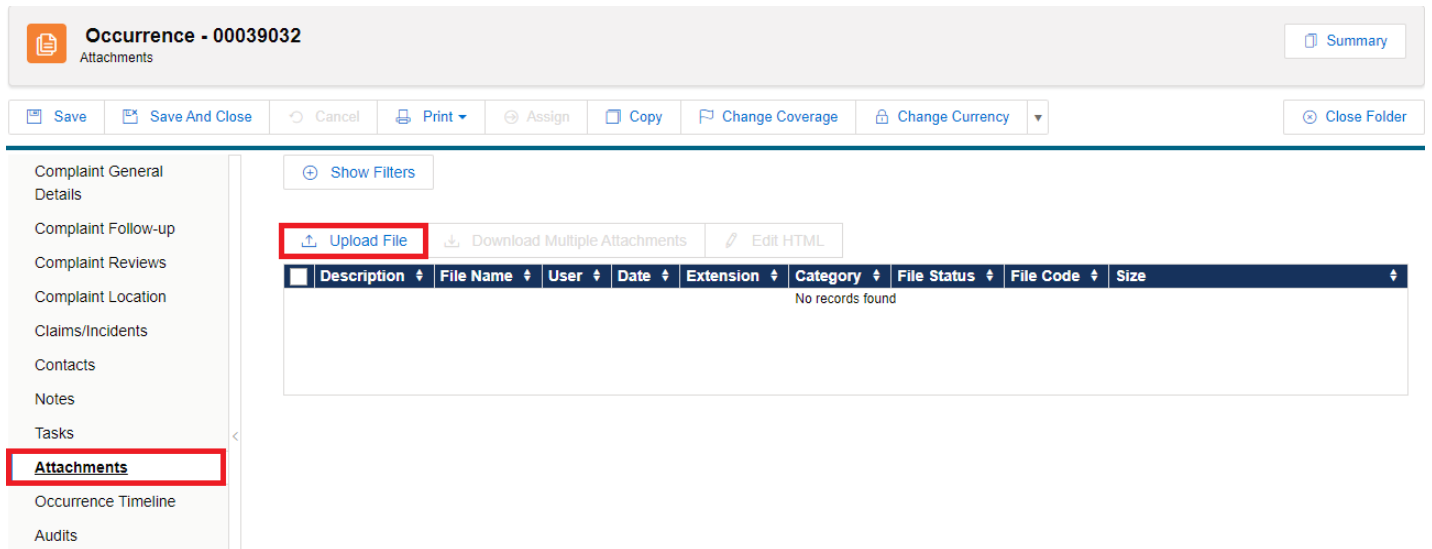
3. Select files to upload from your PC using Drag and drop or File browser function:
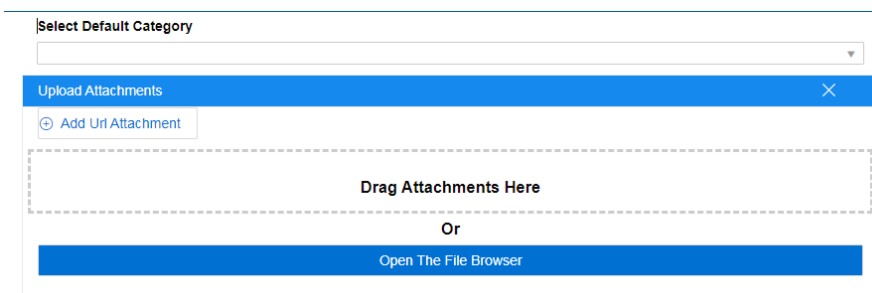
4. Select one or more files to drag and drop or click **Open The File Browser** to select the file to attach from files saved on your device.
    You can (optionally) add a *Description* and *Category* to the files.
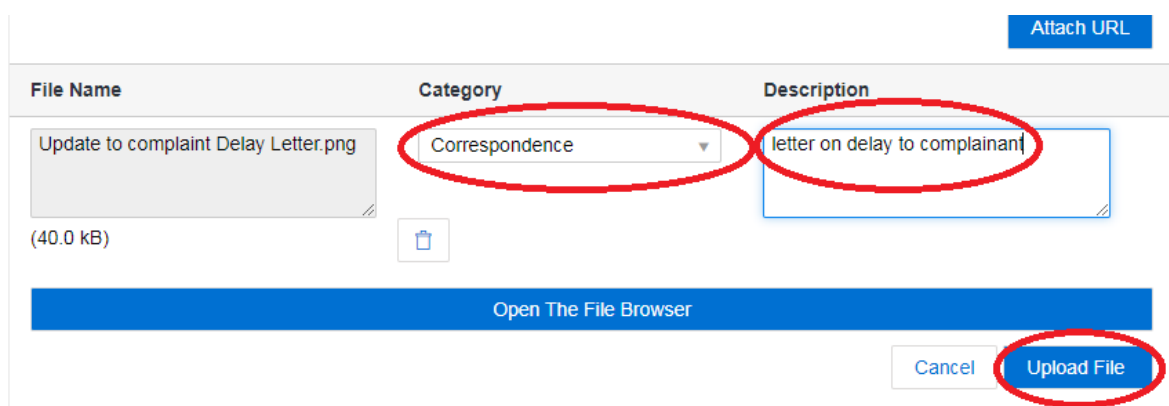
5. Click **Upload File(s)**.

The file attached :
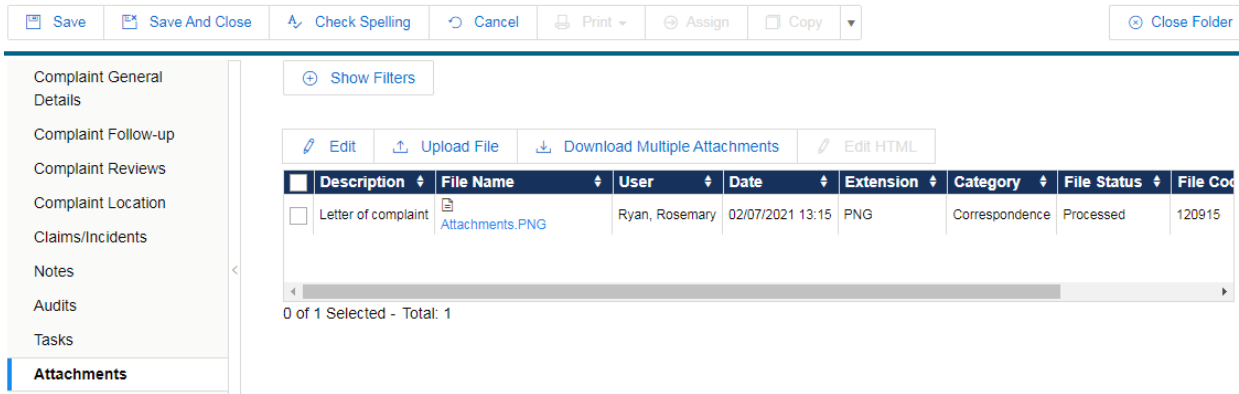
Note: if the *Description* is left blank, the filename is used.

Notes

The Notes screen allows you to add notes to a Complaint or Issue or Recommendation. These automatically add the date note added, and the user that created the note.

Adding a Note:

1. Open **Notes**.
2. Click the **New** button.
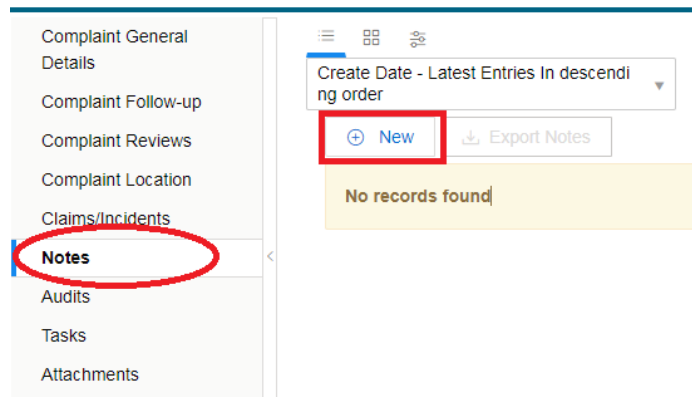
3. Enter:
a. *Text*
b. *Description* (optional)
c. Select *Category* (optional)

4.   Click **Save and Close.** Note is time and date stamped.

Deleting Records

Users cannot delete records. In the unlikely event that a record must be deleted, for example a user saves an incident to the Complaints Management System in error they must complete the following form. This should be sent to the CMS Team at cmstraining@hse.ie. The form is called NIMS Occurrence/Complaint created in Error – REQUEST FOR DELETION and it can be found in the following location.

- https://www.hse.ie/eng/about/who/complaints/ncglt/toolkit/cmstoolkit/forms.html

Further Assistance

- All other relevant forms can be located also at the following location on the HSE website https://www.hse.ie/eng/about/who/complaints/ncglt/toolkit/cmstoolkit/forms.html

- Scheduled training dates will be circulated to Complaints Officers for Complaint Officer training with regard to the Complaint Process via their local Consumer Affairs Area Office.

- You can contact the CMS Team directly for help at cmstraining@hse.ie or Help Desk phone 061-483296

Appendix 1: Sample Complaint (Fictional)

Dear Sir or Madam
I want to complain
about the time I spent
~~[redacted]~~

I was very unhappy
about my treatment there
Staff were not pleasant, one
in particular but I don't
know her name as she
didn't tell it to me.
I didn't feel I was spoken to
with any concern or respect
even during ~~[crossed out]~~
appointments

When I stayed there the area
around my bed was not
clean - There was no soap
in the bathroom. I was cold
all the time and the radiator
didn't work

I am allergic to wheat and
I was still not given any
options or choices. Just told
not to eat the bread.

I lost my dentures while in
there and no effort was made
to find them. It took me
3 weeks to get replacements,
and it was very hard
to eat.

I hope you will let me know
what you are going to do
about these issues

Yours Sincerely
J. Bloggs.
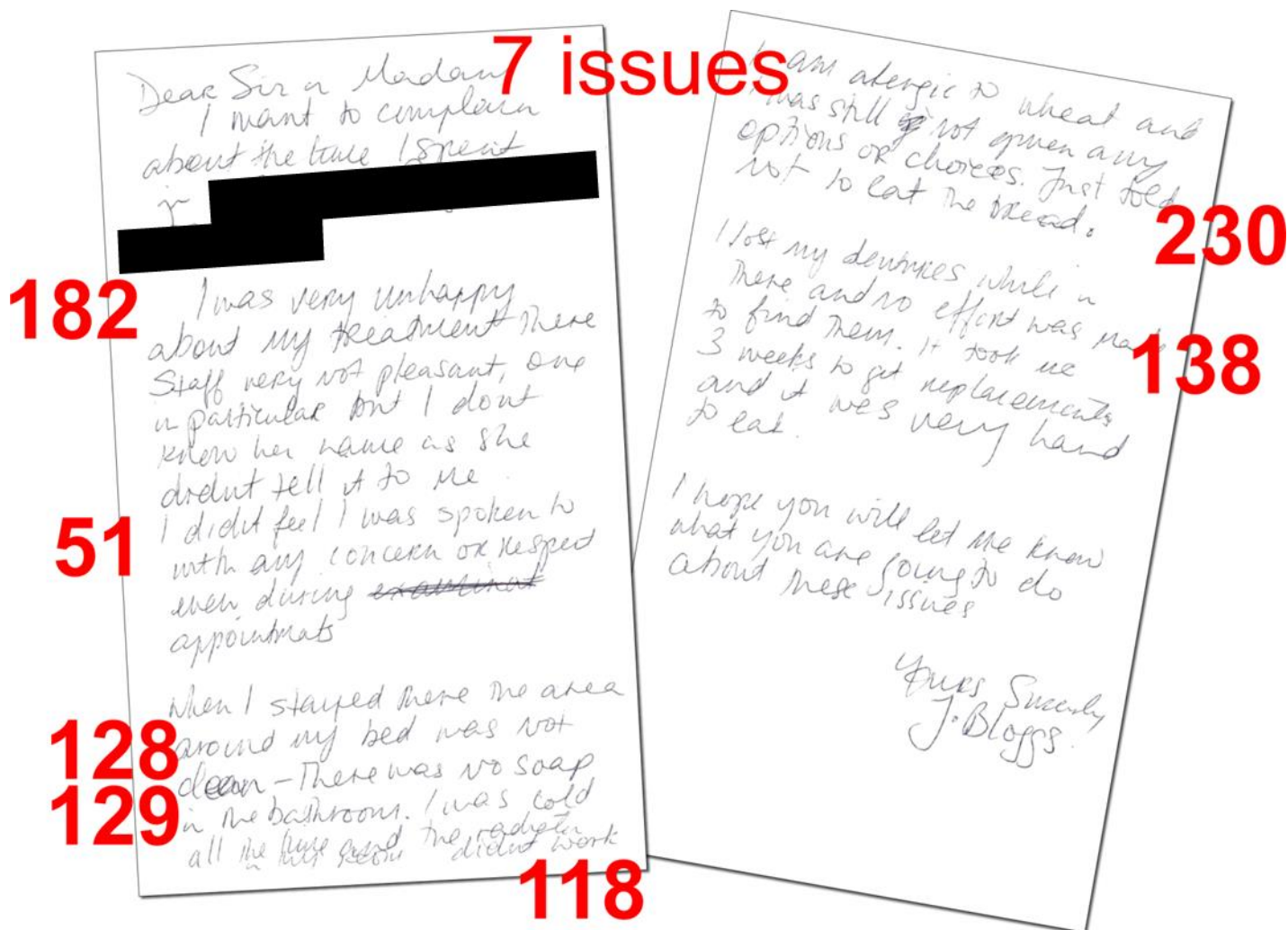
1. **182**: Communication & Information Communication skills Staff not introducing themselves and letting patients know their role

2. **51**: Dignity and Respect Delivery of care Lack of respect shown to patient during examination / consultation   Delivery of care

3. **128**: Safe & Effective Care Hygiene Cleanliness of area

4. **129**: Safe & Effective Care Hygiene Hand Hygiene / Gel Dispensers

5. **118**: Safe & Effective Care Health and Safety issues Temperature regulation

6. **230**: Improving Health Catering Dietary requirements not met

7. 138: Safe & Effective Care Patient property Dentures

Appendix 2: A Guide to Determining Severity and Harm level in Complaint Issues

NOTE: This guide should be used in conjunction with **Section 4.1 of the Complaints Management System Training** eLearning module suite in the *Discovery Zone Hub* on HSELand.

The first stage in assessing a healthcare complaint is the identification of issues contained within a letter of complaint, and an assessment of their severity and harm.

The examples in this guide can be used as a support in assessing the severity and harm on an issue.

To facilitate the identification of issues within a healthcare complaint, each subcategory of complaint has been assigned a suggested severity rating range, however the Complaints Officer may raise or lower the level based on the seriousness of the complaint. The suggested severity rating range are available in the appendices of the Complaints Management System User Manual and in the appendices of this document.

Identifying Severity Levels

Severity ratings should be independent of outcomes (ie, harm).

To analyse a healthcare complaint, the following steps should be undertaken:

1) Read through the letter of complaint without coding anything
2) On second reading, identify the issue category (and, if required, sub-category) being complained about using the issue definitions and the keywords.
3) For each issue category identified, determine the severity level. The indicators are examples of (1) low, (2) medium, and (3) high severity issues for each issue category. Refer to HSE Issus Severity Levels.xlsx for the baseline and the examples in this document if the severity level should be higher for the specific issue. Raise only after consideration of the seriousness of event (regardless of actual outcome).
4) If an issue category is not identified and attributed at severity score, it should be rated as 0 (not present).

1. Safe and Effective Care

Relates to:

- ***Clinical standards of healthcare staff behaviour:*** Neglect (Hygiene & personal care; Nourishment & hydration; general). Rough handling & discomfort; Examination & monitoring; Making & following care plans; Outcomes & side effects.
- ***Errors, incidents, and staff competencies:*** - Error (diagnosis; medication; general); Failure to respond; Clinician skills; Teamwork.
- ***Problems in the facilities, services, clinical equipment, and staffing levels:*** - Accommodation; Preparedness; Ward cleanliness; Equipment; Staffing; Security, Continuity

Keywords:

"not provided", "was not done", "did not follow guidelines", "poor standards", "should have", "not completed", "unacceptable quality", "not successful", "incorrect", "medication error", "did not notice", "mistake", "failed to act", "wrong", "poor coordination", "unaware", "missed the signs", "diagnosis", "not available", "shut", "not enough", "dirty", "shortages", "broken", "poor equipment", "soiled", "used before", "poorly signed", "lack of"..

Examples		
1. Low Severity	**2. Medium severity**	**3. High severity**
Slight delay in making diagnosis	Clinical Staff failed to diagnose a fracture	Clinical Staff misdiagnosed critical illness
Slight delay in administering/prescribing medication	Failure to administer/prescribe required medication	Incorrect medication administered/prescribed
No care plan developed	Aspect of care plan overlooked	Failing to heed warnings in patient notes
Patient left with some scarring	Patient required follow-up operation	Patient left with unexpected disability

2. Access

Relates to:

- ***Problems in bureaucracy, resources, facilities, waiting times, and accessing care:*** - Delay (access; procedure; general); Bureaucracy; Visiting; Disability, Documentation.

Keywords:

"delayed", "postponed", "cancelled", "lost", "not admitted", "refused", "administrative problems", "not referred", "confused notes", "more paperwork", "unaware of me", "lack of", "parking", "visiting".

Examples		
1. Low Severity	**2. Medium severity**	**3. High severity**
Difficulty contacting healthcare unit	Waited in emergency room for hours	Unable to access specialist care
Waiting for appointment/treatment 6-12 months	Waiting for appointment/treatment 13-18 months	Waiting for appointment/treatment 18+ months

3. Communication and Information

Relates to:

- ***Absent or incorrect communication from healthcare staff to patient/service users****: -* Delayed communication; Incorrect communication; Absent communication
- ***Healthcare staff disregard or do not acknowledge information from patient/service users:*** - Ignoring patients; Dismissing patients; Token listening.

Keywords:

"no-one said", "I was not informed", "he/she said 'X'", "they told me", "no-one explained", "contradictory", "unanswered questions", "confused", "incorrect" , "I said", "I told", "ignored", "disregarded", "battled to be heard", "not acknowledged", "excluded", "uninterested" and "not taken seriously".

Examples		
1. Low Severity	**2. Medium severity**	**3. High severity**
Patient/service user question ignored	Patient-provided information dismissed	Critical patient-provided information repeatedly dismissed
Short delay communicating test results	Long delay communicating test results	Urgent test results delayed

4. Dignity and Respect

Relates to:

- ***Disrespect or violations of patient/service user rights by staff***: **-:** Disrespect; Confidentiality; Rights
Keywords: "rude", "attitude", "humiliated", "disrespectful", "scared to ask", "embarrassed", "inappropriate", "no consent", "abused", "assaulted",

Examples		
1. Low Severity	**2. Medium severity**	**3. High severity**
Staff member lost temper	Patient intimidated by staff member	Patient discriminated against
Staff spoke in condescending manner	Rude behaviour	Humiliation in relation to incontinence

5. Participation

Relates to:

- ***Disregard, or not appropriate care taken by staff to ensure service user understood and had given consent***: - Consent, exclusion from decision-making. **Keywords: "**no consent", "not asked", "not allowed", "not included".

Example		
1. Low Severity	**2. Medium severity**	**3. High severity**
Patient's opinion discounted/not involved in care plan	Patient excluded from decision making process	Patient coerced
Unclear information for consent	Consent was obtained just prior to the procedure giving no discussion time	Do-not-resuscitate decision without obtaining consent

6. Privacy

Relates to:

- ***Violations of patient/service user rights to privacy by staff***:**: -** Confidentiality; Privacy

Keywords: "privacy", "breach"

Example		
1. Low Severity	**2. Medium severity**	**3. High severity**
Private information divulged to the receptionist	Private information divulged to family members	Private information shared with members of the public
Lack of privacy during discussion	Lack of privacy during examination/consultation	Patient/Service user experienced emergency medical care without privacy

7. Improving Health

Relates to:

- *Failure to educate the service user/carer, not providing information on care and prevention, ignoring the service users non-clinical needs, catering issues.*:: - Empowerment; Holistic Care, Catering

Keywords: "didn't explain", "didn't tell X","asked for", "ignored my request for"

Example.		
1. Low Severity	**2. Medium severity**	**3. High severity**
Staff were disrespectful towards patient/ family preferences	Parent not allowed to go to theatre with child.	Parent's request to be involved in decision-making (minor child) refused.
Request to be involved in care ignored by staff	Staff failed to educate patient in the current and next steps of their care	Independence and self care not supported

8. Accountability

Relates to:

- *Failure to adhere to the HSE's service user feedback policy. Concerns about invoices, billing and insurance*: - Feedback; Finance

Keywords: "complaint", "bill", "invoice", "income collection"

Example		
1. Low Severity	**2. Medium severity**	**3. High severity**
Disputing charge for attending A&E	Lack of care/ poor treatment – not happy to pay bill as a result	Patient contacted by debt collection agency for invoice issued in error
Information on how to make a complaint not easily accessible	Concerns of service users not dealt with promptly	Service user had to go further about complaint due to no response, i.e., the Ombudsman or other body.

Identifying Harm Levels

The second stage in assessing a healthcare complaint is to specify the level of harm experienced and reported in the letter of complaint.

Assessments of harm should focus on the overall harm caused to patients by the issues raised in the letter of complaint.

For example, if the patient dies, but the complaint is about dignity after death, then the harm relates to the consequences of the lack of dignity. It is important to note that harm is independent from issue severity. For example, a patient describing a severe safety issue (eg, a medication error) may not have experienced harm due to the error being identified.

Patient/service user harm	
0. N/A	No information on harm is reported, or no harm came to the patient/service user
1. Minimal harm	Minimal intervention or treatment required, upset caused to patient/service user
2. Minor harm	Minor physical or mental harm caused to patient/service user, intervention from Clinical Staff or other primary care provider required to ameliorate harm
3. Moderate harm	Significant mental or physical harm, secondary care intervention required to ameliorate harm
4. Major harm	Patient/service user experienced or faces long term incapacity, either physical or mental
5. Catastrophic harm	Death or multiple/permanent injuries, or chronic mental health problems.

Appendix 3: Complaint Categories and Suggested Severity Level Range

No.	Incident/Category	Sub Category Type	Sub Category Please Specify	Suggested Severity Level Range: select or adjust as appropriate
1.	Access	Accessibility / resources	Equipment	2 to 3
2.	Access	Accessibility / resources	Medication	2 to 3
3.	Access	Accessibility / resources	Personnel	2 to 3
4.	Access	Accessibility / resources	Services	2 to 3
5.	Access	Accessibility / resources	Treatment	2 to 3
6.	Access	Appointment - delays	Appointment - cancelled and not rearranged	2 to 3
7.	Access	Appointment - delays	Appointment - delay in issuing appointment	1 to 3
8.	Access	Appointment - delays	Appointment - postponed	1 to 3
9.	Access	Appointment - delays	Surgery / therapies / diagnostics - delayed or postponed	1 to 3
10.	Access	Appointment - delays	Operation and opening times of clinics	1 to 2
11.	Access	Appointment - other	No / lost referral letter	1 to 2
12.	Access	Appointment - other	Appointment - request for earlier appointment	1 to 3
13.	Access	Appointment - other	Unavailability of service	2 to 3
14.	Access	Admission - delays	Delayed - elective bed	1 to 2
15.	Access	Admission - delays	Delayed - emergency bed	2 to 3
16.	Access	Admission - delays	Admission - delay in admission process	1 to 3
17.	Access	Admission - delays	Admission - postponed	2 to 3
18.	Access	Admission - other	Admission - refused admission by hospital	2 to 3
19.	Access	Hospital facilities	Crèche	1 to 2
20.	Access	Hospital facilities	Lack of adequate seating	1 to 2
21.	Access	Hospital facilities	Lack of baby changing facilities	1 to 2
22.	Access	Hospital facilities	Lack of / minimal breastfeeding facilities	1 to 2
23.	Access	Hospital facilities	Lack of toilet and washroom facilities (general)	1 to 2

24.	Access	Hospital facilities	Lack of toilet and washroom facilities (special needs)	1 to 2
25.	Access	Hospital facilities	Lack of wheelchair access	1 to 3
26.	Access	Hospital facilities	No treatment area / space for consultation / trolley facilities	1 to 3
27.	Access	Hospital facilities	Shop	1 to 2
28.	Access	Hospital facilities	Signage (internal and external)	1 to 2
29.	Access	Hospital room facilities (access to)	Bed location	1 to 2
30.	Access	Hospital room facilities (access to)	Disability facilities	1 to 3
31.	Access	Hospital room facilities (access to)	Isolation / single room facilities	1 to 3
32.	Access	Hospital room facilities (access to)	Overcrowding	1 to 3
33.	Access	Hospital room facilities (access to)	Public	1 to 2
34.	Access	Hospital room facilities (access to)	Semi-private / private	1 to 2
35.	Access	Parking	Access to disabled spaces	1 to 3
36.	Access	Parking	Access to spaces	1 to 2
37.	Access	Parking	Car parking charges	1 to 2
38.	Access	Parking	Clamping / Declamping of car	1 to 2
39.	Access	Parking	Condition or maintenance of car parks	1 to 2
40.	Access	Parking	Damaged cars	1 to 2
41.	Access	Parking	Location of pay machine	1 to 2
42.	Access	Transfer issues	External transfer	1 to 3
43.	Access	Transfer issues	Internal transfer	1 to 3
44.	Access	Transport	External transportation	1 to 3
45.	Access	Transport	Internal transportation	1 to 3
46.	Access	Visiting times	Lack of visiting policy enforcement	1 to 2
47.	Access	Visiting times	Special visiting times not accommodated	1 to 2
48.	Dignity and Respect	Alleged inappropriate behaviour	Patient	2 to 3
49.	Dignity and Respect	Alleged inappropriate behaviour	Staff	2 to 3
50.	Dignity and Respect	Alleged inappropriate behaviour	Visitor	2 to 3

51.	Dignity and Respect	Delivery of care	Lack of respect shown to patient during examination / consultation	1 to 3
52.	Dignity and Respect	Delivery of care	No concern for patient as a person	1 to 3
53.	Dignity and Respect	Delivery of care	Patient's dignity not respected	1 to 3
54.	Dignity and Respect	Discrimination	Age	2 to 3
55.	Dignity and Respect	Discrimination	Civil status	2 to 3
56.	Dignity and Respect	Discrimination	Disability	2 to 3
57.	Dignity and Respect	Discrimination	Family status	2 to 3
58.	Dignity and Respect	Discrimination	Gender	2 to 3
59.	Dignity and Respect	Discrimination	Membership of traveller community	2 to 3
60.	Dignity and Respect	Discrimination	Race	2 to 3
61.	Dignity and Respect	Discrimination	Religion	2 to 3
62.	Dignity and Respect	Discrimination	Sexual orientation	2 to 3
63.	Dignity and Respect	Discrimination	Socio-economic	2 to 3
64.	Dignity and Respect	End-of-Life Care	Breaking bad news	2 to 3
65.	Dignity and Respect	End-of-Life Care	Breaking bad news - private area unavailable	2 to 3
66.	Dignity and Respect	End-of-Life Care	Death cert - delay in issuing death cert	2 to 3
67.	Dignity and Respect	End-of-Life Care	Death cert - incorrect / returned death cert	2 to 3
68.	Dignity and Respect	End-of-Life Care	Delay in release and condition of body	2 to 3
69.	Dignity and Respect	End-of-Life Care	Inattention to patient discomfort	2 to 3
70.	Dignity and Respect	End-of-Life Care	Mortuary facilities	2 to 3
71.	Dignity and Respect	End-of-Life Care	Organ retention	2 to 3
72.	Dignity and Respect	End-of-Life Care	Palliative care	2 to 3
73.	Dignity and Respect	End-of-Life Care	Poor communication	2 to 3
74.	Dignity and Respect	End-of-Life Care	Single room for patient unavailable	2 to 3
75.	Dignity and Respect	End-of-Life Care	Treatment of deceased not respected	2 to 3
76.	Dignity and Respect	Ethnicity	Insensitivity to cultural beliefs and values	1 to 2
77.	Dignity and Respect	Ethnicity	Requests not respected	1 to 2
78.	Dignity and Respect	Ethnicity	Special food requests unavailable	1 to 2
79.	Safe & Effective Care	Human Resources	Competency	1 to 3

80.	Safe & Effective Care	Human Resources	Complement	1 to 3
81.	Safe & Effective Care	Human Resources	Skill mix	1 to 3
82.	Safe & Effective Care	Diagnosis	Diagnosis - misdiagnosis	2 to 3
83.	Safe & Effective Care	Diagnosis	Diagnosis - delayed diagnosis	1 to 2
84.	Safe & Effective Care	Diagnosis	Diagnosis - contradictory diagnosis	2 to 3
85.	Safe & Effective Care	Test	Delay / failure to report test results	1 to 3
86.	Safe & Effective Care	Test	Incorrect tests ordered	2 to 3
87.	Safe & Effective Care	Test	No tests ordered	2 to 3
88.	Safe & Effective Care	Test	Mislabelled test result/sample	2 to 3
89.	Safe & Effective Care	Test	Mislaid sample	2 to 3
90.	Safe & Effective Care	Test	Performed on wrong patient	2 to 3
91.	Safe & Effective Care	Test	Repeat test required	2 to 3
92.	Safe & Effective Care	Test	Result not available	2 to 3
93.	Safe & Effective Care	Test	Delay in transport/collection of sample	1 to 2
94.	Safe & Effective Care	Continuity of care (internal)	Poor clinical handover	1 to 3
95.	Safe & Effective Care	Continuity of care (external)	Lack of approved home care packages	1 to 3
96.	Safe & Effective Care	Continuity of care (external)	Lack of community supports	2 to 3
97.	Safe & Effective Care	Continuity of care (external)	Lack of medical devices / faulty equipment	2 to 3
98.	Safe & Effective Care	Continuity of care (external)	Lack of support services post discharge	2 to 3
99.	Safe & Effective Care	Continuity of care (external)	Unsuitable home environment	2 to 3
100.	Safe & Effective Care	Discharge	Adherence to discharge policy	1 to 2
101.	Safe & Effective Care	Discharge	Delayed discharge	1 to 2
102.	Safe & Effective Care	Discharge	Discharge against medical advice	2 to 3
103.	Safe & Effective Care	Discharge	No discharge letter	1 to 2
104.	Safe & Effective Care	Discharge	Patient / family refuse discharge	1 to 2
105.	Safe & Effective Care	Discharge	Premature discharge	2 to 3
106.	Safe & Effective Care	Health and Safety issues	Building not secure	2 to 3
107.	Safe & Effective Care	Health and Safety issues	Central heating	1 to 2
108.	Safe & Effective Care	Health and Safety issues	Equipment (lack of / failure of / wrong equipment used)	2 to 3

109.	Safe & Effective Care	Health and Safety issues	Failure to provide a safe environment	2 to 3
110.	Safe & Effective Care	Health and Safety issues	Fixtures and fittings	1 to 2
111.	Safe & Effective Care	Health and Safety issues	Furnishing	1 to 2
112.	Safe & Effective Care	Health and Safety issues	Lights	1 to 2
113.	Safe & Effective Care	Health and Safety issues	Manual handling	2 to 3
114.	Safe & Effective Care	Health and Safety issues	Noise levels	1 to 2
115.	Safe & Effective Care	Health and Safety issues	Overcrowding	2 to 3
116.	Safe & Effective Care	Health and Safety issues	Pest control	2 to 3
117.	Safe & Effective Care	Health and Safety issues	Slips / trips and falls	2 to 3
118.	Safe & Effective Care	Health and Safety issues	Temperature regulation	1 to 2
119.	Safe & Effective Care	Health and Safety issues	Waste Management	1 to 2
120.	Safe & Effective Care	Health care records	Admission / registration process error	1 to 2
121.	Safe & Effective Care	Health care records	Inaccurate information on healthcare record / hospital systems	1 to 3
122.	Safe & Effective Care	Health care records	Missing chart	1 to 2
123.	Safe & Effective Care	Health care records	Missing films/scans	1 to 2
124.	Safe & Effective Care	Health care records	Patient impersonation (identify theft)	2 to 3
125.	Safe & Effective Care	Health care records	Poor quality control of chart	1 to 3
126.	Safe & Effective Care	Health care records	Poor recording of information	1 to 3
127.	Safe & Effective Care	Health care records	Wrong records applied to patient	2 to 3
128.	Safe & Effective Care	Hygiene	Cleanliness of area	1 to 2
129.	Safe & Effective Care	Hygiene	Hand Hygiene / Gel Dispensers	1 to 2
130.	Safe & Effective Care	Hygiene	Linen (beds and Curtains)	1 to 3
131.	Safe & Effective Care	Hygiene	Spills on floors	1 to 3
132.	Safe & Effective Care	Hygiene	Waste management	1 to 3
133.	Safe & Effective Care	Infection prevention and control	Communication deficit - infection status	2 to 3
134.	Safe & Effective Care	Infection prevention and control	Health Care Associated Infection	2 to 3
135.	Safe & Effective Care	Infection prevention and control	Non compliance with Infection and Control policies and protocols	2 to 3
136.	Safe & Effective Care	Infection prevention and control	Personal hygiene of staff	2 to 3
137.	Safe & Effective Care	Patient property	Clothes	1 to 2

138.	Safe & Effective Care	Patient property	Dentures	1 to 2
139.	Safe & Effective Care	Patient property	Glasses	1 to 2
140.	Safe & Effective Care	Patient property	Hearing Aid	1 to 2
141.	Safe & Effective Care	Patient property	Jewellery	1 to 2
142.	Safe & Effective Care	Patient property	Lack of secure space	1 to 2
143.	Safe & Effective Care	Patient property	Money	1 to 2
144.	Safe & Effective Care	Patient property	Personal equipment	1 to 2
145.	Safe & Effective Care	Patient property	Toys	1 to 2
146.	Safe & Effective Care	Medication	Administering error	2 to 3
147.	Safe & Effective Care	Medication	Dispensing	2 to 3
148.	Safe & Effective Care	Medication	Prescribing	2 to 3
149.	Safe & Effective Care	Tissue Bank	Bone marrow	2 to 3
150.	Safe & Effective Care	Tissue Bank	Cord blood	2 to 3
151.	Safe & Effective Care	Tissue Bank	Cornea implant	2 to 3
152.	Safe & Effective Care	Tissue Bank	Cryogenics	2 to 3
153.	Safe & Effective Care	Tissue Bank	Fertility issues	2 to 3
154.	Safe & Effective Care	Tissue Bank	Heart valves	2 to 3
155.	Safe & Effective Care	Tissue Bank	Samples/test results	2 to 3
156.	Safe & Effective Care	Tissue Bank	Skin	2 to 3
157.	Safe & Effective Care	Tissue Bank	Stem cell	2 to 3
158.	Safe & Effective Care	Treatment and Care	Failure / delay in treatment / delivery of care	1 to 3
159.	Safe & Effective Care	Treatment and Care	Failure / delay to diagnose	2 to 3
160.	Safe & Effective Care	Treatment and Care	Failure to act on abnormal diagnostic results	2 to 3
161.	Safe & Effective Care	Treatment and Care	Inconsistent delivery of care	2 to 3
162.	Safe & Effective Care	Treatment and Care	Insufficient time for delivery of care	2 to 3
163.	Safe & Effective Care	Treatment and Care	Lack of follow-up care	2 to 3
164.	Safe & Effective Care	Treatment and Care	Lack of knowledge in staff	2 to 3
165.	Safe & Effective Care	Treatment and Care	Lack of monitoring of pain control	2 to 3
166.	Safe & Effective Care	Treatment and Care	Lack of patient supervision	2 to 3

167.	Safe & Effective Care	Treatment and Care	Practitioners not working together / cooperating	2 to 3
168.	Safe & Effective Care	Treatment and Care	Prolonged fasting	2 to 3
169.	Safe & Effective Care	Treatment and Care	Unsatisfactory treatment or care	2 to 3
170.	Safe & Effective Care	Treatment and Care	Unsuccessful treatment or care	2 to 3
171.	Communication & Information	Communication skills	Patient felt their opinion was dismissed / discounted	1 to 2
172.	Communication & Information	Communication skills	Disagreement about expectations	1 to 2
173.	Communication & Information	Communication skills	Inadequate listening and response	1 to 2
174.	Communication & Information	Communication skills	Inappropriate comments from staff member	1 to 2
175.	Communication & Information	Communication skills	Lack of support	1 to 2
176.	Communication & Information	Communication skills	Language barrier between patients/relatives and staff	1 to 2
177.	Communication & Information	Communication skills	No opportunity to ask questions	1 to 2
178.	Communication & Information	Communication skills	Non verbal tone / body language	1 to 2
179.	Communication & Information	Communication skills	Open disclosure (lack of)	2 to 3
180.	Communication & Information	Communication skills	Patient dissatisfied with questions	1 to 2
181.	Communication & Information	Communication skills	Patient felt rushed	1 to 2
182.	Communication & Information	Communication skills	Staff not introducing themselves and letting patients know their role	1 to 2
183.	Communication & Information	Communication skills	Staff unsympathetic	1 to 2
184.	Communication & Information	Communication skills	Tone of voice	1 to 2
185.	Communication & Information	Communication skills	Untimely delivery of information	1 to 3
186.	Communication & Information	Delay and failure to communicate	Breakdown in communication between staff or areas	1 to 3
187.	Communication & Information	Delay and failure to communicate	Failure / delay to communicate with outside agency/organisation	1 to 2
188.	Communication & Information	Delay and failure to communicate	Failure / delay in communicating with patient	1 to 3
189.	Communication & Information	Delay and failure to communicate	*Advising patient of treating consultant*	*1 to 2*
190.	Communication & Information	Delay and failure to communicate	Failure / delay in communicating with relatives	1 to 3
191.	Communication & Information	Delay and failure to communicate	Failure / delay in notifying consultant (external)	1 to 2
192.	Communication & Information	Delay and failure to communicate	Failure / delay to communicate with GP / referral source	1 to 3
193.	Communication & Information	Delay and failure to communicate	*Lack of information provided about medication side effects (KPI)*	*1 to 2*
194.	Communication & Information	Diverse Needs	Interpretation service (e.g. Braille services)	1 to 2
195.	Communication & Information	Diverse Needs	Special needs	1 to 2

196.	Communication & Information	Diverse Needs	Translation service	1 to 2
197.	Communication & Information	Information	Conflicting information	1 to 2
198.	Communication & Information	Information	Confusing information	1 to 2
199.	Communication & Information	Information	Insufficient and inadequate information	1 to 2
200.	Communication & Information	Information	Misinformation	1 to 3
201.	Communication & Information	Telephone calls	Telephone call not returned	1 to 2
202.	Communication & Information	Telephone calls	Telephone call unanswered	1 to 2
203.	Participation	Consent	Consent not obtained	2 to 3
204.	Participation	Consent	Lack of informed consent	2 to 3
205.	Participation	Consent	Patient felt coerced	2 to 3
206.	Participation	Parental Access and Consent	Consent, guardianship and information issues related to lesbian, gay parental relationships	2 to 3
207.	Participation	Parental Access and Consent	Correct procedure not consented for	2 to 3
208.	Participation	Parental Access and Consent	Guardianship consent not explained	2 to 3
209.	Participation	Parental Access and Consent	Mother or father unable to access information	2 to 3
210.	Participation	Parental Access and Consent	Mother/Father/Guardian not informed	2 to 3
211.	Participation	Patients/ Family/ Relatives	Excluded from decision making process - family / relatives / advocate / next of kin	1 to 3
212.	Participation	Patients/ Family/ Relatives	Excluded from decision making process - patient	2 to 3
213.	Participation	Patients/ Family/ Relatives	Opinion discounted - family / relatives / advocate / next of kin	1 to 2
214.	Participation	Patients/ Family/ Relatives	Opinion discounted - patient	1 to 3
215.	Participation	Patients/ Family/ Relatives	Parent not allowed accompany child in recovery room	1 to 2
216.	Participation	Patients/ Family/ Relatives	Parent not allowed accompany child to theatre	1 to 2
217.	Participation	Patients/ Family/ Relatives	Second opinion	1 to 2
218.	Privacy	Confidentiality	Breach of another patient's confidentiality	1 to 3
219.	Privacy	Confidentiality	Breach of patient confidentiality	1 to 3
220.	Privacy	Confidentiality	Security of files and records	1 to 2
221.	Privacy	Hospital Facilities (Privacy)	Lack of privacy during consultation/discussing condition	1 to 3
222.	Privacy	Hospital Facilities (Privacy)	Lack of privacy during examination/ treatment	1 to 3

223.	Privacy	Hospital Facilities (Privacy)	Privacy - No single room	1 to 2
224.	Privacy	Hospital Facilities (Privacy)	Privacy - Overcrowding	1 to 2
225.	Improving Health	Empowerment	Independence and self care not supported	1 to 2
226.	Improving Health	Empowerment	Lack / provision of patient / carer education	1 to 2
227.	Improving Health	Empowerment	Patient / family preference discounted / disrespected	1 to 2
228.	Improving Health	Holistic Care	Lack of information / support on how to prevent further illness / disease	1 to 2
229.	Improving Health	Holistic Care	Lack of understanding as to what is important to the patient	1 to 2
230.	Improving Health	Catering	Dietary requirements not met	1 to 2
231.	Improving Health	Catering	Food quality	1 to 2
232.	Improving Health	Smoking Policy	Non-compliance (visitor, patient, staff smoking)	1 to 2
233.	Accountability	Patient feedback	Feedback not provided to patients on improvements made as result of their feedback	1 to 2
234.	Accountability	Patient feedback	Information about the complaints / patient feedback process not available	1 to 2
235.	Accountability	Patient feedback	Patient concerns not dealt with promptly	1 to 2
236.	Accountability	Patient feedback	Quality of response to the complaint made	1 to 3
237.	Accountability	Patient feedback	Where to go to ask questions in relation to services and giving feedback (visibility of customer services)	1 to 2
238.	Accountability	Finance	Bill dispute	1 to 2
239.	Accountability	Finance	Bill sent to deceased patient	1 to 2
240.	Accountability	Finance	Cost of products	1 to 2
241.	Accountability	Finance	Insurance cover	1 to 2
242.	Accountability	Finance	Invoice error	1 to 2
243.	Accountability	Finance	Unhappy with income collection process	1 to 2