A National Complaints Management Protocol for the Public Health Sector of South Africa

AUGUST 2014
The National Complaints Management Protocol for the Public Health Sector of South Africa (August 2014) will as from the date upon which it was signed, serve as a national protocol to manage complaints to be followed by all health authorities, health establishments, professional councils and/or boards and other institutions mentioned in this Protocol.

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DIRECTOR-GENERAL: HEALTH

DATE SIGNED
18/08/2014
# National Complaint Management Protocol

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1. INTRODUCTION

As enshrined in the national Patients’ Rights Charter everyone in South Africa has the right to complain about the health care they receive, to have such complaint investigated and to receive a full response on such investigation. This is enforced by Section 18 of the National Health Act and supported by requirements set out in domain one of the National Core Standards for Health Establishments in South Africa.

This National Complaints Management Protocol for the Public Health Sector of South Africa serves as a contribution towards upholding the right to complain and to improve the quality of health services. It aims at readily providing information to the public on how to complain within the public health sector and what to then expect in the event of complaining, and at providing guidance to the public health sector on how to manage complaints in view of resolving them as quickly as possible, particularly through immediate informal responses by frontline health workers, or through subsequent investigation and conciliation by staff empowered to deal with complaints as they arise. Furthermore, it guides a process whereby valuable information is gathered from which the health system could learn and to which it can positively respond by bringing about the required change.

Although this protocol serves as a guideline for the public health sector in South Africa, the principles underlying the protocol are equally applicable in the private health sector.

2. BACKGROUND

In April 2003, the National Department of Health (NDOH) released the first National Complaints Procedure/ Guideline for the Public Health Sector after a lengthy process of consultation with provincial officials and professional councils. Since this first release, the said guideline has been revised and released twice, i.e. in August 2006 and November 2009. However, both revisions entailed only minor changes to the original guideline. Despite the changes, the three documents have kept their focus as a national guideline on ensuring a coherent approach to managing complaints, while at the same time acknowledging the distinctive character of different provincial/ district and municipal complaints procedures as well as those procedures followed by professional bodies within the health domain.

The latest revision of the national guideline was triggered when a rapid assessment of provincial complaints management systems conducted during October 2012, revealed that the guideline had over time made limited inroads in ensuring a coherent national approach to managing complaints. Wide variations in managing complaints existed between provinces and even between facilities within the same province; for example, provinces were collecting statistical data on complaints differently, each province had their own view on what is meant by a resolved complaint and provinces all had their own systems to categorize complaints. Also, in an audit conducted in 100 public health facilities (hospitals, health centres and clinics around the country) during the period February to October 2012 and using the National Core Standards, an average compliance score of only 53% was obtained for the two standards related to complaints management.

Furthermore, a revision of the guideline became apparent when the Office of the President started to report that the complaints lodged at the Presidential Hotline are poorly managed
by the public health sector. This resulted in low complaints resolution rates, the latter being one of the indicators monitored by the Forum of South African Director-Generals (FOSAD).

The need to have a system in place that monitors the efficiency and effectiveness of a complaints management system also emerged when the Department of Public Service and Administration (DPSA) published their *Citizen Complaints and Compliments Management Framework in March 2013. In section 11 of the Framework government departments are requested to set in place such system that has been approved by the executive authority of a department.*

Due to the establishment of a Health Standards Ombud within the Office of Health Standards Compliance, there is no doubt that the ‘landscape’ in which complaints is being managed, will in future change. To be effective and efficient, such body will require an efficient and effective national standardised complaints management system that can deliver on the higher demands set by the Health Standards Ombud. 

Improving the overall management of complaints at establishment, district, provincial and national level has therefore become imperative. This revised protocol, along with the introduction of very specific standards and criteria as contained in the set of National Core Standards for Health Establishments and its accompanying audit tool, is a renewed attempt at improving the management of complaints at all levels of the health care system.

### 3. DEFINITION

For the purpose of this protocol a complaint is defined as the dissatisfaction, displeasure, disapproval or discontent expressed verbally or in writing by any person about the specific health services being rendered and or care being provided within the public health sector.

The complaints procedure as described in Section 8 of this protocol has however not been designed to address:

- Staff–specific grievances that is codified within Labour Relations legislation and thus be addressed through labour relations processes,
- Complaints that relate more to broad national health policies, for example the placement and building of new health facilities, the drug regimes for the treatment of specific diseases or disapprovals expressed towards legislation falling under the Portfolio Responsibilities of the Minister of Health, e.g. the Choice on Termination of Pregnancy Act and the Tobacco Products Control Amendment Act, and
- Complaints that relate to corruption which should be referred to the National Anti-Corruption Hotline (NACH)."
National Complaint Management Protocol

4. **OBJECTIVES**

In setting up a National Complaints Management Protocol, the perspective of both the complainant and the health sector should be considered, i.e. the health sector must be clear on why it needs a protocol and it must be understood why complainants make their grievances known.

4.1 **The key objectives of the public health sector**

The public health sector would like to attain the following key objectives through this protocol:

- **To respect the user/patient’s right to complain**: Rights are the cornerstone of any democracy. Constitutionally, all South Africans have the right to health care services and legally they may complain about the manner in which these services are provided to them. The public health sector must therefore respect, protect, promote, and fulfill this right to complain, and not revert to any form of victimization.

- **To resolve problems and satisfy the concerns of the complainant**: Concerns of complainants must always be taken seriously. The actions needed to address a complaint should always be geared towards resolving the problem.

- **To provide a simple complaints procedure everybody can understand**: All the steps of the complaints procedure must be clearly documented and must be made known to the public through various means of communication, for example pamphlets, brochures and posters in the appropriate languages.

- **To provide health service managers with a means to extract lessons on quality and to subsequently improve services for patients**: Complaints should be recorded and classified in such a manner that they can be easily analysed, trends identified and lessons drawn from the information at hand.

- **To ensure fairness for staff and complainants alike**: When complaints are investigated, the views, opinions, experiences and observations of all concerned should be objectively obtained and assessed without any prejudice.

- **To strive for honesty and thoroughness**: Investigatory processes when instituted should promote thoroughness and not protect the health establishment or staff’s own interest at the expense of the patient’s autonomy and interest.

- **To avoid unnecessary litigation**: Long delays in resolving complaints often lead to great frustration and to subsequent litigation. Unnecessary litigation as a means to resolve a complaint is not cost-effective, thus innovative ways of avoiding such cases should at all times be sought.
4.2 The key objectives of complainants

Complainants may have a variety of objectives when making their grievances known. These objectives need to be at least partially met during redress if the complainant is to be satisfied with the response he or she receives. These objectives can be one or more of the following:

- **To get acknowledgement**: Complainants’ views must be taken seriously. The mere fact that they had reason to complain must be acknowledged.

- **To receive an apology**: As a simple apology can be a very important objective for complainants, such an apology, if warranted, must be given without too long a delay.

- **To receive an explanation**: Information on what happened and why it happened needs to be provided to the complainant. This must be done in a language he/she understands. The explanation should not deny the complainant’s experience of events and it should also not degenerate into a form of making excuses.

- **To prevent recurrence**: People often complain in an altruistic manner to ensure something is done to prevent their (bad) experience happening to others as well. Getting a commitment to action in this regard becomes the main objective. This commitment must be given and conveyed to the complainant, and all actions committed to must be carried through.

- **To ask for compensation or special consideration**: Often complainants want action to take place that has a more direct bearing on either their own care or the care received by the patient on whose behalf they are complaining. This may include preferential or additional treatment, or even financial compensation.

- **To seek retribution**: Although seeking retribution is rather the exception than the rule, in some cases the complainant does want steps to be taken against individual health workers/health establishments for their ‘alleged’ wrongful actions or where they (the complainants) feel there is a cover-up of mistakes.
5. LEGAL AND POLICY FRAMEWORK

The constitutional, legislative and policy framework for the Complaints Protocol is as follows:

5.1 The Constitution of the Republic of South Africa.

Chapter 2 of the Constitution\(^2\), i.e. the Bill of Rights, bestow citizens \textit{inter alia} the right to have their dignity respected and protected, to take action against the State if they believe their constitutional rights have been infringed, and to have access to information held by the State which they need in order to be able to take action.

5.2 The National Health Act.

Section 18 of the National Health Act\(^3\) states that, (i) any person may lay a complaint about the manner in which he or she was treated at a health establishment and have the complaint investigated, (ii) the relevant Member of the Executive Council [MEC] and every municipal council must establish a procedure for the laying of complaints within those areas of the national health system for which they are responsible, and (iii) in laying the complaint, the person or user referred to above must follow the procedure established by the relevant MEC or the relevant municipal council, as the case may be. Section 18 also states that the procedure for laying complaints must, (a) be displayed by all health establishments in a manner that is visible for any person entering the establishment and the procedure must be communicated to users on a regular basis, (b) include provisions for the acceptance and acknowledgement of every complaint directed to a health establishment, whether or not it falls within the jurisdiction or authority of that establishment, and (c) allow for the referral of any complaint that is not within the jurisdiction or authority of the health establishment to the appropriate body or authority.

5.3 The White Paper on Transforming Public Service Delivery.

The White Paper on Transforming Public Service Delivery\(^4\) (the \textit{Batho Pele} White Paper) states it unequivocally as a principle that if a promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy. Furthermore, when complaints are made, citizens should receive a sympathetic, positive response. In section 4.7 of the White Paper clear guidance on remedying mistakes and failures are also provided to national and provincial departments.

5.4 Public Service Legislative Framework.

In terms of the Public Service Regulations, 2001 (based on the Public Service Act, 1994 as amended), an executive authority shall establish and sustain a service delivery improvement programme (SDIP) for her or his department. One of the key

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\(^3\) National Health Act, Act 61 of 2003  
\(^4\) The White Paper on Transforming Public Service Delivery, Department of Public Service and Administration Notice 1459 of 1997
elements of the service delivery improvement programme (as per the regulations), is that it should stipulate a system or mechanism for (managing) complaints. To assist departments in developing their complaints management systems, the Department of Public Service and Administration (DPSA) developed the *Citizen Complaints and Compliments Management Framework in March 2013.*

5.5 **Ethical rules for health providers.**

All health professionals are bound by ethical rules in their specific professional practice. As the gist of these rules has to do with the protection of their patients and the public at large, health professionals are thus held accountable for their professional acts and omissions. The ethical rules guide judgment against unethical practices of health professionals. Public health workers are also subject to the *Code of Conduct for Public Servants* in which the expected relationship of the employee with the public is clearly defined.

5.6 **The National Patients’ Rights Charter.**

One of the key objectives of the Patients’ Rights Charter is to empower users of health services to contribute towards improving the services. The right to complain as enshrined in the Patients’ Rights Charter provides citizens one way of contributing towards improving service delivery.

5.7 **The National Health Amendment Act.**

Section 78 of the Act states the objectives of the Office of Health Standards Compliance is to protect and promote the health and safety of users of health services by *inter alia* ensuring consideration, investigation and disposal of complaints relating to non-compliance with prescribes norms and standards in a procedurally fair, economical and expeditious manner. The said Act also states in Section 81A.(1) that the Ombud (within the said Office) may, on receipt of a written or verbal complaint relating to norms and standards, on his or her own initiative, consider, investigate and dispose of the complaint in a fair, economical and expeditious manner.

5.8 **National Core Standards for Health Establishments in South Africa.**

The National Core Standards for Health Establishments is structured into seven cross-cutting domains (see figure 1), with a domain being defined by the World Health Organisation as ‘an area where quality or safety might be at risk’, thus the need for standards under each domain. By implication these seven domains therefore do carry the potential to elicit a complaint of some kind should there be a breach or alleged breach of any of the standards under each domain.

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5 *Citizen Complaints and Compliments Management Framework, Department of Public Service and Administration (DPSA), March 2013, p9*

6 *The National Patients’ Rights Charter, DOH 1999*

7 *The National Health Amendment Act, Act 12 of 2013*

8 *National Core Standards for Health Establishments in South Africa, DOH 2011*
Domain 1 (*Patient Rights*) sets out what health establishments must do to make sure users or patients are respected, treated with dignity and their rights being upheld, including their right to complain. In Sub-domain 1.8, the following two standards on complaints management are listed:

a) Patients who wish to complain about poor service are helped to do so and their concerns are properly addressed, *and*

b) Complaints are used to improve service delivery

To meet these two standards, health establishments must ensure that they meet the following criteria:

(i) A clear procedure is used to manage complaints.
(ii) Patients are made aware of the complaints procedure.
(iii) Complaints are recorded using a formal procedure.
(iv) Complaints are screened to ensure adverse events are identified and appropriately managed.
(v) A procedure is in place for acknowledging, investigating and dealing with complaints.
(vi) Complaints are used to improve the quality of service delivery.
(vii) Complaints are addressed within nationally agreed timescale

These two standards are measured by means of assessment questionnaires and checklists.
6. CLINICAL GOVERNANCE, COMPLAINT MANAGEMENT AND SERIOUS ADVERSE EVENT MANAGEMENT

It is important to be mindful of the fact that managing complaints forms an integral part of clinical governance which aims at ensuring patients receive safe, accountable and effective care that will culminate in the best possible patient experience. Clinical Governance is defined as: “A systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes”, and it is described using 4 key pillars as set out in figure 2 below.

Figure 2: Four key pillars of Clinical Governance

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<td>a. Consumer liaison:</td>
<td>• Clinical Standards • Clinical Indicators • Clinical audits</td>
<td>• Incident and adverse event (AE) reporting, monitoring and trend analysis</td>
<td>• Selection and recruitment of staff • Ongoing professional development • Maintenance of provisional standards • Control and monitoring of new and innovative procedures • Staff Satisfaction Surveys</td>
</tr>
<tr>
<td>• Complaints Management • Patient Satisfaction Surveys • Providing information</td>
<td>b. Consumer participation:</td>
<td>• Sentinel event reporting, monitoring and clinical investigation • Risk profile analysis</td>
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<tr>
<td>• Involvement of consumers in Health Service planning, policy development and decision making</td>
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From figure 2, pillar 1 it is apparent that a complaints management system creates a platform through which the user of health services is able to positively influence (add value) to the health care he/she will receive.

Many serious adverse events (SAE), i.e. unfavourable events related to medical care causing injury or posing the risk of harm to a patient, are often firstly brought to the fore as a complaint and thus managed accordingly. This highlights the importance of having an effective complaints management system in place. The effectiveness of such system is demonstrated by its ability to, (a) easily identify the severity of the event/incident described by the complainant, (b) classifying it as being an adverse event or not, and (c) avoid the complaint from developing into a case of litigation.

Western Australia Clinical Governance Guidelines, Health Reform Implementation Taskforce, 2005, p2
It is recommended that once a complaint has been classified as a serious adverse event or a complaint has turned into a case of litigation, the further management thereof (e.g. investigation and resolution) will be done through systems other than the complaints management system and by provincial and local structures specifically set up to deal with serious adverse events and cases of litigation respectively. Should the latter be the case, the further investigation of the complaint as a complaint will cease immediately, because any report emanating from such investigation could lead to the use thereof as evidence in a court of law, thus the case becomes *sub-judice*.

### 7. GUIDING PRINCIPLES

The following principles guiding the National Complaints Management Protocol embrace the objectives both of the complainant and of the public health sector\(^\text{10}\).

#### 7.1 Accessibility

It must be made as easy as possible for users to complain. The complainant should be encouraged to complain at the point of service. All attempts should therefore be made to reduce potential barriers such as race, language, literacy, attitude etc. An easy-to-understand complaints procedure is desirable, because it is then likely to also be more accessible for vulnerable groups such as blind and deaf people, and illiterate people, as well as being easier to use by those managing it.

#### 7.2 Responsiveness

The procedure should be responsive to the complainant's needs and expectations. Although it should aim at satisfying the complainant, it should also satisfy the objectives of the public health sector. This can be achieved by optimally utilising the procedure to learn, to avoid unsatisfactory events recurring, and to identify system problems that need improvement.

#### 7.3 Speed

Resolving complaints as quickly as possible, particularly through immediate informal responses by frontline health workers, is imperative. This can help prevent dissatisfaction growing or further complaints arising about delays. Where a delay is unavoidable, the complainant should be kept informed of progress and told when an outcome can be expected.

#### 7.4 Impartiality/fairness

Once a complaint is made, the procedure should ensure that different points of view from both complainant and respondent are listened to and investigated without prejudice. All investigations should also be conducted in an open and non-defensive way.

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\(^{10}\) Citizen Complaints and Compliments Management Framework, Department of Public Service and Administration (DPSA), March 2013, p14-15
7.5 Confidentiality

The complainant’s right to confidentiality of all information pertaining to his/her complaint must at all times be respected. The patient’s expressed consent is not needed if his/her personal information is required to investigate a complaint. However care must be taken throughout the complaints management procedure to ensure that any information disclosed about the patient is confined to that which is relevant to the investigation of the complaint and only disclosed to those people who have a demonstrable need to know it for the purpose of investigating the complaint.

7.6 Cost effectiveness

It is important that the investment in complaint handling is not disproportionate to the resources available to improve services. International literature indicates that cost increases substantially the more formally complaints are investigated and considered.

7.7 Review

A complaints management system should incorporate a system for review of complaints and feedback suggestions for change to departments, so that mistakes and failures do not recur.

7.8 Training

Complaints management procedures should be publicized and staff members trained so that they know what action(s) to take when a complaint is lodged.
8. **A SYSTEM TO LODGE AND MANAGE COMPLAINTS**

In figure 3 below, a three-stage system for managing complaints is set out. Every stage represents a level of authority where certain steps need to be taken to ensure a complaint is successfully managed. It should be noted that the users of health services have the right to lodge a complaint at any level they wish, though they may at any stage be referred back to the relevant level of authority when applying the principle of encouraging users to complain at the point of service.

**Figure 3:** Flow diagram of a three-stage system to manage complaints

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**8.1 Stage 1:** Aims at resolving the complaint at the health establishment, i.e. at the point of service and as quickly and amicably as possible.

- As soon as a complaint gets lodged, providers shall resolve it as quickly as possible. Immediate investigation/ conciliation is instituted which involves an oral and first line response.
- If the complaint cannot be resolved on the spot, it will be referred to the head of the establishment concerned.
- The head of the health establishment or his/ her appointee must be the *Complaints Manager* of the health establishment who will investigate the complaint.
8.2 Stage 2: Aims at reviewing and investigating complaints that were not resolved to the satisfaction of the complainant during Stage 1. This stage also ensures that complaints that cannot be resolved by the health establishments within the specified time frame as determined by the Provincial Head of Health (see section 10.i), are escalated. This stage ensures that the District Manager or Provincial Head of Health heeds complaints.

- In case of no response or dissatisfaction with how the complaint was managed during Stage 1, the complainant has the right to take the matter to the Provincial Head of Health or the District Manager.
- If the health establishment was not able to resolve the complaint within the specified time frame as determined by the Provincial Head of Health (see Section 10.i), the health establishment must escalate the complaint to the District/Provincial Office for further management.
- The Provincial Head of Health or District Manager will review and investigate the complaints he/she receive.
- Any complaint received by the Minister of Health, Director-General of Health or National Department of Health about provincial health services, may be referred to the relevant Provincial Head of Health for his/her further investigation and feedback to the complainant (see Sections 10.e and 10.h) or to the institutions listed in Stage 3.

8.3 Stage 3: Aims at reviewing and investigating complaints that were not resolved to the satisfaction of the complainant during Stages 1 and 2 that warrant the attention/intervention of other institutions. Once the time frame for resolving complaints has lapsed, the complainant becomes entitled to approach other institutions.

- If the complaint is not resolved to the satisfaction of the complainant during stages 1 and 2, or time frames for resolution have lapsed, the complainant has the right to take recourse to the following institutions:
  - The Health Standards Ombud situated in the Office of Health Standards Compliance.
  - The Public Protector, Public Service Commission, Human Rights Commission and Consumer Commission that serve to protect the public from mal-administration and impropriety.
- Lodging a complaint with one of the above-mentioned institutions will be with the Head of the said institution.
- Each institution will manage complaints in accordance with the appropriate regulations pertaining to their relevant complaints management and disciplinary processes promulgated in terms of their respective acts.
- The complainant may also take recourse to the South African private legal system or approach the High Court for relief in instances where he/she is aggrieved by the outcome of the investigations conducted by the different levels of authority/institutions during stage 1, 2 and 3.\textsuperscript{11}

\textsuperscript{11} Citizen Complaints and Compliments Management Framework, Department of Public Service and Administration (DPSA), March 2013, p16
8.4 Complaints that directly relate to the professional conduct of health professionals

- Complaints made by the public that directly relate to the professional conduct of a health professional can be -
  - Lodged directly at the relevant professional Council and/or professional Board.
  - Referred to the professional Council/Board by the relevant health establishment/health authority/institution during stage 1, 2 or 3.

- The complaint must be lodged with the Registrar of the relevant professional Council and/or professional Board who in turn could oblige a establishment/health authority/institution to provide documents related to the complaint.

- Each professional Council and/or Board will manage complaints in accordance with the appropriate regulations pertaining to their relevant complaints management and disciplinary processes promulgated in terms of their respective acts.

- Where the complainant remains dissatisfied with the outcome of his/her complaint, he/she can take the matter on appeal to an appeals committee appointed by the relevant Council.

9. REQUIRED ACTIONS FOR HEALTH ESTABLISHMENTS

All procedures relevant to the Complaints Management Protocol must be upheld by all health establishments. The manager of a health establishment will be responsible and held accountable for ensuring complaints are managed according to this protocol\(^\text{12}\) and there is adherence to the principles that guide this protocol (see Section 7).

The following actions need to be taken:

9.1 A written Complaints Procedure

The health establishment must have a written procedure for the management of complaints. The procedure must include the following:

- The name and contact details of the Complaints’ Manager and the location of his/her office. These details must be displayed in a conspicuous manner throughout the establishment.
- The procedure for lodging a complaint (including telephonic complaints).
- The procedure around acknowledgement.
- The procedure for investigating a complaint.
- The procedure for determining the required action to be taken according to the severity of the complaint (risk rating).
- The procedure for identifying patterns in system failures (categorisation).
- The procedure around redress.
- Timelines to be adhered to.
- Monitoring mechanisms and their response timelines.

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\(^{12}\) Citizen Complaints and Compliments Management Framework, Department of Public Service and Administration (DPSA), March 2013, p20, section 11.
• Mechanism to ensure children’s participation in the complaints process.
• Mechanism to ensure that vulnerable groups such as disabled people, the elderly, mentally ill people, illiterate people and people speaking foreign languages can easily participate in the complaints process.

9.2 Conveying information to the public regarding the lodging of complaints

• Every health establishment must prominently display its complaints procedure together with the Patients' Rights Charter and the Patients' Responsibilities at all entrances and exits used by patients/users of the services.
• The Complaints Procedure must be made available at all health establishments in the form of a pamphlet/booklet/poster, written in languages understood by at least the majority of users of an establishment. Special communication methods shall be established for those that have visual and hearing impairments. Patients unable to understand the local language should be assisted.
• The Complaints Procedure must on a routine basis be provided to all first time users of the service in the form of a booklet/pamphlet. This process shall be addressed as part of health education for users.
• Health establishments shall have visible signposting to lead the user/complainant to the point where complaints should physically be lodged.

9.3 Forum for reviewing complaints

• Health establishments must have forums for reviewing complaints.
• These review forums must have clear Terms of Reference. However, should it transpire that setting up a separate forum for reviewing complaints is impracticable, this function of reviewing complaints should be part of the Terms of Reference of Hospital Boards and Clinic Committees.
• These committees could assist in addressing/resolving complaints. They have an important role to play in translating the views, opinions, wishes and advice of their communities back into establishment plans aimed at rectifying system failures identified through the complaint management process.
• The health establishment’s Complaint Manager will facilitate forum meetings where complaints are reviewed and minutes of these meetings will be kept.

9.4 Lodging a complaint

• Health establishments should encourage users and their families and make it easy for them to complain in any manner they wish to. Therefore the necessary forms should be readily available as well as staff that can assist them to complete it.
• A standardised complaint form (See Annexure A, Section A) is to be completed by every person that wishes to lodge a complaint in person at a health establishment.
• In cases where health establishments receive complaints via fax, post or per e-mail, there is no need to complete Annexure A, Section A because these written complaints (usually) carry the relevant details that are needed to conduct a meaningful investigation. In cases where the written complaint does not contain all the information needed to investigate the complaint, the complainant must be contacted and the information must be requested. It is recommended that
Annexure A, Section A is used in these instances

- Staff members responsible for managing complaints must complete the form for complaints that are lodged with the establishment telephonically.
- Health establishments will avail staff members to assist those complainants in need, to fill in the complaint form. If a user cannot write, the complaint should be written down verbatim.
- Health facilities should have complaint/ compliment boxes in designated areas where complainants/ patients can put their completed complaint forms in. These boxes should be emptied on a daily basis. If health facilities do not check the boxes on a daily basis a notice should be placed next to the box stating the times when the boxes are emptied, e.g. opened every Monday or opened on the first Monday of every month. The notice should also inform complainants/ patients that if their complaint is to be attended to immediately, they should approach the Complaint Manager of the establishment directly.
- For convenience, Annexure A, Section A (form to lodge a complaint) should be printed back to back along with Annexure A, Section B (form to log the processing of a complaint).

9.5 Acknowledgement of complaints

- A complaint must be acknowledged within 5 working days after receipt by the relevant health establishment.
- Acknowledgement can be done in writing (by means of posting, e-mailing or faxing the acknowledgment letter to the complainant) or telephonically (date on which acknowledgment is done must be recorded).
- Complainants must be informed on how long they can expect to wait to receive a response.
- The reference number allocated to the complaint (taken from complaint form) must also be conveyed to the complainant when acknowledging his/ her complaint.

9.6 Taking appropriate action according to the severity of the complaint

- All formal complaints must upon receipt be assessed immediately to identify the severity/ risk and the appropriate course of action that needs to be taken.
- The purpose of risk assessment is to identify high risk complaints that raise significant safety, legal or regulatory issues, which need to be dealt with by senior management immediately after they have been notified, or through systems other than the complaints management system (refer to Section 6).
- The severity assessment matrix\(^{13}\) (see Annexure B) is a useful tool to assist with consistent and reliable risk assessment.
- A rank rating can be obtained by combining the consequences (or severity) of an incident with the probability (or likelihood) of the same type of incident recurring as per the matrix.

9.7 Investigating a complaint

- No single strategy applies to all investigations of a complaint. Strategies should be specifically tailored to the situation each investigation requires.
- The critical first step in conducting an investigation is writing down the allegation(s) contained in a complaint. It determines the specific issue(s) to be investigated as well as the facts that needs to be determined/obtained.
- Good planning is the key to a good investigation. An investigative plan may be simple or complex. It provides a strategy that focuses on determining/obtaining only the essential information required that will ultimately resolve the complaint.
- The investigative plan should amongst others include who should be interviewed, what records should be reviewed, what questions should be asked and what the most effective strategy for conducting the investigation would be.
- It is important to interview everyone who has knowledge of and direct interest in the event(s) that is being investigated. It is also important to identify and scrutinize all relevant documentation or records that may contain information that could help the investigating officer determine all the facts¹⁴.

9.8 Identifying system failures (Categorisation)

- Health establishments are expected to categorise the complaints they do receive according to the categories as prescribed by the provincial office (see Section 10.i).
- It is important for health facilities to follow trends of the types of complaints they do receive, because in so doing they are able to identify the most common system failures and whether these failures become worse or improve over time as a result of improvements.
- Once a significant system failure has been identified the root cause must be identified and addressed in order to improve the quality of care.
- Health establishments must report on these categories to the provincial office per reporting period.

9.9 Resolution of complaints

9.9.1 Redress of complainants

- Once the investigation of a complaint has been conclude the complainant must be redressed. The aim of such redress is to reach a fair and reasonable resolution in an amicable manner (see Section 4.2).
- Redress refers to a range of appropriate responses that can be provided to a complainant by a health establishment. Such responses or remedies can include one or more of the following:
  - An apology, explanation or an acknowledgement of responsibility.
  - Remedial action that may include (i) the review or changing of a decision on the service or care provided to an individual complainant, (ii) revising published material, (iii) revising a procedure to prevent the recurrence of a wrong event/incident, and (iv) the training of staff members or strengthening of their

¹⁴ Guide for Ombudsman institutions – how to conduct investigations, United Nations Development Programme, 2006, p61-63
supervision; or any combination of the above.

- A written letter/report on the outcome of the investigation must be provided to the complainant. In the event of a redress meeting being held, the complainant must also be provided with a report on such meeting.

9.9.2 Time frames for resolving complaints
The complaint will be investigated and the final outcome of the investigation will be conveyed to the complainant within a target time of 25 working days. However, should the complexity of the investigation require an extension of this 25-day period the complainant will be provided with a progress report within the said 25 working days\(^1\).

9.9.3 Types of resolution
A complaint is viewed as having been resolved under the following circumstances:

- **Patient is satisfied/ Redress done**: The complainant indicates that he/she accepts the establishment’s response regarding the complaint and/or any redress meeting with the complainant concludes that the complaint is now resolved. In some instances it does happen that complaints cannot be resolved to the satisfaction of the client. Should this happen the reasons need to be carefully documented as to why the complainant is still dissatisfied and what attempts were made, to resolve the complaint.

- **Litigation**: The complainant indicates at any stage of the complaint management process that he/she is dissatisfied with the way in which his/her complaint has been managed and has therefore taken legal action against the establishment (i.e. when a complaint proceeds to litigation).

- **Serious Adverse Event**: It becomes apparent at any stage of the complaint management process that the complaint is in reality a serious adverse event which requires to be managed as such, i.e. through serious adverse event management processes. Should the latter be the case, the reference number assigned to it in the adverse event register must also be recorded in the Complaints’ Register.

- **Complainant/patient cannot be traced**: When additional information is required from the complainant/patient to enable further investigation of the complaint, the complainant/patient must be contacted to obtain the information. In instances where the complainant/patient could not be reached on the first attempt, he/she must be contacted at least twice thereafter for two consecutive weeks. If the complainant/patient could still not be traced, the complaint can be seen as resolved (closed). In such circumstance the dates and the methods used to contact the complainant/patient must be documented. The same also applies when a complainant/patient cannot be traced to conduct redress.

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\(^1\) Citizen Complaints and Compliments Management Framework, Department of Public Service (DPSA), March 2013, p16)
Please note that for the purpose of this protocol and considering the definition of “resolved” as applied by auditors when auditing the two national Annual Performance Plan (APP) indicators related to complaints management (see Section 9.10 below), a “resolved” complaint is viewed as “closed” and a “closed” complaint as being “resolved”.

9.10 Complaints Register

Each health establishment must log all their complaints in a register that contains the following information (see Annexure D):

- The reference number of the complaint.
- The date the complaint was received.
- The surname and name of the complainant.
- The surname and name of the patient.
- A short summary describing the essence of the complaint.
- Action taken to resolve the complaint, including the outcome of the complaint (level of satisfaction of the complainant) as well as the remedial action taken to prevent a recurrence of the same incident.
- The category of the complaint (assessed when logged and reassessed once the complaint has been resolved).
- The severity of the complaint (determined when logged and reassessed once the complaint has been resolved).
- Type of resolution (refer to Section 9.8.3 above).
- The date the complaint was resolved.
- The number of working days it took to resolve the complaint.

A manageable filing system should be laid on as to ensure all documents relating to complaints are filed and a paper trace of each individual complaint is developed. Section B of the Complaint form (see Annexure A), i.e. ‘form to log the processing of the complaint’ can be completed once the investigation and redress has been finalized in order to have a summary on the management of the complaint. This can be filed together with Section A of the Complaint form (see Annexure A), i.e. ‘form to log a complaint’ and all other documents pertaining to the specific complaint collected during the investigation.

All statistical data that is being submitted, letters of complaints and investigative reports must tally with the number of complaints registered in the complaints’ register.

9.11 Reporting on complaints: Indicators and Categories

Health establishments shall on a monthly basis report to their provincial office, on all the complaints they have received and resolved. The report must contain the following information relating to complaints:

- \[ \% \text{ Complainants resolved} = \frac{\text{Number of ComplaintsResolved} (\text{numerator})}{\text{Number of ComplaintsReceived} (\text{denominator})} \times 100 \]
• % Complaints resolved within 25 working days (see Annexure E):
  \[
  \frac{\text{Number of Complaints Resolved within 25 working days (numerator)}}{\text{Number of Complaints Resolved (denominator)}} \times 100
  \]

• Number of complaints received per category (see Annexure C).

10. REQUIRED ACTIONS FOR PROVINCIAL HEADS OF HEALTH

It is recommended that the Provincial Head of Health (PHOH) takes the responsibility for ensuring the following in his/her province:

a) At least one person on his/her establishment is appointed to oversee the complaints procedure in the province. This person will be the provincial Complaints Manager who could be assisted by a provincial panel constituted by the PHOH, when managing and resolving complaints.

b) The functionality of the provincial Complaints Management System is regularly assessed to determine its effectiveness and efficiency.

c) Complaints management procedures are publicised throughout the organisation and training is provided to all staff members to ensure they know what actions to take when a complaint is received, needs investigation, and redress with complainants needs to take place.

d) The Complaints Management Procedure is made available at all facilities throughout the province in the official language(s) commonly understood by the communities that are served by the facilities.

e) All complaints referred to or lodged with the PHOH are investigated according to the actions required by health facilities as set out in Section 9.

f) Complaints are referred to the relevant professional Council and/or Board, if so required.

g) A complaint is referred to the Ombud within the Office of Health Standards Compliance for further investigation should the complainant remain dissatisfied with the outcome of the province’s initial investigation and/or disagrees with the actions taken by the province in dealing with the complaint.

h) A set number of days is allocated to stages 1 and 2 (see Sections 8.1 and 8.2) respectively. The combined number of days set for the two stages should be set within the APP parameter of 25 working days. For example, 20 working days can be allocated to the establishments to investigate the complaint (i.e. Stage 1), but if the establishment is not able to resolve the complaint within the 20-day period, it will have to escalate the complaint to the District/ Provincial Office (Stage 2) who will then in turn have 5 working days to investigate and resolve the complaint. See figure 4 as example\textsuperscript{16}.

\textsuperscript{16} Citizen Complaints and Compliments Management Framework, Department of Public Service (DPSA), March 2013, p17)
Figure 4: Flow diagram to illustrate the allocation of the number of days per Stage 1 and Stage 2

i) Complaints should be categorised based on selected key sub-domains and standards of the National Core Standards to enable staff to identify system failures in time (see Annexure C). From the list of 26 categories, provincial offices should select categories according to those priority areas that still need improvement in their province. It is recommended that not less than 10 categories are selected and that the category “Other” does not become more than 20% of the total number of complaints that are being categorised, because this will render an analysis of the complaints meaningless.
11. REQUIRED ACTIONS FOR PROFESSIONAL COUNCILS AND/OR BOARDS AND OTHER BODIES

a) The relevant Professional Council and/or Board and other institutions mentioned in Section 8.3 must acknowledge receipt of any complaint either referred to them by the national and provincial health departments or directly received from the public, in terms of their own regulations.

b) Professional Councils and/or Boards and the Health Standards Ombud in the Office of Health Standards Compliance must provide a written report on progress made with or on the final outcome of their investigation to either the national or the provincial health departments, depending on who originally referred the complaint to them.
**National Complaint Management Protocol**

**ANNEXURE A**

**SECTION A**

**FORM TO LODGE A COMPLAINT:** (Please complete only Section A of the form to lodge a complaint on services rendered at our establishment)

<table>
<thead>
<tr>
<th>Today’s Date</th>
<th>Ref no</th>
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<table>
<thead>
<tr>
<th>Details of the complainant/patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Name</td>
</tr>
<tr>
<td>Your Surname</td>
</tr>
<tr>
<td>Your file number</td>
</tr>
<tr>
<td>If you were admitted, the ward no. (where you were admitted)</td>
</tr>
<tr>
<td>Your Contact details</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you are lodging a complaint on behalf of someone else; please complete the section below:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your relation to the patient; e.g. mother, husband, etc.</td>
</tr>
<tr>
<td>The patient’s Name</td>
</tr>
<tr>
<td>The patient’s Surname</td>
</tr>
<tr>
<td>The patient’s File Number</td>
</tr>
<tr>
<td>If patient was admitted; the Ward No. (where he/she was admitted)</td>
</tr>
<tr>
<td>Contact details of the patient</td>
</tr>
</tbody>
</table>

**Please describe the incident that you want to complain about:** (Where possible indicate the date of the incident, the staff involved and department where the incident took place)

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</table>
# National Complaint Management Protocol

## ANNEXURE A

### SECTION B

**FORM TO LOG THE PROCESSING OF THE COMPLAINT** (To be completed by the health establishment)

<table>
<thead>
<tr>
<th>Manner in which complaint was lodged (mark the applicable with a cross)</th>
<th>Written</th>
<th>Verbal</th>
<th>Physical visit</th>
</tr>
</thead>
</table>

| Date of acknowledgment to complainant |

**Category of Complaint**

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Date Complaint was resolved</th>
<th>Date Complaint was Lodged (retrieved from section A)</th>
</tr>
</thead>
</table>

**Number of working days to resolve complaint** (calculate by using above two dates)

| Date response given to complainant |

**Type Of Resolution** (mark the applicable with a cross)

<table>
<thead>
<tr>
<th></th>
<th>Patient Satisfied/redress done</th>
<th>Serious Adverse Incident</th>
<th>Litigation</th>
<th>Complainant/Pt couldn’t be traced</th>
</tr>
</thead>
</table>
ANNEXURE B

THE SEVERITY ASSESSMENT MATRIX

Step 1: Determine the likelihood of the complaint reoccurring in the table for Likelihood
Step 2: Determine the severity of the complaint in the table for Severity
Step 3: Determine risk by aligning the likelihood with the severity in the SAM
Step 4: Determine action to be taken

Step 1 - Table: Likelihood

<table>
<thead>
<tr>
<th>LIKELIHOOD</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost certain (5)</td>
<td>Recurring, frequent, predictable. Under normal circumstances, this event occurs persistently (perhaps three or four times a month?)</td>
</tr>
<tr>
<td>Likely (4)</td>
<td>Happens regularly. Under normal circumstances, this event is likely to occur (perhaps once or twice a month?)</td>
</tr>
<tr>
<td>Possible (3)</td>
<td>Happens from time to time – not frequently or regularly. Under normal circumstance, this event may occur occasionally (perhaps three to four times a year?)</td>
</tr>
<tr>
<td>Unlikely (2)</td>
<td>Rare, unusual, but may have happened before. Under normal circumstances, this event is unlikely to occur (perhaps less than twice a year?)</td>
</tr>
<tr>
<td>Rare (1)</td>
<td>Isolated or “one off” – slight or vague connection to service provision. Under foreseeable circumstances, this event is not expected to occur again (perhaps less than twice in five years/)</td>
</tr>
</tbody>
</table>

Step 2 - Table: Severity

<table>
<thead>
<tr>
<th>SEVERITY</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| Insignificant / Minor (1) | No harm to patients as a result of receiving health care. 
No harm to visitors that requires medical treatment. 
No loss of service. 
Low financial loss. 
Minor damage to customer service relationship. |
| Moderate (2) | A patient has suffered harm in the course of treatment, no further treatment is required. 
Reduced efficiency or some disruption to services. 
Significant financial loss. 
Significant loss of customer service relationship. |
| Major (3) | A patient has suffered harm as a result of receiving health care in a manner that is unrelated to the natural course of the illness and differing from the expected outcome of patient management, resulting in hospitalisation (or increased length of stay). 
Permanent injury to visitors. 
Loss of service capability including cancelled appointments. 
Major financial loss. 
Serious breakdown of customer service relationships. |
| Catastrophic (4) | A patient has died as a result of receiving health care in a manner that is unrelated to the natural course of the illness and differing from the expected outcome of patient management. 
Death of a visitor. 
Complete loss of service capability. 
Huge financial loss. 
Serious threat to customer service relationships, permanent harm to reputation of the service |

### Step 3 - Severity Assessment Matrix (SAM)

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Insignificant/ Minor (1)</th>
<th>Moderate (2)</th>
<th>Major (3)</th>
<th>Catastrophic (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost certain (5)</td>
<td>Medium</td>
<td>High</td>
<td>Extreme</td>
<td>Extreme</td>
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<tr>
<td>Likely (4)</td>
<td>Medium</td>
<td>High</td>
<td>Extreme</td>
<td>Extreme</td>
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<tr>
<td>Possible (3)</td>
<td>Medium</td>
<td>High</td>
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<td>Extreme</td>
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<tr>
<td>Unlikely (2)</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td>Extreme</td>
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<tr>
<td>Rare (1)</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
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### Step 4 - Table: Outcome: Determining Action Required

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<tr>
<th>ACTION REQUIRED</th>
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<tr>
<td><strong>4 Extreme</strong></td>
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<td><strong>3 High</strong></td>
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<tr>
<td><strong>2 Medium</strong></td>
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<tr>
<td><strong>1 Low</strong></td>
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### ANNEXURE C

**Categories for Complaints according to the Sub-domains and Standards of the NCSs**

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<tr>
<th>Sub-domain</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
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<td>1.1 Respect and dignity</td>
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<td>1.2 Access to information for patients</td>
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<td>1.3 Physical access</td>
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<td>1.4 Continuity of care</td>
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<td>1.5.1 Waiting times and queues are managed</td>
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<td>1.5.2 Waiting lists for operations are kept short</td>
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<td>1.6 Emergency care</td>
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<td>1.8 Complaints management</td>
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<td>2.2 Clinical management of priority health conditions</td>
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<td>2.4.2 Pregnant mothers, children, mentally ill &amp; elderly pt's receives special attention</td>
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<td>2.4.3 Patients undergoing high risk procedures are protected</td>
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<td>2.6 Infection prevention and control</td>
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<td>3.1.2 Medicines and medical supplies are in stock</td>
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<td>3.1.4 Medicines correctly prescribed/patients educated</td>
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<td>3.2 Diagnostic services</td>
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<td>3.3 Therapeutic and support services</td>
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<td>3.7 Clinical Efficiency Management</td>
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<td>6.7 Medical Records</td>
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<td>7.1 Buildings and grounds</td>
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<td>7.3 Safe and secure environment</td>
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<td>7.4 Hygiene and cleanliness</td>
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* Calculate: (Number received per category/Grand Total)*100 (e.g. 20 complaints categorised under Respect and dignity. Grand Total for number of complaints received is 40: 20/40*100= 50%)
COMPLAINTS REGISTER

<table>
<thead>
<tr>
<th>Ref No. (Column A)</th>
<th>Date Received</th>
<th>Complainant's Name &amp; Surname</th>
<th>Patient's Name &amp; Surname</th>
<th>Summary description of the Complaint</th>
<th>Information on i.) Action taken, ii) Outcome, iii) Remedial action</th>
<th>Category of Complaint (NCS Sub-domain)</th>
<th>Severity of Complaint (Risk Rating)</th>
<th>Type of Resolution</th>
<th>Date Resolved (Column B)</th>
<th>Number of working days to resolve Complaint (Column D)</th>
</tr>
</thead>
</table>

Column name (e.g. A, B and D) in the heading of the complaints register refer to the columns to be completed in Annexure F:

- To obtain column A of Annexure E count the number of reference numbers for the month.
- To obtain column B of Annexure E count the number of complaints resolved (count the rows where dates have been entered). Very important: also check previous month’s registers for complaints that have been resolved for the current month and add all the complaints that have been resolved for the current month. In some instances you can have more complaints resolved than received for a specific month because complaints of previous months were resolved in that specific month.
- To obtain column D of Annexure E count the number of complaints resolved within 25 days only. Same principle applies as previous bullet; therefore check previous month’s registers.
ANNEXURE E

FORMAT FOR SUBMITTING STATISTICAL DATA ON COMPLAINTS

Name of Establishment/Province: ________________________________

Financial Year: ________________________________

<table>
<thead>
<tr>
<th>Column Name</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
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