Complaints, Problems and Events Overview

- This overview aims to simplify the recording and management of problems, complaints and Events. For the purpose of this overview, problems, complaints and events are all called **'Events'**

- An individual Event Record (G 110A) is created for every Event

- A log is made of every Event Record in the Event Register (G 110B). Note that you may decide to file patient complaints records, logs and related documentation separately from other Event records

- A **complaint** is any expression of dissatisfaction by a patient (or their representative) about a dental service or treatment. Complaints can be verbal or written and can be about any part of the service you provide. All complaints must be logged internally, even if the complaint was verbal and resolved within 24 hours.

- A **problem** is any untoward incident that occurs at the practice including staff complaints, late deliveries, repeated laboratory errors, management mistakes and equipment breakdowns

- An **Event**, for the purposes of this procedure, is something untoward that happens in your practice that has an impact, good or bad. Events can fall into a number of classifications, some of which need to be reported e.g.:
    - *A Safety Incident*: Any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare including an adverse incident or clinical error. [Scotland call this an Adverse Event] [Northern Ireland call this an Adverse Incident]
    - *A Serious Incident*: Includes death, injury, abuse, something that stops the practice delivering acceptable care as well as taking out or treating the wrong tooth. [Scotland call this a Significant Adverse Event] [Northern Ireland call this a Serious Adverse Incident]
    - *A Never Event*: Events that should never take place if available guidelines and standards are followed, for example wrong tooth extraction or implant placement
    - *A Negative online review*: These do not need to be reported, but should always be investigated internally

- When an Event happens – if it needs recording it is probably a Significant Event and needs **Significant Event Analysis** (SEA) – then you will decide if it is a Never Event, Safety Incident, Serious Incident or equivalent– then you need to decide if it needs reporting and who to report it to

- A Significant Event, such as one of the incidents above, is something good or bad that happens, which impacts on a member of staff, a patient or the practice. It is an unusual event rather than an everyday occurrence

- Significant Event Analysis (Root Cause Analysis in Wales) is a way to learn from all incidents and improve patient care. You are expected to carry out by the CQC and most other regulatory bodies. The National Patient Safety Agency (NPSA) strongly recommends that SEAs should be routinely undertaken by primary care teams

- Many Events must also be notified. See the Managing Events section below for further details of when and how to notify

- Make sure that your procedures comply with the NHS regulations, GDC Standards and are in line with the current regulators in your region. If in doubt consult your professional indemnity organisation

Patient Complaints Management

Complaints manager
Practices must appoint a complaints manager and include their details in the Patient Complaints Procedure (G 110C or G 110CW). Complaints should be managed following the Patient Complaints Procedure, Complaints Handling Policy (M 233-COM) and this overview on Patient Complaints Management.

The Complaints Handling Policy and Patient Complaints Procedure should be reviewed regularly by the practice and all new team members must be trained on complaints management at their Staff Induction (M 225A). Complaints management is reviewed at the iComply Annual Management Review and can be audited with Optional Audit of Patient Complaints (G 180-APC).

Responsible person
NHS providers must also appoint a 'Responsible Person' who ensures the practice complies with its procedure and carries out any necessary actions following a complaint. For sole traders this must be the practice owner and for partnerships it must be a partner in the practice. Exceptions to the above are that Scottish contract holders are allowed to delegate this role to a suitable person within the practice and corporates in all regions can appoint their practice managers. The responsible person and the complaints manager can be the same person.

New complaints principles
Practices should develop a framework for managing complaints and feedback based on these principles:

1. All patient feedback is important to us
2. We want to make it easy for patients to raise a concern or complain, if they need to
3. We follow a complaints procedure and keep patients informed
4. We will try to answer all patient questions and any concerns raised
5. We want patients to have a positive experience of making a complaint
6. Patient feedback helps us to improve our service

Display and publishing of complaints procedure
The Patients Complaints Procedure (G 110C or G 110CW) must be clearly displayed in the practice where patients can easily see it. GDC standards require that the complaints procedure is available on your website and NHS practices are required to include the procedure in their patient information leaflet.

Handling and resolving complaints
Acknowledgement
Most complaints must be acknowledged in writing within a specific time:

- In England, complaints must be acknowledged within 3 working days

A copy of the Patient Complaints Procedure (G 110C or G 110CW) should be enclosed with the acknowledgement.

Local early resolution
In **England, Wales and Northern Ireland** if a simple verbal complaint can be resolved easily within 24 hours there is no requirement to write to a patient. If a verbal complaint cannot be resolved within 24 hours a written copy of the complaint must be created and sent to the complainant along with an acknowledgement letter.

In both of the scenarios above a full and accurate record must be kept of the complaint

Recording complaints
All complaints must be recorded on an Event Record (G 110A) and also be logged in the Event Register (G 110B). Complaint Records must be treated as confidential, kept separately from clinical records and only be accessible by authorised persons. Any correspondence or investigation records about the complaint must also be stored with the Record and Register.

Handling manner
Patient complaints should be handled politely, showing consideration, by listening to patients and by involving them fully in the process of resolving the complaint.

Timescale of resolution
Aim to resolve a complaint as quickly, effectively and smoothly as possible. Speed is a top priority when handling complaints. The longer you leave a complaint unresolved, the more dissatisfied the patient may become.

GDC Standards for the Dental Team states:

> *"5.3.4 You must respond to complaints within the time limits set out in your complaints procedure*
>
> *5.3.5 If you need more time to investigate a complaint, you should tell the patient when you will respond*
>
> *5.3.6 If there are exceptional circumstance, which mean that the complaint cannot be resolved within the usual timescale, you should give the patient regular updates (at least every 10 days) on progress."*

Complaints from patients must be resolved within a specific time:

- In England, for written complaints and those that require investigation, a full response must be provided in writing as soon as is practical. Generally, practices aim to resolve complaints within 10 working days

If a response to a complaint is likely to take longer than anticipated, or if there are any other delays, the patient must be informed about the reasons for the delay and the expected date of the full response. In case of a delay, the patient should be given regular progress reports.

Response to complainant
In a response to a complainant, all the points of their complaint should be addressed and practical solutions offered for each point if possible. In particular you should try to meet the outcomes requested by the patient. An apology should also be given when appropriate.

The complaints manager may propose practical solutions to the patient in the first response. This can be done by telephone so long as full records of the conversation are kept. If responding verbally, the patient is sent a follow-up letter confirming the details of the telephone conversation with a copy of the Patient Complaints Procedure (G 110C). In the full response the patient should be invited to a meeting to discuss any suggested solutions and any other aspects of the complaint.

In England and Wales, the written response to the complaint must be signed by the 'responsible person' for complaints about NHS care and treatment. This is the chief executive, the sole proprietor of the practice, a partner or director.

Closing the complaint
Once the patient is satisfied and the complaint has been resolved the Event Record should be signed to show that the matter is closed and the entry in the Event Register should also be signed off.

NHS practices in Northern Ireland must send anonymised copies of the complaint and response to the HSCB within 3 working days of the response being sent to the patient.

NHS practices in all UK countries must submit an annual complaints report to their primary care organisation and make available their report to any person on request.

Practices that perform any private treatment in Wales must submit an annual complaints report to HIW and in Northern Ireland to RQIA.

Apology
The majority of complaints can be resolved if there is a sincere apology. This can avoid lengthy, costly and stressful disputes. An apology does not mean admitting responsibility. It may be necessary to apologise that something has gone wrong, as a way of showing concern and understanding. The GDC Standards for the Dental Team states:

> *"5.3.8 You should offer an apology and a practical solution where appropriate."*

Timescales for patients to make complaints
In England and Wales NHS complaints should normally be made within 12 months of the date of the event, or when the problem first came to the attention of the patient. In Northern Ireland complaints should be made within six months of becoming aware that you have a cause for complaint and normally no longer than 12 months after the event.

Note: Overall patients have 10 years to raise issues related to treatment under general litigations rules. This is why it is recommended to keep clinical records 10 years or more. See the Overview on Record Retention (M 215)."

Who to complain to and escalation

NHS patients

Ideally a patient would firstly complain to the practice. In England a patient can choose to raise a complaint to NHS England. In Wales and Scotland, patients can also complain to their local Health Board and in Northern Ireland to the Health and Social Care Board (HSCB).

If a patient is still dissatisfied with the outcome of their complaint to the NHS, they can request a review by the relevant Ombudsman (refer to Patient Complaints Procedure (G 110C or G 110CW) for contact details).

Private patients

Private patients should contact the practice manager. If they are not satisfied with the response they can contact GDC's dental complaints service within 12 months of the treatment or within 12 months of becoming aware of the issue.

Professional indemnity

When a complaint appears to be escalating or is serious, it is best to contact your professional indemnity organisation to help you to handle it.

Learning from complaints

Practices in all countries are required to analyse and learn from their complaints. The Event Record (G 110A) can be used to help practices record their findings. Where appropriate, the results of complaint analysis and any resulting actions should be shared with the team at practice meetings. Regulators will look at this aspect of compliance management during inspection.

iComply Application practices can use the 'ToDo' feature in the software to schedule any follow up actions.

Online Reviews

Regulators, such as the CQC, will investigate a practice before carrying out an inspection. This can include looking at online review sites such as google or NHS choices. CODE recommends treating negative online reviews as an 'event' and investigating where necessary.

The following approach has been developed by CODE for dealing with online reviews:

1. Appoint a team member to regularly check for and respond to online reviews
2. Respond to all reviews, both positive and negative, thanking the patient for the feedback
3. If a review is negative, explain that that you take complaints seriously, but never address the complaint directly online or mention confidential details
4. Express that you are sorry that the patient felt their expectations were not met and invite them to use complaint channels (if they haven't already)
5. Use the opportunity to discuss positive aspects of the practice
6. Report and investigate internally using an Event Record (G 110A)

Here is an example of a good response where a patient hasn't left their name:

'Thank you for your feedback. It's great to hear you have had a good experience with one of our dentists and we are disappointed this hasn't been the same with our reception team. How our patients are treated in all areas of the practice is very important to us and we regularly carry out annual team training in customer service skills. If you could take the time either write a letter with the details of the issues you faced and address it to the manager, or call us on 01409 254 354, we can investigate the problems and provide our staff with any appropriate training to ensure your experience is more pleasant in the future.'

Managing Events

Managing problems
A problem is any untoward incident that occurs at the practice including staff complaints, late deliveries, management mistakes and equipment breakdowns. Each practice must decide which problems to record to suit its circumstances; otherwise problem reporting could get out of hand. An appointed member of staff such as the Practice Manager should have the authority to determine if a problem needs to be recorded and whether it needs further Significant Event Analysis. For each problem an Event Record (G 110A) is created and recorded on the Event Register (G 110B). When the problem has been resolved the Record is closed and the Register entry signed off as closed.

Repetitive or difficult problems
Problems are normally reviewed during the Practice Audits and at the iComply Annual Management Review (G 170-TM2) each year. However, if there is a repetitive problem, e.g. a supplier continually delivers late, you may decide to carry out significant event analysis. Problems are considered closed when the issue has been explored, corrective actions have been taken and any necessary preventive actions put into place. This may involve changing practice procedures, giving individual training or having a group discussion at a practice meeting.

Managing Incidents
Safety Incidents
A Safety Incident (referred to as an adverse incident in Northern Ireland) is any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare including an adverse incident or clinical error. Safety Incidents can be clinical or non-clinical. It must be reported to the National Reporting and Learning System (NRLS) by practices providing NHS treatment in England and Wales, to the Northern Ireland Adverse Incident Centre (NIAIC) in Northern Ireland and to the Incident Reporting and Investigating Centre (IRIC) in Scotland. Refer to the Policy on Safety Incidents (M 233-SIR) for details about reporting.

Serious Incidents
If the incident is severe, it may be considered as a Serious Incident, which will have to be reported to your Regional team (England), local Health Board (Wales and Scotland), or Health and Social Care Board (Northern Ireland). See the Serious Incidents Policy (M 233-SUI) for the definition of a Serious Incident and how to report it. Serious Incidents are always analysed with SEA.

Reporting to external bodies
The requirements to report incidents vary according to your location. As well as the reporting guidelines in the two policies referred to above, regulatory bodies have their own requirements. Practices in all countries should refer to the Notifications to Regulators Policy (M 233-NTC) and Accident Reporting Overview (M 252).

Never events
Never Events are defined as serious incidents that are entirely preventable if you follow national standards and implement protective measures. Never events are listed in the NHS's Never Events List published in January 2018. Three of these relate to dentistry:

1. Wrong site surgery – this includes extracting the wrong teeth (excluding milk teeth unless the procedure was carried out under general anaesthetic). It also includes interventions such as wrong site block or biopsy, which are considered surgical but may be performed outside a surgical environment

2. Wrong implant/prosthesis – this includes implanting a tooth in the wrong area or extracting a wrong tooth and then doing an implant

3. Retained foreign object post procedure

A further list of Never Events specific to dentistry was published in May 2018, following research led by the University of Edinburgh. The list included the following, which practices may take into consideration when developing clinical procedures:

- Breaking the patient's jaw
- Pulling out the wrong tooth
- Treating the wrong patient
- Injecting the wrong anaesthetic
- Injuring the patient's eye, due to the omission of appropriate eye protection
- Leaving foreign objects behind in the patient after surgical procedures
- Inhalation by patient of 'foreign objects'
- Failing to sterilise instruments
- Failure to register patient's history of allergies to medication
- Use of dental material in a patient with known history of allergy to the dental material used
- Prescription of a drug to a patient with a known allergy to the drug
- Reusing disposable items instead of throwing them away
- Failure to refer for oral cancer assessment after patient's lesions do not heal after two weeks of receiving treatment
- Failure to implement oral cancer screening as part of the routine assessments
- Prescribing incorrect medication to children

Local Safety Standards for Invasive Procedures (LocSSIPs)
The National Safety Standards for Invasive Procedures (NatSSIPs), published in 2015 to help organisations reduce the number of Never Events, recommends that NHS providers create their own local clinical procedures (LocSSips) to cover the events outlined above. A LocSSip is a detailed point by point procedure for clinical teams to follow to prevent the occurrence of a never event.

As CODE do not supply clinical procedures, we advise that all practices review the NHS Never Events Policy and Framework and NatSSIPs to create these important documents. Templates are available here.

Investigating and reporting never events
Never events require full investigation, should be reported as serious incidents and notified to your regulator.

Significant Events
A Significant Event is something good or bad that happens, which impacts on a member of staff, a patient or on the practice. It is an unusual event, rather than an everyday occurrence. Serious Incidents, Safety Incidents and in Scotland Adverse Events can be Significant Events. Significant Event Analysis (Root Cause Analysis in Wales) provides the opportunity of using incidents or near misses as a personal learning opportunity for the healthcare professional or for the practice as a whole, with the intention that formal reflection on the Event will ultimately result in improved safety and/or provision of patient care. You will also need to decide whether or not to report the Significant Event elsewhere, for example to the NRLS or to the CQC.

How to carry out Significant Event Analysis (SEA)
Significant Events can be analysed at practice meetings:

- Decide who is responsible for SEA, this responsibility can be set in iComply Application
- Use the Event Record (G 110A) and Register (G 110B), but keep the SEA documents confidentially

In a SEA you can ask these questions:

- What actually happened – for instance, did something go well, did something nearly go wrong or was a patient harmed?
- What was the impact on the patient, on the person reporting the Significant Event and on the practice?
- Could the event have been avoided?
- Is there anything the team could do to stop the event happening again? What action points and recommendations can the team suggest – who needs to do what and by when?
- What has the team learnt from the event?

Agree a course of action at the meeting – use the Record (G 110A) to register the outcome of each SEA discussion. It's useful to aim to arrive at one of these five categories of outcome:

- Congratulate the team members involved
- Take immediate action to rectify an obvious problem
- Carry out some further work – for instance you may need more time to discuss a particular issue
- Take further action – for example you may need to collect more information
- Take no action

For each Significant Event, the team should agree who will be responsible for taking forward any action points and recommendations, and over what period of time. The team should then review progress at a subsequent meeting. Full records should be kept, including the changes that have been made to improve patient care or service.

Note that any discussion of negative Events should be constructive rather than focusing on who is to blame. It's also important to make sure that the SEA meeting does not become a place to discuss team members' professional performance or competency.

It is important to record any lessons learned from a Significant Event, any actions taken and the training given to prevent the Event from happening again. The regulatory bodies are keen to see how you respond to Events and Audits and often to see the written details of your completed follow up actions.

Duty of candour
The professional duty of candour is part of the GDC standards, and is about being open and honest with people who use services when things go seriously wrong with their care and treatment. England and Scotland have specific notification requirements. In Northern Ireland and Wales, Duty of Candour has not yet been set in legislation, however practices should have a policy to comply with the GDC regulations. For definitions and notification guidelines see Duty of Candour (M 291) and Duty of Candour Policy (M 233-DOC). You can use the Event Record (G 110A) and Register (G 110B) to record and manage the incident details and notifications and you may have to follow the SEA and the other notification guidelines in this document.

Further information

Related policies

Duty of Candour (M 291), Record Keeping (M 215), Safety Incidents Policy (M 233-SIR), Serious Incidents Policy (M 233-SUI), Notifications to the Regulators Policy (M 233-NTC), Accident Reporting (M 252).

General information

Care Quality Commission (England)

Legislation

England

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

Complaints

England

Complaining about NHS dental treatment
DCS – Helping you resolve private complaints
Handling Complaints –England
Dental Care Provider Handbook, CQC, March 2015
Dental Complaints Service, GDC
The Parliamentary Health Ombudsman (England)
NHS complaints: local investigation and resolution

Serious events

The National Patient Safety Agency, Seven steps to patient safety for primary care, February 2009
Serious Incident Framework, NHS England, March 2015 (England and Wales)
National Reporting and Learning System (NRLS)
Scotland Incident Reporting Centre
Duty of Candour (Scotland)
HSC Business Services Organisation (Northern Ireland)
Report a Serious Incident Requiring Investigation (SIRI) or a Significant Event (SEA)
Revised NHS policy and framework on never events and serious incidents

Never events

England

Revised Never Events policy and framework
Never Events list 2018
Dentistry.co.uk List of Never Events
Frequently asked questions related to Dental Wrong Site Surgery
Never events and LocSSIPs
National safety standards for invasive procedures
Create your own Local Safety Standards for Invasive Procedures