

POLICY A-10 GRIEVANCE PROCESS FOR HEALTHCARE COMPLAINTS

<p align="center"><b>POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION</b></p>	<p align="center"><b>POLICY NUMBER A-10</b></p>	<p align="center"><b>TOTAL PAGES 8 ATTACHMENTS none</b></p>
<p><b>RELATED ACA/NCCHC STANDARDS:</b>                  ACA: 5-ACI-6A-01 (Mandatory), 5-ACI-6C-01,                  5-ACI-5E-02, 4-ALDF-2A-27, 4-ALDF-6B-01,                  4-ACRS-6B-03                  NCCHC: J-A-10 (Essential), P-A-10 (Essential),                  MH-A-10 (Essential), O-A-11</p>		
<p><b>CHAPTER: 11 BUREAU OF HEALTHCARE, SUBSTANCE ABUSE, AND MENTAL HEALTH SERVICES</b></p>	<p><b>SUBJECT: GRIEVANCE PROCESS FOR HEALTHCARE COMPLAINTS</b></p>	
<p><b>APPROVED BY THE BUREAU CHIEF: Bureau Chief, Michael Records (signature on file with BHSAMH)</b></p>		
<p><b>APPROVED BY THE COMMISSIONER AND EFFECTIVE THIS DATE: Commissioner Terra Taylor, April 2, 2026 (signature on file with BHSAMH)</b></p>		
<p><b>APPROVED FOR PUBLIC RELEASE</b></p>		

- I. **AUTHORITY:** 11 *Del. C.* §§ 6502, 6517, 6536; 29 *Del. C.* §§ 8903.
- II. **PURPOSE:** To ensure that the facility protects an individual’s right to disagree with or question the healthcare system.
- III. **APPLICABILITY:** All Delaware Department of Correction (DOC) staff and contract provider staff, patients/incarcerated individuals (individual) in custody of or under the supervision of the Department, and any outside healthcare provider servicing DOC individuals.
- IV. **DEFINITIONS:** See Glossary
- V. **POLICY:** It is the policy of the DOC that the facility protects an individual’s right to disagree with or question the healthcare system through a formal grievance process.

**Compliance Indicators:**

- A. A grievance process is in place for healthcare-related concerns.
- B. The healthcare-related grievance policy includes the following:
  - 1. A time frame for response.
  - 2. The process for appeal.

C. Responses to healthcare-related grievances:

1. Are timely.
2. Are based on principles of adequate healthcare.
3. Include documentation of response.

D. Healthcare grievance log is maintained and includes, at a minimum:

1. Patient name or identification number.
2. Date the grievance was received by health services.
3. Nature of grievance (for example, medical, dental, or mental health).
4. Outcome (response, plan of action, resolution of grievance).
5. Date and time the grievance was completed and the individual notified.
6. Name and title of person completing the grievance response.

E. Healthcare-related grievances are collected, investigated, monitored, and reported to the continuous quality improvement CQI committee.

**VI. PROCEDURES:**

A. Healthcare grievances will be submitted in accordance with the DOC Bureau of Prison (BOP) Policy 4.4 *Offender Grievance Process*.

B. All individuals are informed of the grievance process at the time of admission/intake at a facility. This information shall be provided both verbally and in writing in language that is easily understood by each individual. If a literacy, language, and/or disability prevents an individual from understanding written information, a certified translator (i.e., language line) or teletypewriter (TTY) device will be utilized to assist the individual.

C. Responses to individual healthcare-related grievances are timely and based on principles of adequate healthcare.

1. Individuals must submit a grievance form to the Institutional Grievance Chair (IGC) within 7 calendar days of the incident (e.g., a sick call encounter).
2. Only one healthcare issue may be addressed in a single grievance submission.

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3. Individuals must fully utilize the sick call process before submitting a grievance related to a healthcare concern.
- D. The healthcare grievance process will comprise three steps. Those steps and associated processes are outlined as follows:

1. Step 1 - Informal Resolution

- a. Healthcare staff will receive the grievance from the IGC electronically through the Delaware Automated Correctional System (DACS) and attempt to resolve the grievance.
  - i. The IGC shall forward the grievance to the appropriate healthcare staff (based on the nature of the grievance) as follows:
    - (i) Grievances related to medical will be forwarded to the facility Health Services Administrator (HSA), or designee.
    - (ii) Grievances related to mental health concerns will be forwarded to the facility's mental health director or designee.
    - (iii) Grievances related to substance use disorder (SUD) treatment shall be forwarded to the facility's SUD program director or designee.
- b. The designated healthcare staff (as listed above) will review grievances no later than the next business day and attempt to resolve concerns raised by individuals before initiating a Step 2 Grievance Hearing.
  - i. The designated healthcare staff shall attempt to resolve the grievance at Step 1 by utilizing a variety of methods that may include, but are not limited to, the following:
    - (i) Review the grievance.
    - (ii) Investigative actions.
    - (iii) Interview staff.
    - (iv) Make appropriate appointments.
    - (v) Perform necessary follow-up, and/or meet with the individual.
  - ii. Information in the investigation must be entered into DACS and shall include the following:
    - (i) Date of interview.
    - (ii) Date of response.
    - (iii) Nature of response.
    - (iv) Staff response.
    - (v) Resolution category.

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- c. The designated healthcare staff shall meet with the individual and review the individual's grievance and the possible resolution.
  - d. The individual may accept this Step 1 resolution or request a formal hearing.
    - i. The individual must sign and date the grievance within 7 days, indicating a resolution was accepted or rejected.
    - ii. DACS will be updated accordingly, and the grievance will be returned electronically through DACS to the IGC.
  - e. The Step 1 process must occur and be completed within 14 days of receipt of grievance from the IGC or the grievance proceeds to a Step 2 Grievance Hearing.
  - f. If an individual does not sign and return the grievance to the IGC within 7 days, indicating their acceptance or rejection of the informal resolution, the grievance is deemed abandoned.
  - g. If the IGC receives a rejection within the specified time period, they will schedule the grievance for a Step 2 Medical Grievance Hearing.
2. Step 2 – Medical Grievance Committee (MGC) Hearing
- a. The MGC has at minimum three members of the health service staff, and one of the three must be a licensed healthcare professional (e.g., licensed nurse for medical grievances and a licensed mental health clinician (or licensed SUD staff) for behavioral health grievances).
    - i. The IGC shall also be present to record the MGC results into DACS.
    - ii. Any healthcare staff member who was involved in Step 1 cannot be part of Step 2.
  - b. The MGC shall meet at least twice monthly or more often as needed.
    - i. If there are no grievances to be heard, the MGC is not required to meet.
  - c. The MGC must conduct the hearing within 30 days of receipt of the Step 1 resolution rejection.
  - d. The MGC hearing shall be conducted in the presence of the individual and shall have the following steps, at a minimum:
    - i. A review of the pertinent sections of the health record,
    - ii. A complete review of the grievance,
    - iii. Discussion of the information contained in the grievance, and

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- iv. Comments from the individual.
  - e. The MGC will then discuss and render a determination to deny or uphold the individual's grievance.
  - f. At the conclusion of the MGC hearing, an MGC Log will be created and/or updated that will include the following information:
    - i. Individual's name and SBI.
    - ii. Grievance number.
    - iii. Nature of grievance.
    - iv. Type of grievance.
    - v. MGC decision.
    - vi. Agreed outcome.
    - vii. Date issue is to be resolved.
  - g. The MGC Log shall be submitted to the Bureau of Healthcare, Substance Abuse, and Mental Health Services (BHSAMH) on the 5<sup>th</sup> of each month for the previous month.
  - h. The MGC's recommendations must be implemented within 7 calendar days of the Step 2 Hearing. If the recommendation involves attendance at an outside healthcare provider beyond the MGC's control, the scheduling of the appointment will suffice.
- 3. Step 3 – Appeal of MGC Recommendation
  - a. An individual who chooses to appeal the Step 2 decision must do so within 7 days of receipt of the decision.
  - b. BHSAMH Bureau Grievance Officer (BGO) - a BHSAMH employee - will review the grievance, investigate as necessary, and submit a recommendation through DACS to the BHSAMH Bureau Chief, or designee, for review and final decision. The BGO must do one of the following:
    - i. Uphold or deny the grievance,
    - ii. The BGO may also partially uphold or deny the grievance, by:
      - (i) Request additional investigation and withhold rendering a recommendation until the results of the investigation are complete, or
      - (ii) Provide a partial accommodation or request that an outside consultation be completed.
  - c. The BHSAMH Bureau Chief, or designee, will then review the BGO's recommendation along with the MGC's recommendation, and the results

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of the informal resolution, and render a final decision to be entered in DACs.

- d. The decision of the BHSAMH Bureau Chief, or designee, is final and must be followed as directed.
4. The maximum amount of time between initial receipt of the grievance and the Bureau Chief's final decision cannot exceed 180 total calendar days.
5. The individual shall receive a decision in writing from the IGC after the BHSAMH determination is complete.

### E. Emergency Medical Grievances

1. In the event of an emergency medical grievance, the IGC shall expedite and forward emergency medical grievances to the BHSAMH Bureau Chief or designee for review.
  - a. The BHSAMH Bureau Chief or designee may forward the emergency grievance to the facility HSA for a determination if the grievance qualifies as a medical emergency.
2. If the grievance qualifies as an emergency, BHSAMH Bureau Chief, or designee (or the HSA) shall provide for a solution and respond in DACS within 24 hours of receipt.
3. If the BHSAMH Bureau Chief, or designee (or the HSA) determines that the grievance is not an emergency, the grievance will be electronically returned to the IGC for regular grievance processing. The IGC shall notify the individual that the grievance does not qualify as an emergency and will proceed with regular processing.

### F. Tracking, Reporting, and Trending

1. Grievances shall be tracked and recorded in DACS and maintained for a minimum of three years.
2. The facility HSA or designee shall track the status of medical grievances.
  - a. A log must be maintained indicating the status of each grievance. This log shall include, but is not limited to, the following:
    - i. Name and SBI of the individual.
    - ii. Facility and housing unit.
    - iii. Grievance number.
    - iv. Date grievance was received.
    - v. Description of grievance complaint.

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- vi. Date grievance received by medical staff.
  - vii. Date seen for Step 1 – Informal Resolution.
  - viii. Date of Step 1 Resolution.
  - ix. Details of informal resolution.
    - (i) Date and Time.
    - (ii) Staff member completing Step 1.
    - (iii) Accepted or rejected.
    - (iv) Individual notified.
  - x. If not accepted, date of Step 2 – Formal resolution.
  - xi. Date seen for Step 2.
  - xii. Details of formal resolution.
    - (i) Date and Time.
    - (ii) Staff member completing Step 2.
    - (iii) Accepted or rejected.
    - (iv) Individual notified.
  - xiii. If not accepted, date of Step 3 – bureau grievance final resolution.
  - xiv. Results of Step 3.
  - xv. Details of final resolution.
    - (i) Date and time.
    - (ii) Staff member completing Step 3.
    - (iii) Individual notified.
- b. A copy of the Tracking Log shall be provided to BHSAMH monthly.
3. The status and trending of grievances shall be reported at quarterly Healthcare Advisory Committee (HAC) meetings.
- G. Grievances that pertain to key healthcare systems or functions should be discussed at monthly Continuous Quality Improvement (CQI) meetings at each facility, where grievances are reviewed to identify recurrent issues and associated corrective action plans as needed.
- H. BHSAMH may audit grievances and the grievance process for timeliness of grievance referrals, effectiveness of proposed resolutions, and completion, or follow-through, on upheld grievances.
- I. Copies of individual grievances shall never be placed in an individual’s healthcare record.
- J. The grievance system must be evaluated annually by the facility's Continuous Quality Improvement (CQI) Committee (In accordance with BHSAMH Policy *A-06*

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*Continuous Quality Improvement Program*) to determine its efficiency and effectiveness. This will include an analysis of both the quantity and nature of individual grievances for the previous year. The results of these evaluations shall be reported to the Statewide CQI Committee annually.