

3701-7-15

Complaints; quality assurance; reports.

- (A) Each maternity unit, newborn care nursery, or maternity home shall develop and follow policies and procedures to effectively receive, investigate, and report findings of complaints regarding the quality or appropriateness of care and services. The documentation of complaints shall, at a minimum, include the following:
- (1) The date complaint was received;
 - (2) The identity, if provided, of the complainant;
 - (3) A description of the complaint allegations;
 - (4) The identity of persons, or provider of the services, or both, involved;
 - (5) The findings of the investigation; and
 - (6) The resolution of the complaint.
- (B) Each maternity unit, newborn care nursery, and maternity home shall post the department's toll free complaint hotline in a conspicuous place.
- (C) Each maternity unit or newborn care nursery shall establish a quality assessment and improvement program designed to systematically monitor and evaluate the quality of patient care provided in each maternity unit or newborn care nursery, pursue opportunities to improve patient care, ensure compliance with the applicable quality standards set forth in Chapter 3701-7 of the Administrative Code, and resolve identified problems.
- (D) The quality assessment and improvement program shall do all of the following:
- (1) Monitor and evaluate all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction;
 - (2) Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems;
 - (3) Establish expectations, develop plans, and implement procedures to assess and improve the maternity unit and newborn care nursery's governance, management, clinical and support processes;

- (4) Establish information systems and appropriate data management processes to facilitate the collection, management, and analysis of data needed for quality improvement;
 - (5) Internally document and report findings, conclusions, actions taken, and the results of any actions taken to the health care service's management and medical director;
 - (6) Document and review all unexpected complications and adverse events, being serious injury or death resulting from medical management, which arise during the provision of the service or during the hospital stay; and
 - (7) Hold regular meetings, chaired by the medical director of the maternity unit or newborn care nursery, or designee, as necessary, but at least within sixty days after a death or complication, to review all deaths and complications and to report findings. Any pattern that might indicate a problem shall be investigated and remedied, if necessary.
- (E) Each maternity unit, newborn care nursery, and maternity home shall, on a form prescribed by the director, report to the department:
- (1) Fetal death, to include all fetuses of twenty weeks gestation or greater that showed evidence of life at any point from the mother's admission through delivery;
 - (2) Neonatal death, to include all liveborn neonates before twenty-eight days of age, from delivery or admission through transfer or discharge;
 - (3) Infant death, to include all liveborn infants twenty-eight days of age through one year of age, from delivery or admission through transfer or discharge;
 - (4) Maternal death, to include the death of a woman from any cause related to or aggravated by pregnancy or its management, from the woman's admission and care at the delivering hospital through transfer or discharge;
 - (5) Neonatal or infant abduction; and
 - (6) Discharge of a neonate or infant to the wrong family or organization.