POLICY AND PROCEDURE MANUAL

PROGRAM/DEPT.: ALL PROGRAMS

Subject: Reporting of Incidents/Critical Incidents and Sentinel Events Involving Consumers (i.e. Abuse/Neglect, Consumer Injury, Attempted Suicide, Death, etc) (DMH /JC/CMS/Alabama Medicaid Agency/DHR/ADAP Incident Reports)

POLICY#: PI 1.8/RI 1.5

EFFECTIVE DATE: 08/88 REVISED: 10/15

POLICY:

All Critical Incidents as defined by the Alabama Department of Mental Health and Substance Abuse Services (DMH), all Sentinel Events as defined by Joint Commission (TJC), and all incidents as defined by Centers for Medicaid/Medicare Services (CMS), the State Department of Human Resources Office (DHR) of Licensure, Alabama Medicaid Agency and the Alabama Disabilities Advocacy Program (ADAP) are reviewed by AltaPointe Health Systems, Inc. (AHS) for proper reporting to comply with law enforcement authorities and other agencies as appropriate.

PROCEDURE:

I. Reporting Procedures

In the event that a DMH Critical Incident, TJC Sentinel Event or other incident as defined by Centers for Medicaid/Medicare Services (CMS), the State Department of Human Resources Office (DHR) of Licensure, Alabama Medicaid Agency and the Alabama Disabilities Advocacy Program (ADAP) occur in an AHS program, the employee discovering the incident must notify their supervisor immediately. The program supervisor must notify the Chief Executive Officer and the Chief of Staff with details of the incident. Following, the Human Resources and Performance Improvement departments must be notified for proper reporting and investigation of the incident to comply with law enforcement authorities and other agencies as appropriate.

A. AHS Programs Certified by DMH:

In AHS programs certified by DMH, the following procedures are followed for incidents (or allegation of incidents) involving consumers that occur:

- in 24-hour care settings, which include residential group homes, locked residential units, foster homes, Crisis Stabilization Units, and MOMS Apartments

- in AHS contracted care certified by DMH
- on AHS premises (any location with a DMH Certificate)
- While involved in an event supervised by AHS.

Note: *The reporting requirements do not apply to designated mental health facilities (DMHF) that are licensed by the Alabama Department of Public Health as hospitals or consumers residing in nursing homes. For Transitional Age programs, follow child/adolescent reporting requirements.*

All abuse/neglect allegations involving staff members of AHS are reportable regardless of where the abuse/neglect was alleged to have occurred.

Allegations or suspected incidents of physical, verbal, or sexual abuse, neglect, exploitation, or mistreatment of consumers, regardless of age, being served in any AHS program must be reported in the following manner:

- Where the alleged perpetrator is an employee or other person working in the program to the Department of Human Resources in accordance with applicable statutory requirements; to law enforcement if criminal behavior is involved; and to the DMH Performance Improvement Office in accordance with published reporting procedures.
- Where both the perpetrator and the victim are consumers, reports shall be made to the parties listed above as appropriate if it is the judgment of the CEO or designee that the incident may have been the result of neglect.

Critical Incidents, as defined by DMH published procedures, are reported to the DMH within 24 hours of occurrence. Incidents that are judged by the CEO or designee to be severe in nature, scope, or consequences to the consumer or AHS in addition to those defined above should be reported to the Director, Office of Community Programs, as soon as possible, but no later than 24 hours of occurrence utilizing the DMH published reporting procedures.

* (See attached DMH guidelines on Critical Incident Reporting Procedures).

Once an Incident or Critical Incident is reported to or discovered by a staff member, these steps should be followed:

1. The staff member immediately notifies the program coordinator who follows the appropriate lines of authority in notification. The coordinator or designee then immediately reports the incident to the Consumer Needs Specialist or other available Performance Improvement (PI) department staff. In the event of a consumer suicide attempt, the consumer's medical condition, his/her last contact with an AHS program, and his/her level of participation in treatment should be communicated to the PI staff for inclusion in the report.

2. If the PI staff determines that the incident does not meet the definition of Incident or Critical Incident as defined by DMH, the staff member should submit the ***Incident Report*** per **AltaPointe Policy & Procedure # HS 1.1/PI 1.9.**

3. If applicable, law enforcement or other appropriate reporting agencies should be contacted at the program level.

4. Protocol for investigating the incident/allegation should be initiated immediately and clear, concise documentation of all findings is mandatory. Investigations are conducted immediately after their reported occurrence and are completed within 30 days of their initiation as required by DMH standards. The PI department staff will be responsible for completing a thorough investigation per DMH guidelines as described in **AltaPointe Policy & Procedure # PI 1.13**.

5. The PI department staff is responsible for contacting, reviewing, and routing all initial and follow up reports to the DMH. **However, Incidents/Critical Incidents as defined by DMH, occurring between 5:00 PM on Friday and 8:00 AM on Monday (and/or Holidays) must be verbally reported to the DMH Director of Community Services (or designee) at 334-242-3200 within 24 hours of occurrence of the incident. Report forms must be faxed to 334-595-2703.** In this case, the program staff will contact his/her immediate Supervisor for guidance in completing DMH reporting procedures. When contacting DMH, indicate that you are calling with an Incident/Critical Incident report so the message can be routed to the appropriate DMH staff member.

6. In the case of a consumer death occurring on AHS premises, in AHS contracted care, during an activity away from AHS premises, the medical record is reviewed by the PI department staff.

7. The Clinical Staff Sub-Committee is responsible for reviewing all Incidents/Critical Incidents on a quarterly basis. Identification of trends and patterns and actions taken to reduce risks and to improve the safety of the environment of care for consumers, families and staff members are made.

C. DMH Intellectual Disabilities (DD) Programs:

All "significant incidents" and "other incidents" that involve the safety of consumers, staff and the public that occur at a DMH contracted agency or which involves a resident of a contracted agency, must be reported to the **Region III Community Service Department (RCS) at (251)443-1769. (See attached DMH guidelines on Procedure for Incident Reporting).**

Significant incidents are defined as, but not limited to death, elopements, and serious injuries requiring medical treatment (those that are life threatening and/or requires hospitalization and/or emergency room treatment and/or medical procedures. Seizures requiring medical treatment, severe behavior altercation (those that involve local authorities; such as physical altercations between consumers and/or staff, damage to property, rape, physical injury to consumers and/or physical danger to consumers and/or others. Suspected consumer abuse and/or neglect incidents must be reported to the RCS office immediately.

Other incidents are defined as, but not limited to medication error(s), injuries requiring no medical attention. Community providers receiving services through Region III will report incidents of this nature to RCS within 24 hours.

As a condition of Department certification, providers of community based programs and services will report all cases of suspected consumer abuse, neglect, or exploitation to the county Department of Human Resources (DHR) in accordance with State laws, rules, and regulations.

Once a "Significant/Other" Incident is discovered by a staff member, the staff member immediately notifies the program supervisor who then follows the appropriate lines of authority in notification. The incident must be reported to the Region III Community Service Department (RCS) immediately, but no later than 24 hours after the incident. A Region III Community Services Incident Report must be completed and sent to RCS. The Supervisor or designee must also report the incident to the Performance Improvement Department.

When allegations of abuse/neglect, or mistreatment occur, allegations must be thoroughly investigated, and correcting actions taken as needed. (MR Community Standards 580-5-30B-12). The internal investigation must be completed within 30 days. Upon completion of the investigation, a summary of the findings and actions taken must be forwarded to RCS. RCS will complete a review of each investigation to consider the finding and action taken.

If applicable, law enforcement or other appropriate reporting agencies should be contacted at the program level.

In the event of a death of a consumer, the service provider is required to provide RCS with the following information: demographic data, historical information, treatment history, circumstances of death, response to emergency, date and time of death, cause of death, family involvement and final arrangements, internal review by agency, and resolution of any questionable circumstances.

II. The following procedures are followed for allegations of historical abuse, neglect, or exploitation.

A. If a consumer reports abuse/neglect, the AltaPointe staff is responsible for reporting the incident to the Department of Human Resources (DHR). The report is made by telephone and by completion of the appropriate DHR Reporting form.

B. The staff member reporting the suspected abuse/neglect report shall notify the Program supervisor. A copy of the notification to DHR should be placed in the Consumer's record, under legal tab. A notation referencing the allegations and completion of the report should be included in the daily progress note.

C. Following mandatory reporting law, in the event a staff member is informed of possible abuse/neglect of any member of the community, a report to DHR by telephone and completion of the appropriate DHR Reporting Form should be made.

*Staff having any questions about this procedure (protocol, forms, etc.) should contact the Consumer Needs Specialist, Risk Management Specialist or other available PI department staff member for assistance.

D. Psych Under 21 Serious Occurrence Incidents (BayPointe Hospital, Child and Adolescent Residential Services and Adolescent Independency Program-Three Notch)

1. Psychiatric residential treatment facilities providing inpatient psychiatric services for individuals under the age of 21 (Psych < 21), as required in 42 C.F.R. 483.374 and which have a provider agreement with the Alabama Department of Human Resources are required to report any and all serious occurrences to Alabama's Medicaid Agency; Alabama Disabilities Advocacy Program (ADAP), the state designated protection and advocacy system; DHR, the licensing agency; and the legal guardian of the consumer.

2. This report must be submitted no later than the close of business the next business day after a serious occurrence by completing the ***Psych < 21 Serious Occurrence Reporting Form.***

3. Serious occurrences that must be reported include:
   - A consumer's death (for any reason)
   - Serious injury (for any reason) to a consumer as defined in 42 C.F.R. 483.352.
   - Suicide attempt by a consumer

4. For each serious occurrence, the ***Psych < 21 Serious Occurrence Reporting Form*** must be submitted to each of the three agencies and a copy placed in the consumer's medical record.

5. In addition, a Death Reporting Worksheet (PRTF) must be submitted to the Centers for Medicare and Medicaid Services (CMS) regional office before close of business the next business day after the consumer's death (CMS regional office notification is only required for deaths). Reports to the CMS Regional office may be submitted via fax at 404-562-7435. Documentation that the death was reported to CMS must be made in the consumer's medical record.

6. Details of the incident must be documented in the consumer's medical record including the report to the CMS Regional Office, State of Alabama Medicaid Office, Department of Human Resources and the DMH Advocacy Office.

7. Once a serious occurrence is reported to or discovered by a staff member, the staff member immediately notifies the program supervisor who follows the appropriate lines of authority in notification. The Supervisor or designee then immediately reports the incident to the Consumer Needs Specialist or other available Performance Improvement (PI) department staff.

8. The PI department staff is responsible for contacting, reviewing, and routing all initial and follow up reports of serious occurrences to the required agencies.

E. DHR Adolescent Independency Program - Intensive Residential Group Home and BayPointe Residential

1. The incidents listed below shall be reported to the State Department of Human Resources Office of Licensure within 24 hours after occurrence or the first work day following the occurrence, which ever is sooner. An immediate report of any of the above incidents will be made to State DHR by phone (334- 242-8177) and followed by a written explanation within 5 days (334-353-2653 fax):
   - Any injury requiring professional medical treatment of any consumer or staff person while at the facility or during activities away from the facility.
   - Any illness occurring at the facility or during activities away from the facility which requires emergency medical treatment.
   - Any death occurring at the facility or during activities away from the facility.
   - Major damage to the facility
   - Any litigation involving the facility
   - Any traffic accident involving a consumer while using facility transportation
   - Any arrest or conviction of the licensee or any staff person

- Final disposition of any consumer abuse/neglect investigation involving the facility, the licensee or any staff person
- Any incident occurring which places the health, welfare, or safety of a consumer at risk

2. The following shall be reported in writing to the State Department of Human Resources, Office of Licensure ***prior*** to occurrence:
   - Change in ownership (if a change in ownership occurs, the facility shall not continue to operate until the new owner applies for and is issued a license/permit/approval.
   - Change in location (if a change in location occurs, the facility shall not continue to operate until a new license is applied for an a license/permit/approval is issued for the new location).
   - Change the director of the facility.
   - Change of chief executive officer of the corporation or a member of the board.
   - Alterations to the facility or grounds.
   - Major change to the basic operating schedule or program.

F. Joint Commission Sentinel Events

1. In accordance with The Joint Commission standards, AHS provides a mechanism for the reporting of Sentinel Events.

2. The definition of Sentinel Event according to the Joint Commission is:
   a. An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
   b. Such events are called "sentinel" because they signal the need for immediate investigation and response.
   c. The terms "sentinel event" and "error" are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.

3. AHS identifies and responds to all Sentinel Events occurring in the organization or associated with care, treatment, or services that the organization provides, or provides for.

4. Appropriate response includes conducting a timely, thorough, and credible root cause analysis; developing an action plan designed to implement improvements to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements.

5. The following are Sentinel Events that are reviewable by The Joint Commission:
    a. The event has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the individual's condition, or
    b. The event is one of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the individual's illness or underlying condition):
        i. Suicide of any individual served receiving care, treatment, or services in a staffed around-the-clock setting or within 72 hours of discharge from a 24-hour setting
        ii. Abduction of any individual served receiving care, treatment, or services
        iii. Sexual abuse/assault (including rape).

6. Examples of reviewable sentinel events are:
    - An individual served commits suicide within 72 hours of being discharged from a behavioral health care setting that provides around-the-clock care
    - Assault, homicide, or other crime resulting in death or major permanent loss of function of the individual served
    - If medication is prescribed or administered within the organization, any individual served death, paralysis, coma, or other major permanent loss of function associated with a medication error
    - An individual served is abducted from the organization where he or she receives care, treatment, or services
    - Any elopement, that is, unauthorized departure, of an individual served from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function
    - An individual served fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall

Note: An adverse outcome that is directly related to the natural course of the individual served condition(s) is **not** reportable except for suicide in, or following elopement from, a 24-hour care setting (above).

7. Once a Sentinel Event is reported to or discovered by a staff member, these steps should be followed:

    a. The staff member immediately notifies the program Coordinator who follows the appropriate lines of authority in notification. The Coordinator or designee then immediately reports the incident to the Consumer Needs Specialist or other available Performance Improvement (PI) department staff. In the event of a consumer suicide attempt, the consumer's medical condition, his/her last

contact with an AHS program, and his/her level of participation in treatment should be communicated to the PI staff for inclusion in the report.

b. If the PI and other Administrative staff (CEO, Chief Medical officer, etc.) determine that the incident does not meet the definition of Sentinel Event as defined by The Joint Commission, the staff member should complete the ***AltaPointe Incident Report*** per **AltaPointe Policy & Procedure # HS 1.1/PI 1.9.**

8. If applicable, law enforcement or other appropriate reporting agencies should be contacted at the program level.

9. Protocol for investigating the Sentinel Event should be initiated immediately and clear, concise documentation of all findings is mandatory. Investigations are conducted immediately after their reported occurrence and are completed in a timely manner. The PI department staff will complete a thorough investigation per The Joint Commission guidelines.

10. The PI department staff is responsible for contacting, reviewing, and routing all initial and follow up reports to The Joint Commission.

11. The Clinical Staff Sub-Committee is responsible for reviewing all Sentinel Events on a quarterly basis. All Sentinel Events are reported to the AHS Board of Directors. Identification of trends and patterns and actions taken to reduce risks and to improve the safety of the environment of care for consumers, families and staff members are made.