WEST MICHIGAN COMMUNITY MENTAL HEALTH SYSTEM
ADMINISTRATIVE MANUAL

	Chapter: 2	Section: 12	Subject: 8
CHAPTER: Board Services and Program Administration			
SECTION: Safety and Therapeutic Environment			
SUBJECT: Reporting Critical Incidents			
Administrative Approval:	Date of Governing Board Action: 5/23/96		Page 1 of 8

I. **PURPOSE:** To establish policy and procedures for reporting and following-up critical incidents.

II. **APPLICATION:** All program and services operated by West Michigan Community Mental Health and all entities operated by or under contract with the West Michigan Community Mental Health Governing Body.

III. **REQUIRED BY:** Michigan Department of Health and Human Services Administrative Rules R330.7046, and accrediting bodies.

IV. **DEFINITIONS:**

1. Critical Incident: An occurrence that disrupts or adversely affects the course of consumer care or agency business. Whether an incident is critical may depend upon individual consumer needs or treatment. When in doubt, staff should consult the Service Enhancement Team to determine if an incident must be reported. Critical incidents may include, but are not limited to the following:

1.1. Apparent, suspected, or alleged Recipient Rights violations, including abuse or neglect (always must be reported).

1.2. Arrest or conviction of a consumer who is enrolled in Habilitation Supports Waiver, Serious Emotional Disturbance Waiver, Children's Waiver Program, or receiving specialized residential services. (always must be reported).

1.3. Death of a consumer (always must be reported).

1.4. Suspected sentinel events as defined in WMCMH Administrative Manual Chapter 2-6-6 (always must be reported).

1.5. Use of physical management (always must be reported).

1.6. Vehicular accidents involving agency vehicles or occurring while on agency business (always must be reported).

1.7. Injury or illness that resulted in a consumer or staff requiring emergency medical treatment (always must be reported).

1.8. Emergency situations in which police, fire, or other first responders were involved (always must be reported).

1.9. Incidents which involved noncompliance with agency policy or procedure and which placed or could have placed people or property at risk of harm to include bio-hazardous accidents.

1.10. Injury or illness that resulted in a consumer or staff requiring first aid.

1.11. Incidents that could have placed staff or consumers at risk of serious injury.

1.12. Unexplained injury of a consumer.

1.13. Medication errors.

1.14. Serious maladaptive behaviors not addressed in a person-centered plan to include wandering, elopement, the use of unauthorized weapons, use and possession of legal or illegal substances, and sexual assault.

1.15. Suicide or attempted suicide

2. MDHHS/PIHP Critical Incident Events: Five MDHHS identified types of critical incidents identified to replace the PIHP/CMHSP death reporting and sentinel event reporting process. The five (5) Reportable Events are:

- Suicide
- Non-suicide death
- Emergency Medical Treatment due to Injury or Medication Error
- Hospitalization due to Injury or Medication Error
- Arrest

3. Off-Site: Any place other than the buildings and grounds which are owned and operated by WMCMH.

4. Peer Review: A process in which mental health professionals evaluate the clinical competence, quality and appropriateness of care/services provided to the recipients served by WMCMH. The review may focus on an individual event or aggregate data and information on clinical practices. These processes are confidential in accordance with section 748(9) of the Mental Health Code Act 258 of 1974 and are based on criteria established by the facility or community mental health services program itself, the accepted standards of the mental health professions and the Department of Community Health.

5. Physical Management: A technique used by staff to restrict the movement of an individual by direct physical contact in spite of the individual's resistance in order to prevent the individual from physically harming himself, herself, or others. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand.

6. Risk Event: Events that put people at risk of poor outcomes. MDHHS defines the following events as risk events:

   - Harm to self-actions taken by individuals who receive services that cause harm to themselves.
   - Harm to others-actions taken by individuals who receive services that cause harm to others.
   - Police calls-Police calls by staff of specialized residential settings or general (AFC) residential homes or other provider agency staff for assistance with an individual during a behavioral health crisis situation.
   - Emergency Use of Physical Management-Emergency use of physical management by staff in response to a behavioral crisis.
   - Hospitalizations-two or more unscheduled admission to a medical hospital (not due to planned surgery of the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.

7. Sentinel Event: A sentinel event is an unexpected occurrence involving death (not due to the natural course of a health condition) or serious physical harm or emotional harm, or the risk thereof to a customer. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

V. **POLICY**: It is the policy of the West Michigan Community Mental Health that all critical incidents that occur while conducting agency business are reported, reviewed, and investigated, if necessary.

VI. **PROCEDURES**:

1. The purpose of reporting and reviewing critical incidents is to evaluate the quality and appropriateness of care, to improve the quality of care for consumers, and to improve safety of the environment for consumers and staff.

2. All potential critical incidents will be reviewed by appropriate staff to determine if the event meets reporting criteria for:

   2.1. Sentinel events

   2.2. MDHHS/PIHP Critical Incidents

   2.3. Risk Events

3. The WMCMH employee, contract employee, or volunteer who has primary knowledge of the critical incident must complete the Critical Incident Report (CIR) form. The CIR form must be completed clearly and concisely and submitted to the designated member of the Service Enhancement Team within 24 hours of the incident occurrence. Alleged Recipient Rights violations must be reported to the Recipient Rights Office immediately in accordance with WMCMH Administrative Manual Chapter 5-1-1.

4. WMCMH employee injuries must be verbally reported to the employee's supervisor and Human Resources immediately. Additionally, a CIR Form must be completed and submitted by the end of the business day.

5. The WMCMH employee who has primary responsibility for a consumer during care or who is notified of an incident will complete the CIR and document in the clinical record, as appropriate, a summary of the incident. CIRs completed by WMCMH providers will be routed to the Responsible Care Manager for documentation in the clinical record, as appropriate. The CIR itself will not be entered in the clinical record.

6. An employee who is injured while conducting agency business off-site will file a written report with the entity responsible for the property on which the injury occurred, if applicable. The employee will obtain a copy of the written report, and will submit it with a WMCMH CIR. If a consumer is injured while receiving WMCMH services off-site, an employee will encourage the consumer to file a written report with the entity responsible for the property on which the injury occurred. If the consumer consents, the employee will obtain a copy of the written report and will submit it with a WMCMH CIR. The employee will complete a WMCMH CIR even if the consumer chooses not to file a written report with the entity responsible for the property on which the injury occurred.

7. The Service Enhancement Team will review CIRs, record the appropriate data, and route CIRs to appropriate staff including but not limited to:

7.1. Reports of consumer deaths and suicide attempts will be routed to the Deputy Director of the Service Enhancement Team, the Deputy Director of Clinical Services, the Medical Director and the Recipient Rights Officer. These reports will be reviewed monthly at the Clinical Oversight Committee.

7.2. Reports of apparent or suspected Recipient Rights allegations will be routed the Recipient Rights Officer.

7.3. Reports of suspected Sentinel Events will be routed to the Deputy Director of Service Enhancement.

7.4. Reports of WMCMH employee injuries will be routed to Human Resources.

8. A Critical Incident Debriefing will be done within 30 days. This process includes distribution by email of the CIR to individuals based on the routing matrix so those individuals can follow up on and decide what actions are needed to prevent further CIR's or corrective action. This is done both through email and meeting in person on the CIR. There is also a quarterly report done to look for trends by the SET Team member that goes to PIOC. This process is for the following types of incidents *(instructions are attached to the analysis form)*:

8.1. Death

8.2. Suicide or attempted suicide

8.3. Emergency Medical Treatment or Hospitalization due to:

8.3.1. Injury
8.3.2. Medication Error
8.3.3. Self-Harm
8.3.4. An individual harming another person
8.3.5. Communicable Disease and infection control

8.4. Hospitalization due to illness (2 or more unscheduled admissions not due to chronic or underlying condition within the last 365 days)

8.5. Emergency Physical Management, use of seclusion or restraints

8.6. Arrest

8.7. Staff call to Police response to individual in care's challenging behavior

8.8. Aggression, violence and use or unauthorized possession of weapons

8.9. Wandering or Elopement

8.10. Accidents including vehicle and biohazards

8.11. Unauthorized us and possession of legal or illegal substances

8.12. Abuse or Neglect including sexual assault

8.13. Other sentinel events

9. Review of the Critical Incident Debriefing will take place by the following:

REVIEW LEVEL	FREQUENCY
WM Behavior Treatment Committee: • Emergency Physical Management • Staff Called Police in Response to Recipient's Challenging Behavior	Submit to SET within 30 days Committee will review quarterly
WM Clinical Oversight Committee (COC) • Death • Suicide or attempted suicide	Submit to SET within 30 days Committee will review monthly
WM Team Leader/Supervisor and Responsible Care Manager • Emergency Medical Treatment OR Hospitalization Due To ◦ Injury ◦ Medication Error ◦ Self-Harm ◦ An individual harming another person ◦ Illness (2 or More Unscheduled Admissions Not Due to Chronic Or Underlying Condition Within 365 months) • Arrest of Consumer *(will consults with COC as needed)*	Submit to SET within 30 days RCM/Supervisor review upon receipt

The goal of reviewing the Critical Incident Debriefing Analysis is to prevent recurrence of critical incidents or sentinel events.

10. The Service Enhancement Team will report quarterly on critical and risk events. Also semi-annually provide an analysis and trending report on incidents reported to the Performance Improvement Oversight Committee. They will also trend MDHHS/PIHP Critical Incident Events and Risk Events per PIHP guidelines.

11. The supervisor of the involved department or his/her designee will investigate critical incidents as needed. Results of the investigation, including causal factors and actions to prevent recurrence, will be documented and submitted to the Service Enhancement Team.

12. Critical Incident Reports will be retained by the Service Enhancement Team for at least 7 years.

13. Critical Incident Reports are peer review documents. Unauthorized release or duplication of CIRs is prohibited.

VII. **SUPPORT DOCUMENTS**:

Appendix 2-12-8A: Incidents Requiring Critical Incident Analysis

Appendix 2-12-8B: Instructions For Completing Critical Incident Analysis Form

Refer to:
Critical Incident Report (WMCMH Form EC001
Critical Incident Report for Residential Services (WMCMH Form EC002)
Critical Incident Debriefing Analysis Form (WMCMH Form EC003)

INCIDENTS REQUIRING CRITICAL INCIDENT ANALYSIS

- Death
- Suicide or attempted suicide
- Emergency Medical Treatment OR Hospitalization Due To
  - Injury
  - Medication Error
  - Self-Harm
  - An individual harmed another person
  - Illness (2 or More Unscheduled Admissions Not Due to Chronic Or Underlying Condition Within 365 months)
- Emergency Physical Management
- Arrest of Consumer
- Staff Called Police in Response to Consumer's Challenging Behavior

CONSIDERATIONS FOR CRITICAL INCIDENT ANALYSIS

Input from Person served:
- Give person the opportunity to provide his/her perspective of what he/she experienced
- Ask the recipient if he/she is okay
- Discuss recipient's options and choices and what he/she could do differently next time – possibly review goals and what he/she are working towards in their PCP
- Inform the recipient as to why physical management was used *(if applicable)*

Method/Procedure:
- Was the recipient's Person-Centered Plan (PCP) adequate?
- Was the recipient's PCP complete?
- Did written policies, protocols, and procedures exist?
- Were staff aware of risks and thinking about how to prevent them?

Communication:
- How was information provided to staff?
- Were there barriers to communication?
- Were staff aware of the consumer's PCP?
- Were staff aware of the organization's procedures, policies and protocols?
- Was information/instructions missing?
- Was information/instructions confusing or contradictory?

Staff Related:
- What were the staffing levels at the time of the incident?
- What training had staff received?
- Did staff have skills required to implement procedures?

Environment:
- Was the environment noisy?
- How much space was available to consumers and staff?
- Was lighting adequate?
- Were any physical hazards present?
- Had Emergency Response Procedures been developed?

Equipment/Materials:

- Was equipment available?
- Was equipment used properly?
- Was equipment in good condition?
- Were surfaces safe?

Appendix 2-12-8B

INSTRUCTIONS FOR COMPLETING CRITICAL INCIDENT ANALYSIS FORM

All incident reports must be sent to WMCMH to the Service Enhancement Team within 24 hours. Reports may be faxed or dropped off at any WMCMH office.

If the incident report describes a Critical Incident as described in WMCMH Policy 2-12-8:

- Home manager (for residential settings) or Supervisor (for other settings) should indicate in the submitted incident report that a Critical Incident Debriefing Analysis form will be completed and submitted within 30 days.
- Service Enhancement Team staff will be contracting home managers/supervisors when the incident report are received if there is no indication that the Critical Incident Debriefing Analysis form is forthcoming.
- Home manager or supervisor must complete the Critical Incident Debriefing Analysis form. They may want to consult with the staff person who completed the initial incident report. The home manager and supervisor should describe factors that contributed to the incident and ways of presenting future incidents related to:
    - Input from the persons served
    - Method/procedure
    - Communication
    - Staff related
    - Environment
    - Equipment/materials
    - Other

The Service Enhancement Team is available to provide consultation and assistance.