	Reporting Critical Incidents		
Chapter:	Board Services and Program Administration	**Policy #**	2-12-8
Section:	Safety and Therapeutic Environment	**Revision #**	5

I. **PURPOSE:** To establish policy and procedures for reporting and following up on 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, Contract with Lakeshore Regional Entity (PIHP), 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 their supervisor or a member of the Network, Quality Improvement, and Compliance Department to determine if an incident must be reported. Critical incidents may include, but are not limited to the following:

1.1. Challenging behaviors, including but not limited to, physical or verbal aggression toward others, use of physical management, medication refusal, and wandering or elopement.

1.2. Suicide or non-suicide death.

1.3. Emergency medical treatment for behavioral health assistance, for illness, for injury during physical management, for injury not during physical management, due to a medication error, resulting from harm to self or others, for a suicide attempt, or for an overdose.

1.4. Health and safety, including, but not limited to, falls (regardless of injury), vehicle accidents, injuries requiring first aid at program/home, unexplained or unknown injury, or other health and safety concerns as appropriate.

1.5. Hospitalization due to illness, injury during physical management, injury not during physical management, or due to medication error.

1.6. Law enforcement involvement, including arrest of a consumer.

1.7. Medication errors involving a recipient not receiving a prescribed medication, receiving the wrong dosage, or receiving the wrong medication.

1.8. Other events, including but not limited to, suicide, suspected abuse or neglect, use of seclusion or restraint, communicable disease or infection control, use and unauthorized possession of weapons, biohazardous accidents, unauthorized use and possession of legal or illegal substances, overdose, sexual assault, or other potential Sentinel Events, as defined in IV.7.

2. MDHHS/PIHP Critical Incident Events: Include the following:

   - Suicide
   - Non-suicide death
   - Death of Unknown Cause
   - Emergency Medical Treatment due to Injury, Medication Error, or Overdose for consumers living in 24-hour Specialized Residential setting, consumers in SUD Residential setting, in a Child-Care Institution, or receiving Habilitation Supports, SED, or Child Waiver services
   - Hospitalization due to Injury or Medication Error for consumers living in 24-hour Specialized Residential setting, consumers in SUD Residential setting, in a Child-Care Institution, or receiving Habilitation Supports, SED, or Child Waiver services
   - Arrest for consumers living in 24-hour Specialized Residential setting, in a Child-Care Institution, or receiving Habilitation Supports, SED, or Child Waiver services
   - MAT Medication Error for consumers living in 24-hour Specialized Residential setting, consumers in SUD Residential setting, in a Child-Care Institution, or receiving SUD Services.
   - SUD Medication Error for consumers in SUD Residential setting.
   - Serious Challenging Behaviors for consumers in SUD Residential setting.

3. Peer Review: A process in which mental health professionals evaluate the clinical competence of staff and the quality and appropriateness of care/services provided to the individuals 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 Michigan Department of Health and Human Services.

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

   - Harm to self: Emergency Medical Treatment (EMT) or hospitalization due to an injury that is self-inflicted, such as pica, head banging, biting, and including suicide attempts.
   - Harm to others: Harm to another including family, friends, staff, peers, public, etc., that results in an injury requiring EMT or hospitalization of the other person.
   - Police calls: Police calls made by public mental health staff including specialized residential settings, general residential homes, and other provider agency staff for assistance with an individual during a behavioral health crisis regardless whether contacting the police is addressed in the behavioral treatment plan.
   - Emergency Use of Physical Management: Physical Management is a technique used as an emergency intervention to restrict the movement of an individual by continued direct physical contact in spite of individual's resistance in order to prevent them from physically harming themselves or others. Physical Management should only be used on an emergency basis when the situation places individuals or others at imminent risk of physical harm. To ensure safety

of each consumer and staff, the agency shall designate emergency physical management techniques for use during emergency situations. The term "physical management" does not include briefly holding an individual to provide comfort and or to demonstrate affection or holding their hand.

- Hospitalizations: Two or more unscheduled admissions 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.

5. 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, to reduce the likelihood of recurrence, 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 Network, Quality Improvement, and Compliance Department 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 Policy 5-1-1.

4. 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 a summary of the incident. CIRs completed by WMCMH providers will be routed to the Responsible Care Manager for documentation in the clinical record. The CIR itself will not be entered in the clinical record.

5. The Network, Quality Improvement, and Compliance Department will review CIRs, record the appropriate data, and route CIRs to appropriate staff as outlined in Attachment A, CIR Routing Matrix.

   5.1. A Critical Incident Debriefing will be done within fourteen (14) days on critical incidents determined to warrant further investigation and action. Critical incident debriefing *must* be conducted for the following incident types:

   5.1.1. Unexpected death.
   5.1.2. Suicide or attempted suicide.
   5.1.3. Emergency Medical treatment or hospitalization due to injury in a treatment setting, Medication error in a treatment setting, self-harm in a treatment setting, an individual harmed another person in a treatment setting.
   5.1.4. Emergency use of physical management
   5.1.5. Staff called police in response to a consumer's challenging behavior
   5.1.6. Abuse class I or Neglect Class I.
   5.1.7. Use of seclusion or restraint.
   5.1.8. Other sentinel events.

   Other critical incidents not listed in 5.1 may be assigned for debriefing, to be determined by Director of Network, Quality Improvement, and Compliance.

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

6. The Network, Quality Improvement, and Compliance Department will report a summary of Critical Incidents monthly to the Safety Committee and an annual analysis to the Quality Improvement Steering Committee that includes causes, trends, areas needing improvement, actions recommended and taken for improvement, results of actions taken, training and education of personnel, prevention of recurrence, and internal and external reporting requirements.

7. 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 Network, Quality Improvement, and Compliance Department.

8. Critical Incident Reports will be retained for at least 7 years.

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

VII. **SUPPORTING DOCUMENTS**:

See:
Sentinel Event Procedures 2-6-6
Death Reporting Policy 5-2-9
NQC_QI_08_IR Debriefing Form

VIII. **POLICY/PROCEDURE REVIEW:**

REV#	APPROVED BY	Policy/Procedure	DATE
NC	Unknown		01/17
NC	Unknown		09/19
1	Don Avery/PIOC	Procedure	03/21
2	QISC	Procedure	04/22
3	QISC	Procedure	05/23
4	QISC	Procedure	04/24
5	QISC	Procedure	11/24
***Board Approval Date**: 05/23/1996*			

VIII. **CHIEF EXECUTIVE OFFICER ENDORSEMENT:**

I have reviewed and approved of policy # 2-12-8 Revision# 5.

CEO: Lisa A. Williams Approval Signature:_____