Title:	3.3.07, Incident Reports		
Subject:	CONSUMER TREATMENT, TRAINING, AND LIVING		
Section:	Clinical		
Policy: □ **Procedure: X**	**Issued by:** Director, Quality, Customer Service, Recipient Rights	**Effective Date:** 01/04/11	**Applies to:** **X All CMHA-CEI staff** **X Contract Providers**
Page: 1 of 8	**Approved by:** Board of Directors	**Review Date:** 3/31/17	**□ Other:**

I. Purpose:

To monitor and evaluate incidents or potential incidents as they relate to consumer health and safety, and care; to ensure timely reporting and channeling of pertinent information to appropriate departments within the agency; to monitor the overall effectiveness of consumer care; to aggregate and review critical aspects of care as they relate to Quality Improvement, Utilization Review, and risk management; and to assure issues are tracked and trends are identified and reviewed as necessary.

II. Procedure:

A. Incident Reporting Guidelines

1. An Incident Report needs to be completed when staff either witness or are the first to become aware/informed of an incident (defined above) involving a CMH consumer who is actively receiving services. For the sake of reporting, a consumer is considered to be actively receiving services when any of the following occur:
    a. A face-to-face intake has occurred and the individual was deemed to be eligible for on-going service, or
    b. CEI has authorized the individual for ongoing service, either through a face-to-face assessment or a telephone screening, or
    c. The individual is currently receiving a screening service in Crisis Services.
    d. The individual has received a non-crisis, non-screening encounter.

2. All CMHA-CEI employees, contractors, employees of contractors, students, or volunteers, who witness, discover, or are informed of incidents defined above shall:
    a. Immediately take actions to protect, comfort, and assure treatment of the consumer as necessary;
    b. Immediately verbally notify the designated supervisor of death, apparent serious injury, or serious safety issues;
    c. Immediately verbally notify the Recipient Rights Office of suspected abuse or neglect of a consumer;
    d. Immediately verbally notify the Facility Department of serious safety issues.
    e. Incident reports must be completed as soon as possible, but in no case, later than the workday in which the incident occurred. Completed incident reports will be reviewed by on-site responsible staff.

3. When two (2) or more CMHA-CEI employees, contractors, employees of contractors, students, or volunteers witness an incident requiring an Incident Report, one (1) report shall be completed and signed by the witnesses. Any witness who believes that they have a different perspective on the event from the Reporting Staff perspective and would like to provide a different description of the incident may do so in the body of the Incident Report.

4. All CMHA-CEI employees, contractors, employees of contractors, students, or volunteers shall also adhere to reporting requirements of 1982 Public Act 519, Adult Protective Service Act, 1975 Public Act 238, as amended, Child Protection Act, and 1988 Public Act 32, Mandatory Report of Abuse Act.

5. Staff of some programs (e.g., day programs and residential services) should familiarize themselves with applicable procedures for reporting certain types of events / incidents to the appropriate licensing or regulatory bodies (e.g. MI Department of Health and Human Services).

6. In the case of critical incidents that are reported to the MI Department of Health and Human Services, the following process occurs:
    a. Monthly, the QI Reviewer runs a report from the Incident System Application, in which all reported incidents are logged, for submission to the Mid-State Health Network.
    b. The report identifies the required critical incident categories: Suicide, Non-Suicide Death, EMT due to Injury/Medication Error, Hospitalization due to Injury/Medication Error, and Arrest, and the required programs as follows:

Service	Suicide	Death	EMT	Hospital	Arrest
Community Living Supports (CLS)	●	●			
Supports Coordination	●	●			
Case Management	●	●			
Assertive Community Treatment (ACT)	●	●			
Homebased	●	●			
Wraparound	●	●			
Habilitation Supports Waiver (HSW)	●	●	●	●	●
Serious Emotional Disturbance (SED) Waiver	●	●	●	●	●
Children's Waiver Program (CWP)	●	●	●	●	●
Any other service	●				
Living Situation					
Specialized Residential	●	●	●	●	●
Child Caring Institution (CCI)	●	●	●	●	●

    c. The critical incident report is then uploaded to the MSHN Critical Incident Warehouse by the last day of the month.

7. Incidents that are determined to be sentinel events will adhere to the standards as described in CMHA-CEI Procedure 1.1.14 Sentinel Events.

8. Where a County of Financial Responsibility (COFR) agreement exists, the COFR shall be responsible for reporting the critical incident. If it is determined that a COFR exists, the COFR will be contacted and provided with the necessary information to support the reporting process.

B. Roles within the Incident Reporting System

1. Reporting Staff: The Reporting Staff is the CMH employee, contractor, employees of contractors, student, or volunteer who witnesses an incident. All Reporting Staff enter incidents via. the web portal.

2. On-Site Responsible Staff: The On-Site Responsible Staff is the immediate supervisor of the Reporting Staff. The On-Site Responsible Staff reviews the incident in the web portal, assigns the appropriate incident categories, and notes follow-up action taken.

3. Program Contact: The Program Contact regularly monitors the Incident System Application to complete required notifications, process errors, and alert the Primary/Peer Reviewer that an incident report has been assigned. Additionally, the Program Contact runs reports from the Electronic Health Record (EHR) to monitor the incidents being reviewed and ensure that On-Site Responsible Staff and Primary/Peer Reviewers are completing their required reviews.

4. Primary/Peer Reviewer: The Primary/Peer Reviewer reviews all descriptions and selected categories of the incident report and ensures their accuracy, writes a description of the follow-up action that occurred, and identifies whether or not the incident is a potential critical or sentinel event.

5. QI Reviewer: The QI Reviewer reviews all critical incidents and notes any additional follow-up activity that occurred

C. Incident Review Committees

1. Role of the Quality Improvement Monitoring and Evaluation Workgroup (QIMEW)
    a. QIMEW includes representatives from Quality Improvement, Recipient Rights, and Compliance.
    b. Monthly, reviews all general incidents in each category for which it is assigned responsibility.
    c. Identifies any potential critical incidents requiring additional follow-up beyond that which has already occurred.
    d. Analyzes data for trends and notes any recommendations.
    e. Reports findings to the responsible committee as required:

INCIDENT – General IR Form	Committee for Review
Emergency Care for Illness/Injury	CIRC
Choking	CIRC
Exposure to Blood/Body Fluids	CIRC

Serious Behavioral Events: Aggressive/Property Damage/Self Injury	CIRC
Arrest	CIRC
Missing Recipient	CIRC
Death	CIRC
Other	CIRC

2. Role of the Medication and Pharmacy Workgroup (MAP)
    a. MAP includes representatives from Quality Improvement, Recipient Rights, Clinical Programs, Finance, Contracted Pharmacy Service, and the Medical Director.
    b. Monthly, reviews all medication incidents in each category for which it is assigned responsibility.
    c. Identifies any potential critical incidents requiring additional follow-up beyond that which has already occurred.
    d. Analyzes data for trends and notes any recommendations.
    e. Reports findings to QICC quarterly.

INCIDENT – Medication IR Form	Committee for Review
Medication Error	MAP
Missed Medication	MAP

3. Role of the Critical Incident Report Committee (CIRC)
    a. CIRC includes representatives from Quality Improvement, Compliance, Recipient Rights, Clinical Programs, and the Medical Director.
    b. Monthly, reviews general incident summary reports received from QIMEW.
    c. Monthly, reviews each death incident report individually and other specific critical incidents as identified by QIMEW.
    d. Reviews status reports on sentinel event plans of correction.
    e. Analyzes data for trends and notes any recommendations.
    f. Report findings to QICC quarterly.

4. Role of the Quality Improvement and Compliance Committee (QICC)
    a. QICC includes representatives from Quality Improvement, Compliance, Recipient Rights, Clinical Programs, the Medical Director, and the Chief Executive Officer.
    b. Quarterly, reviews general and medication IR summary reports received from CIRC and MAP.
    c. Analyzes data for trends and notes any recommendations.
    d. Annually, reports findings to the Board.

D. Report Retention / Confidentiality:

1. QIMEW Representatives will be responsible for tracking incidents. This information will be aggregated and reported to the appropriate committee as noted above.

2. The incident report information entered via the web portal, including the initial Reporting Staff report and the On-Site Supervisor review, will be placed in the consumer's clinical record in the EHR.

3. All Primary/Peer and QI reviews/analyses, including minutes collected for or by individuals or committees assigned a peer review function, are confidential, and NOT public record; therefore:
    a. Do not appear in the clinical record.
    b. Are not subject to court subpoena.
    c. Disclosure or duplication is absolutely prohibited, except as provided in the policy and procedure.
    d. The risk identified if the Incident Report is not treated in a confidential manner (e.g., circulated to persons who do not have a need know, or used for purposes unrelated to improving quality of care) is the loss of statutory protection.
    e. A copy of this policy and procedure shall be posted on the intranet and available in each program and residential unit directly operated by or under contract with CMH.

III. Responsibilities:

N/A

IV. Definitions:

Arrest: Arrest is defined as a situation where a consumer is held or taken by a law enforcement officer based on the belief that a crime may have been committed. The following situations are NOT considered to be an arrest:

- Situations where a consumer is transported for the purpose of receiving emergency mental health services, or situations where a consumer is held in protective custody.
- Situations where charges are filed, but the individual is not taken into custody.

Behavioral Event: an event by a consumer that results in serious aggression towards others, serious property damage or serious self-injury.

Choking: The blocking of a consumer's airway as the result of eating or ingesting foreign objects and that requires administration of abdominal thrusts (also known as Heimlich Maneuver).

Death: Any death of a consumer, regardless of whether the death was expected or not expected. This is per MDHHS regulations as part of their Incident Reporting System. (see Policy 3.3.8, Report and Review of Death).

Emergency Care: For injury or illness which requires an intervention beyond first aid, i.e., urgent care, emergency room visit, or hospitalization. Examples would include broken bones, lacerations requiring sutures, sprains, or illnesses such as pneumonia, etc.

Other General Incident: For incidents that do not meet the requirements of the other available options. Should include use and unauthorized possession of weapons and unauthorized use and possession of legal or illegal substances.

Exposure to Blood / Body Fluids: Exposure of non-intact skin or mucous membranes to blood and/or body fluids of another.

Medication Error/Event: Any occurrence involving a medication error/event (in situation where the medication is administered by, or under the supervision of, CEI) that places a consumer at risk due to a variance in medication processes. Medication errors/events in situation where the medication is not administered by, or under the supervision of, CEI, do not require the completion of an IR.

Medication errors/events include:

1. **Adverse medication reaction (Event):** Harmful, unintended response to a medication that requires emergency care.

2. **Wrong dosage Administration:** Medication is administered by staff in a dose that is different than prescribed. (e.g., A person is supposed to receive two 50 mg tablets but is only administered one 50 mg tablet).

3. **Wrong person/medication Administered:** A medication is administered by staff to a consumer for whom it is not prescribed.

4. **Wrong route of Administration:** Medication is administered using a method other than as prescribed (e.g., eye drops are placed in the ear).

5. **Wrong Time/Day:** A medication is administered more than an hour before or after the scheduled time (e.g., A medication that is to be administered at 8 PM is administered at 10:30 PM).

6. **Missed medication:** Prescribed dose is missed (e.g., 3 doses scheduled in a day, consumer receives 2 doses).

7. **Medication Administration Record (MAR) transcription error:** Changes in medications orders or administration of medication not entered onto the MAR (e.g. according to medication count all medications were administered but the MAR has not been signed by staff to reflect that).

8. **Medication Administration Record (MAR) staff signing error:** Staff failure to sign MAR as required.

9. **Medication refusal:** Consumer refuses to take prescribed medications.

10. **Pharmacy error:** medication dispensed incorrectly or not delivered timely.

Missing Recipient: A vulnerable consumer intentionally leaving CMH or contract premises without permission, or wandering away from premises without staff knowledge

NETO – Non-Exclusionary Time Out: The withdrawal of a client, or of a reinforcer that prevents client participation in an activity for a short period of time by either by withdrawing a specific reinforcer, or removing the client to the perimeter of the reinforcing event or activity.

Physical Intervention: A technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others.

Search and Seizure: Search of the person or the person's property (or their living space in the case of residential consumers) and the removal of said person's belongings. When search and seizure is allowed either per House Rules (House of Commons) or allowed for in the consumer's treatment plan, the singular act of search and seizure should not be considered a reportable incident.

Sentinel Event: An unexpected occurrence to a recipient of services involving death or serious physical (loss of limb or function) or psychological injury, or the risk thereof. (Risk thereof includes any process variation that would most likely would result in a sentinel event if it reoccurred).

Behavioral Treatment Plan: A plan that proposes to use restrictive or intrusive interventions with individuals who exhibit seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm.

Critical Incident: A situation that might present risk of significant bodily harm or significant property damage.

Designated On-Site Responsible Staff – Supervisor/Coordinator/Resident Manager of a Home

Incident: As used in the CMH Incident Report (IR) means an occurrence that disrupts or adversely affects the course of treatment or care of a consumer.

Web Portal: The web-based incident report form located at https://incident.ceicmh.org and accessible to all CMHA-CEI staff and contracted providers.

Incident System Application: The CMHA-CEI database of all submitted incident report from the web portal.

V. Monitoring and Review:

This policy is reviewed annually by the Director of Quality, Customer Service, and Recipient Rights. It is monitored by accrediting bodies and regulatory agencies as applicable.

VI. References:

MDCH Description of Event Reporting System,
https://mipihpwarehouse.org/MVC/Documentation#Requirements

VII. Related Policies and Procedures:

CMHA-CEI Policy 3.3.07	Incident Reporting Policy
CMHA-CEI Policy 3.3.08	Report and Review of Death
CMHA-CEI Policy 3.3.10	Confidentiality and Release of Information
CMHA-CEI Policy 3.4.05	Emergency Behavior Management
CMHA-CEI Policy 3.1.07	Suspension
CMHA-CEI Policy 3.3.13	Restraint
CMHA-CEI Policy 3.3.14	Abuse, Neglect, or Mistreatment of Recipients
CMHA-CEI Policy 1.1.14	Sentinel Events
CMHA-CEI Procedure 1.1.14	Sentinel Events

VIII. Review Log:

Review Date	Reviewed By	Changes (if any)
10/14/86 05/10/90 02/14/91 02/21/92 02/09/93 06/09/93 09/30/98 03/16/04 05/28/05 01/01/11 01/04/11 05/05/14 01/31/16		
3/31/17	QIMEW, QCSRR Director	Changes to make more clear of process, update to reflect new process of committee reviews.

IX. Attachments:

A. CMHA-CEI Quality Improvement Committee Organization Chart

CMHA-CEI Quality Improvement Committee Organization Chart July 2016