

Alabama Department of Mental Health

Division of Intellectual Disabilities

Community Incident Prevention and Management Plan

I. Overview of Incident Reporting and Management:

- A. **Purpose:** To describe and implement, through standard actions by the Alabama Department of Mental Health (DMH), Division of Intellectual Disabilities (DID), its Regional Community Services Offices (RCS), and its contractors, a mechanism to protect persons served from harm and to improve the oversight and response capabilities of the systems that serve them. Protection from harm requires an Incident Management component that includes: prevention, identification, classification, proper reporting and investigation, and implementation of effective actions to remedy situations that lead to harm.

Incident Management is one component of the DID larger Quality Improvement/Quality Enhancement Program in which the emphasis is on improvement of systems and processes.

- B. **Philosophy of Incident Management:** Incident Management serves to promote an environment that is free from harm. The DID is committed to the following beliefs:
- People are entitled to appropriate services in a caring and hospitable environment that is free from harm.
 - Providers must eliminate, wherever possible, the occurrence of preventable incidents and respond appropriately to all types of incidents.
 - The fewer the number of incidents, particularly serious incidents, the more caring and hospitable the environment will be under which recipients will live, work, and learn.
- C. **Operations and Definitions of Incident Management:** An incident is any unplanned occurrence that has the potential to affect the health, safety, and welfare of individuals served by the Division of Intellectual Disabilities. Reportable incidents are defined by this plan as Moderate Injuries, Major Injuries, Choking, Seizures, Falls, and Unscheduled Hospital Admissions, Medication Errors—Levels 1, 2, 3, Documentation Error, Missing/Eloped Individual, Death, Severe Behavior Problem, Natural Disaster, Fire, Allegations of Abuse, Neglect, Mistreatment, or Exploitation, Physical Assault, Sexual Assault, Manual Restraint, Mechanical Restraint, Chemical Restraint, and Other occurrences which require the notification

of Police, or DHR. In general, all incidents have three components in common: a definition, a reporting requirement, and a closure requirement.

Definition—Characteristics and details of a particular occurrence that give clarity and meaning to a reportable incident. See Section III. for definitions of reportable incidents.

Reporting Requirement—All reportable incidents must be reported by providers to RCS within certain timeframes based on the nature and criticality of the incident. See Section IV for timelines for reporting of particular incidents. Also, all reportable incidents must be reported by the provider to RCS on the Regional Community Services Incident Report except deaths which are reported on the Regional Community Services Initial Mortality Report. See attached documents.

Closure Requirement—All reportable incidents require some level of review based on the nature and criticality of the incident. Reportable incidents are reviewed and followed-up based on the recommendation of the RCS Director or designee either requiring no further action, requiring action follow-up by either the provider and/or RCS staff, requiring an investigation by police, DHR, provider, 310 Board, and/or RCS, or requiring a death review.

Reportable incidents can generally be divided into three categories based on how they are tracked through the system: those that are assigned or denoted an “I” for investigation, those that are assigned or denoted an “M” for mortality and those are assigned or denoted by an “A” for some type of action follow-up by the RCS Director or designee.

Investigations

All allegations or suspicions of Abuse, Neglect, Mistreatment, or Exploitation must be investigated. Community providers are required to investigate all reports unless some conflict of interest prevents an objective investigation. In addition, the RCS Director or designee makes a determination whether or not additional investigation is needed and who should conduct it based on the circumstances surrounding the allegation.

The RCS Director or designee is authorized to initiate an investigation into other incidents as deemed necessary. Examples include but are not limited to suspicious deaths, notification of local authorities for possible criminal activity, or moderate or major injuries of an unexplained nature.

Death

All deaths require an initial mortality report followed by a comprehensive mortality review to be completed by the community provider or 310 case

manager. The initial mortality report is reviewed by the RCS Director or designee and assigned to an RCS staff for follow-up either directly or through the provider or 310 case manager (see requirements under Section V D-Incidents of Mortalities).

The RCS Director or designee is authorized to assign the completion of the comprehensive mortality review to RCS staff as deemed necessary. Examples include but are not limited to suspicious deaths that may also need investigating or lack of trained staff in the providing agency or 310 board to complete such a review.

Action Follow-up

All reportable incidents excluding deaths and those that do not require investigating are closed in one of two types of follow-up action. They are reviewed and closed with no action necessary or they are reviewed and assigned to an RCS staff to obtain follow-up information either directly or through the provider or 310 case manager. Follow-up action is documented on the Action Follow-up Form. See attached documents.

II. Application:

This plan applies to all recipients of services in the DID certified community programs and to all their employees and agents.

Pursuant to the reporting provisions as specified in the DMH-DID Incident and Prevention Management Plan (and in accordance with DMH-DID Community Program Standards), all DMH-DID certified community providers shall report incidents involving individuals that occur in certified community programs, either on the provider's premises and/or while involved in an event supervised by the provider, in accordance with the procedures outlined in this document.

Pursuant to the responsibilities assumed by the DMH-DID and its contractors for the day-to-day management of Medicaid Home and Community-Based Waiver programs, reporting of incidents is also required when they occur in settings other than those specified above (e.g., overnight visits or outings with family); however, the responsibility to report shall not go beyond gathering information that is readily available (e.g., reports from staff, individuals, and families, and documentation of the injury). There are situations where no contractor has control over or responsibility for an incident, but assessing and recording what allegedly occurred to the individual is a requirement under the waiver.

III. Definitions of Reportable Incidents:

Pursuant to the DMH-DID Incident and Prevention Management Plan, the

following are considered Reportable Incidents. Incidents are to be reported to the DID in the timeframes specified in Section 4 below.

- A. Medical Emergencies – any serious medical emergency that requires unscheduled treatment by a physician, paramedic, other medical professionals, or hospitalization. All vehicle accidents involving an individual where there is a likelihood of a moderate or major injury is considered a reportable incident. In such cases, person(s) should be checked by external medical personnel. Categories of reportable medical emergencies are defined below.
1. **Moderate Injury:** An injury, either explained or unexplained, requiring medical treatment that is not considered major. For example, a small cut that requires suturing (five or less sutures) or an IV infiltrates and needs to be reinserted. Bruises and contusions are considered moderate if they require treatment and sprains as well as suspected bone injury are considered moderate if an x-ray is ordered and there is no fracture.
 2. **Major Injury:** A serious injury, either explained or unexplained, requiring medical treatment, including any fracture, head injury, or wound requiring more than five sutures.
 3. **Choking:** Gagging or choking on food, liquid, or foreign object or material that requires the Heimlich maneuver or evaluation by medical personnel.
 4. **Fall:** Tripping, stumbling, and or collapsing which results in a sudden and involuntary drop to a lower surface or the ground that results in a moderate or major injury.
 5. **Seizure:** An unexpected or uncharacteristic (type, duration) seizure whether or not an injury occurs.
 6. **Unscheduled Hospital Admission:** Any other medical occurrence that cannot be characterized by any medical emergency category above that requires an unscheduled hospital admission.
- B. **Medication Error**– a medication error occurs when a recipient receives an incorrect drug, drug dose, dose form, quantity, route, concentration, or rate of administration. A medication error is also defined as some form of variance of the administration of a drug on a schedule other than intended. Therefore, a missed dose or a dose administered one hour before or after the scheduled time constitutes a medication error.

Severities of medication errors are defined as follows:

1. Level 1 includes incidents in which the individual experienced no or minimal adverse consequences and no treatment or intervention other than monitoring or observation was required.
2. Level 2 includes incidents in which the individual experienced short term, reversible adverse consequences and treatment(s), and/or intervention(s) was/were needed in addition to monitoring and observation.
3. Level 3 includes incidents in which the individual experienced life-threatening and/or permanent adverse consequences.

The agency must report level 1, 2 and 3 medication errors to RCS. Level 3 errors must be reported verbally within 24 hours and must be reported on an incident report form within 72 hours. Level 1 and 2 Medication Errors require a separate written report but may be batched and forwarded to RCS the 5th working day of the month following the month in which the incident occurred. No action follow-up is required by RCS or the provider for Level 1 medication errors.

- C. Documentation Error – a documentation error occurs when a Medication Administration Record (MAR) is not initialed after medication assistance is provided to an individual. Evidence of a documentation error is denoted by a blank space(s) on the MAR following the scheduled administration time of the medication(s).
- D. Missing/Eloped Individual - any time an individual is found to be missing from the home or from work and cannot be located within 30 minutes, the provider staff must immediately report to police and RCS. The report shall include the suspected time of departure, where the individual possibly went, what the individual was wearing, a description of the individual's behavior/attitude prior to disappearance, and what actions have been taken to locate the individual.
- E. Death - all mortalities in any setting are to be reported immediately by the provider or person notified of the mortality to RCS. RCS is to report to the DID immediately upon notification of any mortality. An Initial Mortality Report and a Comprehensive Mortality Review will be required. If the death occurred while the person was not in the provider's care or if the person lives in a relative's home, it is understood that certain information may not be readily available.
- F. Severe Behavior Problem - behavior problems such as physical aggression resulting in injury, self-injurious behavior requiring medical

attention, suicide threats or attempts, or property damage resulting in injury or significant destruction shall be reported to RCS by the provider with information on how the situation was/is being addressed. Incidents resulting from such problems may or may not require action follow-up.

- G. Natural Disaster - (i.e., tornado, flood, wind damage, hurricane). Provider must be familiar with disaster procedures in the home and be prepared to evacuate to a shelter if needed. Notify RCS after evacuation is completed and safety of individuals is ensured.
- H. Fire – flames resulting from the combination of heat, fuel, and oxygen or the unplanned, inappropriate or hazardous burning of a combustible substance where injuries and/or significant structural damages occur.
- I. Allegations of Abuse, Neglect, Exploitation or Mistreatment –
 - 1. Physical Abuse: Any assault by someone other than another individual being served, upon a individual; includes but is not limited to hitting, kicking, pinching, slapping, or otherwise striking a individual or using excessive force regardless of whether an injury results. Assault as defined by this policy implies intent.
 - 2. Sexual Abuse: Any sexual conduct with an individual by someone other than another individual being served with the intent to gratify the sexual desire of himself/herself or the individual. Sexual abuse includes, but is not limited to, sexual intercourse with an individual; deviate sexual intercourse or contact; and any form of sexual contact to include any touching of the sexual intimate parts. Sexual abuse also includes any incitement by an employee/agent of a recipient(s) to engage in any form of sexual activity with another individual or other person.
 - 3. Verbal Abuse: Verbal conduct by someone other than another individual being served that demeans an individual or could reasonably be expected to cause shame or ridicule, humiliation, embarrassment or emotional distress. Verbal abuse includes but is not limited to threatening an individual; using abusive, obscene or derogatory language to an individual; or teasing or taunting an individual in a manner to expose the individual to ridicule.
 - 4. Neglect: The failure to carry out a duty through carelessness, inattention, or disregard of duty whereby the individual is exposed to harm or risk of harm, and includes but is not limited to:
 - a. Failing to appropriately supervise individuals or otherwise leaving individual areas unattended;
 - b. Failing to ensure the individual's basic needs for safety, nutrition,

- medical care and personal attention are met;
- c. Failing to provide treatment in accordance with the treatment plan;
 - d. Utilizing treatment techniques, e.g., restraints, seclusion, etc. in violation of departmental policy and procedures, whether or not injury results.
5. **Mistreatment:** Any act or threat of intimidation, harassment or similar act and includes but is not limited to active verbal aggression or intimidation; use of physical or non-verbal gestures as a means of intimidation; withholding of or the threat of withholding physical necessities or personal possessions as a means of intimidation for the control of the individual; making false statements as a means of confusing or frightening or badgering an individual.
6. **Exploitation:** Utilizing the position of employment to take advantage of an individual for personal benefit and includes but is not limited to improperly requesting individuals to perform employee's work responsibilities or otherwise perform services or tasks for the employee; requesting, taking or receiving money, gifts, or other personal possessions from individuals; utilizing individuals to engage in conduct with other individuals that would be prohibited if performed by an employee.

Note: All incidents of abuse, neglect, mistreatment, or exploitation allegations involving staff members of the provider must be reported immediately to RCS, regardless of whether the incident was believed to have occurred or not.

Note: DMH-DID Abuse/Neglect Reporting requirements do not supersede or replace any other statutory requirements for reporting to DID, Local Law Enforcement Agencies, Advocacy, DHR, etc. Provider agencies and DID staff members must meet all mandated reporting requirements.

- I. **Physical Assault**—any assault by an individual being served upon another individual being served. Includes, but is not limited to, an individual hitting, kicking, slapping, throwing objects at, or otherwise striking another person which caused or may have caused injury. A physical assault results from planned, intentional behavior and/or from agitation or other behavior where there is specific intent to inflict harm (or potential harm) to another individual.
- J. **Sexual Assault**—any touching of the sexual or intimate parts of an individual being served by another individual being served to include intercourse and/or deviant sexual intercourse, involving an individual: (1) under the age of sixteen, or (2) who is coerced, or (3) does not otherwise have the capacity to consent (capacity may be either mental or physical or the individual may be mentally incapacitated) as assess by the individual's team.

- K. **Manual Restraint**—the use of physical holding which is not part of an approved behavior support plan to involuntarily restrain the movement of the whole or a portion of an individual's body as a means of controlling his/her physical activities in order to protect him/her or others from injury.
- L. **Mechanical Restraint**—the use of commercial devices which are not part of an approved behavior support plan to involuntarily restrain the movement of the whole or a portion of an individual's body as a means of controlling his/her physical activities in order to protect him/her or others from injury.
- M. **Chemical Restraint**—the use of medication that is not a standard treatment for the individual's medical or psychiatric condition and is used to control behavior or restrict the individual's freedom of movement. Medications used for the individual's positive benefit as an integrated part of an individual's therapeutic plan of care and specific situation and representing standard treatment for the recipient's medical or psychiatric condition does not meet this restraint definition.
- N. **Other**—Any other occurrence that requires the notification of agencies such as Police, Fire Department, or DHR or an occurrence that could reflect negatively on the image of the DMH-DID.

IV. Incident Reporting

A. Timelines for Reporting Incidents

RCS must be notified by providers or 310 case managers verbally of all reportable incidents either immediately or within 24 hours depending on the particular incident. Level 1 and 2 Medication Errors require a separate written report but may be batched and forwarded to RCS the 5th working day of the month following the month in which the incident occurred. Written reports are to be forwarded to RCS within 72 hours. Additionally, the provider is responsible for notifying an individual's responsible relative/guardian immediately in cases of death and medical emergencies. RCS must notify the DID immediately following notification of an incident requiring immediate notification by a provider. RCS must notify the DID in writing within 5 working days of being reported of all incidents requiring an investigation.

Reportable Incidents Requiring Notification Immediately

Missing/Eloped Individual

Death

Allegations of Abuse, Neglect, Mistreatment, Exploitation

Reportable Incidents Requiring Notification within 24 Hours

Medical Emergencies/Unscheduled Hospitalizations
Medication Errors (Level 3)
Severe Behavior Problems
Natural Disasters
Fires
Physical Assault
Sexual Assault
Restraints which are not part of an approved behavior reduction plan

Reportable Incidents Requiring Notification Monthly

Level 1 and 2 Medication Errors
Documentation Errors

V. Processing of Regional Community Services Incident Report Forms

A. Incidents Determined by RCS to Require No Action Follow-up

1. Notify RCS verbally within time frames required based on the incident. Incident reports are to be prepared by community providers as soon as possible following a reportable incident and after the individual's health and safety is addressed.
2. All areas of the report should be completed as indicated including a supervisory review.
3. Supplemental material may be attached and forwarded to RCS as needed.
4. If an injury is sustained, then Page 2 of the form must also be completed.
5. The completed incident report should be forwarded to RCS within 72 hours.
6. The RCS Director or designee will review the incident report and close the report with no action follow-up necessary if so determined.
7. If action follow-up is determined to be necessary, a responsible RCS Staff member is assigned to obtain the additional information either directly or through the provider.

B. Incidents Determined by RCS to Require Action Follow-Up

1. Notify RCS verbally within 24 hours. Incident reports are to be prepared by community providers as soon as possible following a reportable incident and after the individual's health and safety are addressed.
2. All areas of the report should be completed as indicated including a supervisory review.
3. Supplemental material may be attached and forwarded to RCS as needed. If an injury is sustained, then Page 2 of the form must also be completed.
4. If the reviewing supervisor determines that action follow-up information is indicated, then the type information is indicated in the review section with a required completion date.
5. The completed incident report should be forwarded to RCS within 72 hours.
6. The RCS Director or designee will review the incident report, determine if additional information is needed beyond what is recommended by the reviewing supervisor and assign a responsible RCS staff member to obtain the all additional information either directly or through the provider.
7. The RCS Director or designee establishes a required completion date.

Action follow-up information required after completion of the RCS Incident Report Form should be reported on the RCS Action Follow Up Form. Supplemental material may be attached and forwarded to RCS with the Action Follow-Up Form.

Example: the Action Follow-Up Form would be used to report on the outcome of a medical emergency, a natural disaster, or a behavioral episode.

C. Incidents Requiring Investigating

All allegations or suspicions of Abuse, Neglect, Mistreatment, or Exploitation and incidents reportable to DHR or Local Authorities for suspected felony assault must be investigated. The RCS Director or designee reserves the right to initiate an investigation into other incidents as deemed necessary. Examples include but are not limited to suspicious deaths, notification of local

authorities for possible criminal activity, or moderate or major injuries of an unexplained nature.

1. The Provider shall take immediate action(s) to ensure the individual's safety.
2. All allegations or suspicions of abuse, neglect, mistreatment, or exploitation must be reported to RCS immediately by the provider.
3. Incident reports are to be prepared by community providers as soon as possible following a reportable incident and after the individual's health and safety is addressed.
4. All areas of the report should be completed as indicated including a supervisory review.
5. Supplemental material may be attached and forwarded to RCS as needed. If an injury is sustained, then Page 2 of the form must also be completed.
6. The provider agency will indicate how they plan to investigate the incident and what other authorities (DHR, Police, etc.) will investigate and/or have been notified. In the event that DHR indicates that an individual is not in need of protective services from the department for allegations of physical abuse and/or are not going to investigate and felony assault is suspected, the provider agency must contact the appropriate local authority (e.g., Police or Sheriff).
7. The completed incident report must be forwarded to RCS within 72 hours.
8. The RCS Director or designee will review the incident report and determine who the investigating entity will be in addition to the community provider if any based on the circumstances surrounding the allegation.
9. If additional information is needed beyond what is noted by the provider's reviewing supervisor the RCS Director or designee assigns a responsible RCS staff member to obtain the all additional information either directly or through the provider.
10. The RCS Director or designee establishes a projected completion date for the completion of the investigation.
11. RCS completes a Notification of Initiating a Review form and forwards to the Division of Intellectual Disabilities.

12. As soon as possible but not later than 15 working days from the time of the occurrence of the incident, the provider and/or other assigned entities shall provide to RCS a copy of the investigation report. See Appendix A for information requirements for an investigation report.
13. Within 5 working days after receiving the investigation report, the RCS Director or designee will review and take additional action, if needed, and/or close. Based on circumstances, this 5-day period may be extended with written notice to the Regional Community Service Director (for example, autopsy completed but not available, further action needed but not yet occurred).
14. RCS forwards a copy of the completed investigation to the DID by the 30th day following the incident.

D. Incidents Requiring a Comprehensive Mortality Review

1. All deaths in the community require notification, an Initial Mortality Report, and a Comprehensive Mortality Review whether unexpected or not. A death that occurs under questionable circumstances or as a result of an allegation of abuse, neglect, mistreatment or exploitation additionally requires an investigation as outlined above.

2. Notification

- a. If the person expires on a site or in the care of any provider, the provider is responsible for notification of the responsible relative and/or guardian, RCS, and other entities as appropriate (e.g., ambulance, paramedics, police, residential provider, case manager, etc).
- b. If the person expires while not on site or in the care of any provider, then the first agency to become aware of the death is responsible for notification.
- c. RCS is responsible to ensure that all necessary notifications are made.

3. Initial Mortality Report—Forwarded to RCS within 72 Hours of Death

- a. If the person resides in a residential program, then that program is responsible for completion of the Initial Mortality Report regardless of where the person expired.
- b. If the person does not live in a residential program but attends a day program and expires in the day program, then the day

program is responsible for completion of the Initial Mortality Report.

- c. If the person did not live in a residential program and did not expire while attending the day program, then the case manager is responsible for completion of the Initial Mortality Report.
4. Comprehensive Mortality Review—Forwarded to RCS within 15 Working Days of Death
 - a. If the person resides in a residential program, then that program is responsible for completion of the report regardless of where the person expired.
 - b. If the person did not live in a residential program, then the case manager is responsible for completion of the report.
 5. The RCS Director or designee may request an RCS staff to complete the Comprehensive Mortality Review independent of or in conjunction with the provider or 310 Case Manager.
 6. The Comprehensive Mortality Review submitted by the provider should contain the following information when the individual died from medical conditions:

Demographic Data

Name, age, sex, DOB, Case # and SS #
Current Placement
Other pertinent placement information

Health Information

Health history (conditions)
Medications
Treatment history (doctors orders and follow up)

Circumstances of Death

Events immediately preceding
Response to emergency, as applicable (staff, others)
Medical treatment (ER, hospitalization, etc.)
Date and time of death
Cause of death (hospital and/or coroner)
Autopsy finding, if applicable
Internal review by agency, if applicable.
Recommendations and/or required actions.

Health Information is not necessary if the individual did not die

as a result of a long term medical condition or a medical emergency.

7. In cases where the individual lived alone or in the family home, the 310 Case Manager is requested to provide as much information as possible or as is available. It is understood that the 310 Case Manager has a responsibility to respect the rights and privacy of the immediate family and to be as unintrusive as possible.
8. Within 5 working days after receiving the Comprehensive Mortality Review, the RCS Director or designee will review and take additional action, if needed, and/or close. Based on circumstances, this 5-day period may be extended with written notice to the Regional Community Service Director (for example, autopsy completed but not available, further action needed but not yet occurred).
9. RCS forwards a copy of the completed Comprehensive Mortality Review to the DID by the 30th day following the incident.

VI. Notification of Regional Advocate

Pursuant to the provisions of the DMH-DID Incident and Prevention Management Plan, the Regional Advocate will be notified by the RCS Director or designee of all reportable incidents involving individuals within 24 hours of occurrence. Notification can be by voice mail, e mail, or copy of the incident report.

Incidents reported between 8:00 AM Monday and 5:00 PM Friday will be reported to the Regional Advocate at the time the faxed RCS Incident Report Form is received in RCS.

Incidents reported between 5:00 PM Friday and 8:00 AM on Monday and/or on Holidays shall be verbally reported to the Regional Advocate by the RCS Director or designee the following work day.

The Regional Advocate shall be responsible for notification of the Internal Advocacy Office.

VII. Notification of Case Management Agencies

Providers shall notify the respective 310 case management agency within one business day, preferably by email or fax, of any reportable

incident defined in this plan except Level I and II Medication Errors and Documentation Errors. Notifications shall include basic information regarding the circumstances of the incident to enable follow-up by responsible case managers.

VIII. Review of Incident Data

Each certified community provider shall develop and implement a mechanism via their internal QE/CQI Process to ensure the timely and appropriate review of reportable incident data in their programs by the Agency's executive and clinical leadership (including the Board of Directors). This shall include a mechanism to report incident data, to identify trends, and to take preventative actions to improve the safety of the environment and care for individuals.

The Regional Quality Enhancement Specialist shall compile a quarterly report of all reportable incidents for distribution to the Director of Quality and Planning, Regional Community Services Director, Regional Certification Team member(s) and Regional Advocate.

The Director of Quality and Planning shall compile a quarterly report to the Associate Commissioner for Intellectual Disabilities and State Quality Enhancement Council on all incidents reported by certified community providers.

The Quality Enhancement Council will be responsible for the review of reportable incident data across the Intellectual Disabilities system in order to identify trends and patterns in reportable incident data and to recommend strategies for improving the safety of the environment and care of individuals in certified community programs.