



**Mental Health and Substance Abuse Services Bulletin**  
**COMMONWEALTH OF PENNSYLVANIA \* DEPARTMENT OF PUBLIC WELFARE**

**NUMBER:**

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**SUBJECT:**

Community Incident Management  
& Report System

**BY:**

**Joan Erney**  
**Deputy Secretary for Office of Mental Health  
and Substance Abuse Services**

**SCOPE:**

Community Residential Rehabilitation Service Providers  
Long Term Structured Residence Providers  
County MH/MR Administrators

**Definitions:**

*Community Residential Rehabilitation Services*—Transitional residential programs in community settings for persons with chronic psychiatric disability to assist in their recovery.

*Department*—The Department of Public Welfare of the Commonwealth.

*HCSIS*— Home and Community Services Information System.

*Investigation*— For the purposes of this Bulletin, investigation refers to activities conducted by the provider, county or OMHSAS to determine the circumstances surrounding the reported incident which forms the basis of follow-up activities or corrective action. Although it does not specify the use of a certified investigator, it is expected that investigators be adequately trained and certified investigators may be used if they are available. OMHSAS may modify the Bulletin at some point in the future should it be determined that certified investigators are needed to adequately investigate incidents. Further, it does not preclude investigations by law enforcement agencies.

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

Office of Mental Health and Substance Abuse Services, Division of Quality Management, P.O. Box 2675, Harrisburg, PA 17105. 717-772-6650 (General Office Number).

*Long Term Structured Residence*—A highly structured therapeutic residential mental health treatment facility for adults.

*OMHSAS*— Office of Mental Health and Substance Abuse Services

Licensing Applicability:

Following the processes outlined in this policy statement satisfies the incident reporting requirements of 55 Pa. Code (relating to public welfare) for the following regulation chapters:

- Chapter 20 – Licensure or Approval of Facilities and Agencies
- Chapter 5310 – Community Residential Rehabilitation Services for the Mentally Ill
- Chapter 5320 – Long Term Structured Residences

**PURPOSE:**

The purpose of this Bulletin is to establish guidelines and procedures for a consistent statewide process for reporting, categorizing and investigating incidents involving consumers in the public mental health system. This process also includes the structure for taking immediate corrective actions as well as analyzing incident trends to prevent recurrence. As a result, the Commonwealth’s behavioral health system will be better able to systematically monitor and protect the health, safety, dignity, rights and welfare of consumers receiving services and treatment.

**BACKGROUND:**

Providers of mental health (MH) services throughout the public mental health system need to ensure that safeguards are in place to protect the health, safety and rights of consumers receiving these services. OMHSAS intends to have a unified incident reporting system for county mental health programs and providers. All providers of mental health services, including the county mental health programs, behavioral health managed care organizations, and OMHSAS are partners in the effort to assure the health, safety, dignity, rights and welfare of persons receiving mental health services.

**DISCUSSION:**

The primary goal of an incident management system is to assure that the response, review, and analysis of incidents is adequate to protect the health, safety and rights of the consumer. This bulletin communicates and standardizes clear and specific processes at the provider and county levels for reporting and follow-up of incidents. The continuous review and analysis of incidents is aimed at protecting consumers, identifying trends and formulating action to prevent recurrence. It is understood that all reported events do not necessarily represent a treatment failure or a failure on the part of the provider.

In addition to the OMHSAS reporting processes described in this bulletin, reporting requirements of other laws and regulations must be followed. Notwithstanding the guidelines in the statement of policy, facilities remain obligated to follow the requirements of 18 PA CS 2713 (relating to neglect of care-dependent persons), 35 P. S. § § 10225.101—10225.5102 (notification requirements of the Older Adults Protective Services Act), and 23 Pa.C.S. § § 6301—6384 (relating to Child Protective Services Law). Furthermore, these standards do not preclude counties from requiring additional reporting.

Facilities must comply with the requirements of 55 Pa. Code Chapters 20, 5310, and 5320. Because this statement of policy meets or exceeds the regulatory requirements of Chapters 20, 5310, and 5320, compliance with the reporting procedures in this statement of policy will be accepted as meeting the regulatory requirements (relating to reporting of incidents).

### **REPORTING RESPONSIBILITIES:**

Responsibility for reporting an incident as outlined in this policy, including the use of the standardized reporting tools, is as follows:

- Residential providers, licensed by OMHSAS, limited to Community Residential Rehabilitation Services (CRRS) and Long Term Structured Residences (LTSR). These entities are responsible for completing incident reports on those in their care, including incidents for any consumer enrolled in the CRR or LTSR that occur while the consumer is in the community. Counties are to request the cooperation of providers not covered by the scope of this bulletin in the reporting and investigation of an incident by the residential provider or county program.

Reports are to be made through the Department of Public Welfare's Home and Community Services Information System (HCSIS). The initial notification of the occurrence of an incident is due within 24 hours after the incident, or within 24 hours after the provider learns of the incident.

### **INCIDENTS TYPES:**

The following lists the different types of incidents to be reported.

**Death** - all deaths regardless of cause.

**Suicide Attempt**: - The intentional and voluntary attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an attempt which requires medical treatment and/or where the consumer suffers or could have suffered significant injury or death.

Non-reportable events include:

- Threats of suicide which do not result in an actual attempt.

- Gestures which clearly do not place the consumer at risk for serious injury or death.
- Actions which may place the consumer at risk but where the consumer is not attempting harm to himself/herself.

**Significant Medication Error** - A significant medication error includes a missed medication, incorrect medication or incorrect dosage, where a consumer suffers an adverse consequence that is either short or long term in duration or receives treatment to offset the effects of the error.

Non-reportable events include:

- Refusal by the consumer to take prescribed medication.

**Any event requiring the emergency services of the fire department, or a law enforcement agency** – This includes events such as fires; an individual charged with a crime; an individual who is a victim of a crime; acts of violence; vandalism, or misappropriation of consumer property.

Non-reportable events include:

- Non-emergency services of the fire department or law enforcement agency.
- Police presence related to commitment procedures or rescue squad activities.
- Testing of alarm systems/false alarms, or 911 calls by consumers that are unrelated to criminal activity or emergencies.
- Presence of law enforcement personnel during any activity governed by the Mental Health Procedures Act.

**Abuse** – Allegations of abuse are to be reported. Abuse is occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse. For the purposes of this Bulletin, abuse includes abuse of consumers by staff or abuse of consumers by others. Depending on the nature of the abuse, it may also constitute a crime reportable to police. Abuse includes:

- **Physical Abuse** - An intentional physical act by staff or other person which causes or may cause physical injury to an consumer.
- **Psychological abuse** - An act including verbalizations, which may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean a consumer.
- **Sexual abuse** - An act or attempted acts such as rape, sexual molestation, sexual harassment and inappropriate or unwanted touching of a sexual nature of a consumer by another person. Any sexual contact between a staff person and a consumer is abuse.
- **Exploitation** - The practice by a caregiver or other person of taking unfair advantage of a consumer for the purpose of personal gain, including actions taken without the informed consent of the consumer or with consent obtained through misrepresentation, coercion or threats of force. This could include inappropriate access to or use of a consumer's finances, property, and personal services.

Non-reportable events include:

- Altercations among residents that may result in physical contact but do not cause serious injury and which do not reflect a pattern of physical intimidation or coercion of a resident.
- Discord, arguments or emotional distress resulting from normal activities and disagreements that can be found in typical congregate living situations.

**Neglect** - Neglect is the failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law, contract or regulation. This can include the failure to provide for needed care such as shelter, food, clothing, personal hygiene, medical care, and protection from health and safety hazards.

**Injury or illness of a consumer** – Reportable **injury** includes those where the consumer requires medical treatment more intensive than first aid. First aid includes assessing a condition, cleaning a wound, applying topical medications, and applying simple bandages. Reportable **illness** includes any life threatening illness, any involuntary emergency psychiatric admission, or any illness that appears on the Department of Health's List of Reportable Diseases (pursuant to PA Code, Title 28, Chapter 27), including those appearing on the DOH list as the subject of voluntary reporting by the CDC (reports are only needed when the disease is initially diagnosed).

Non-reportable events include:

- Scheduled treatment of medical conditions, on an outpatient or inpatient basis.
- Any voluntary inpatient admission to a psychiatric facility, or service at a crisis facility or psychiatric department of acute care hospitals for the purpose of evaluation and/or treatment.
- ER visits or inpatient admissions that result from a patient's previously diagnosed, chronic illness, where such episodes are part of the normal course of the illness.
- ER visits where the visit is necessitated because of the unavailability of the consumer's primary care physician.

**Missing person** –Providers are to report a consumer who is out of contact with staff without prior arrangement for more than 24 hours. A person may be considered to be in "immediate jeopardy" based on his/her personal history and may be considered "missing" before 24 hours elapse.

Additionally, it is considered a reportable incident whenever the police are contacted about a missing person or the police independently find and return the consumer, regardless of the amount of time he or she was missing.

**Seclusion or Restraint.** Providers are to report any use of seclusion or restraint as defined in MH Bulletin "OMHSAS -02-01 The Use of Seclusion and Restraint in Mental Health Facilities and Programs."

## **PROCEDURES:**

Providers and counties are to follow the procedures outlined below in order to ensure consistent reporting and management of incidents.

### **A. PROVIDER PROCEDURES**

Providers are to develop written policies and procedures for an incident management process which include the following:

1. Mechanism to ensure that consumers, staff and volunteers have proper orientation and training to respond to, document and report incidents.
2. Notification process for the family of the consumer, with the expressed consent of the adult consumer, obtained at the time of the incident (unless the consumer is physically unable to provide consent). If the consumer has an advance psychiatric directive regarding family contact, it should be respected unless the consumer directs otherwise at the time of the incident and clearly has capacity to make that decision.
3. Assurance the consumer and family member (with consumer's consent) have the opportunity to provide verbal or written comment about the incident that is included in the incident report. The consumer and family should be provided information and assistance, if needed, with making internal and external complaints related to a reportable incident.
4. Mechanism to debrief the consumer, and with consumer permission, family member or contact identified by the consumer regarding the outcome of the investigation and to provide written notification on the closure of an incident investigation.
5. Process for the internal review and investigation of incident reports. The level and intensity of the investigation is based on the seriousness of the incident. In some cases, the information gathered during the completion of the incident report will constitute an adequate investigation. In other cases, further investigation may be necessary to adequately analyze the incident. Investigations may include collection of physical evidence, witness interviews, document review and or visual inspection of the incident location.
6. Procedure for review following the death of any consumer served in the program.
7. Process to review incidents and share information with staff and others, including direct care workers, consumers, family members and advisory groups regarding specific incidents or trends.
8. Procedures that assure compliance with all applicable laws, regulations and policies.
9. Process to analyze the causes and methods of prevention for any significant incidents which would include at a minimum any accidental death; injury resulting in a major, permanent loss of function in a consumer; significant assault including rape and abuse; and any other incident determined by the provider, county or OMHSAS to warrant this level of review.

10. Plan for trend analyses to identify individual consumer and provider program systemic issues.
11. An incident file within the agency that includes all documents related to the incident and the investigation.

#### B. COUNTY OFFICES of MENTAL HEALTH PROCEDURES

County offices of mental health are to develop written policies and procedures for an incident management process that include the following:

1. Review and approval of each contracted provider's and/or behavioral health managed care organization's (BH-MCO's) policies and procedures relating to incident management.
2. Review of provider investigations and a process to initiate county investigations as indicated independently or in collaboration with OMHSAS.
3. Analysis and sharing of information with appropriate individuals.
4. Procedures for reviews to occur following the death of any consumer.
5. Monthly review of incident data, by individual consumer and program for trends in order to:
  - a. Identify consumers at risk.
  - b. Identify programs with significant incident trends.
  - c. Assure provider and or BH-MCO compliance with plans of correction resulting from incident investigations.
  - d. Assess providers' and/or BH-MCO's incident management and investigative processes.
  - e. Follow up in writing with local program administrators when individual consumer or program issues are identified.
6. Response to concerns from consumers or their families about the reporting and investigation processes and results, including requests for county MH or OMHSAS investigations when needed.

#### **REPORTING AND REVIEW:**

Providers and counties are to create an administrative structure that is sufficient to implement the requirements of this Bulletin. Specifically, they are to:

1. Assign an individual with overall responsibility for incident management.
2. Ensure that staff, individuals and families are trained on incident management policies and procedures.
3. Assign roles within their organization for reporting and investigation of incidents.
4. Assure corrective action for individual incidents.

#### **A. PROVIDER REPORTING AND REVIEW**

Providers are to:

1. Identify an incident management representative with overall responsibility for incident reporting and management. The incident management representative receives reports of incidents and ensures that reports are submitted on time as specified in this Bulletin and the providers approved policies. The incident management representative ensures the provider staff:

- a. Take prompt action to protect the consumer's health or safety.
  - b. Follow the OMHSAS reporting procedures to complete the initial incident report no later than 24 hours after the incident or no later than 24 hours after the provider learns of the incident.
  - c. Contact appropriate law enforcement agencies when there is suspicion that a crime has occurred.
  - d. Ensure investigation of the incident per provider policy. Any reportable incident may be investigated by the provider, county and/or OMHSAS. This investigation process in no way precludes investigations by law enforcement agencies.
  - e. Based on the outcome of the investigation, finalize the incident report, documenting results of any investigations and all actions taken to prevent recurrence of the incident.
  - f. Finalize the incident report within 5 working days of the incident for incidents that are readily investigated and resolved. In cases where further investigation of the incident is occurring, the provider should complete the report for review by the County MH office within 30 calendar days.
2. Identify a provider point person(s) who receives verbal or other reports or allegations of incidents from individuals, families and initial reporters. When an incident is reported, the point person, as a representative of the agency, is to:
    - a. Confirm that appropriate actions have been taken or order additional actions to secure the safety of the individual involved in the incident.
    - b. Separate the individual from the target when the individual's health and safety may be jeopardized.
    - c. Determine follow-up that may be needed.
    - d. Secure the scene of an incident when an investigation may be required.
    - e. Notify appropriate supervisory/management personnel within 24 hours of the incident, as specified in provider/entity or county policies.
    - f. Initiate a HCSIS Incident Report within 24 hours as described in the Reportable Incident section of this bulletin.
    - g. Notify the family within 24 hours unless otherwise indicated in the individual care plan or advance directive, if applicable.
  3. Implement a review process. It is recommended that providers dedicate time each day to review prior day incident reports to assure they are properly completed, make decisions on actions to prevent reoccurrence and establish closure on events not under investigation. Incident reports should be reviewed individually to determine if provider action has been appropriate and sufficient.
  4. Analyze incidents which involves:

- a. Analysis of the cause and methods of prevention for any significant incidents which would include at a minimum any accidental death; injury resulting in a major, permanent loss of function in a consumer; significant assault including rape and abuse; and any other incident determined by the provider, county or OMHSAS to warrant this level of review.
- b. Trend analyses to identify individual consumer and provider program systemic issues.
- c. Analysis of quality of data on incidents and the quality of investigations.
- d. Identification and implementation of individual and systemic changes based on risk management analysis.

## B. COUNTY REPORTING AND REVIEW

Counties are to:

1. Identify an incident manager with overall responsibility for incident reporting and management. The incident manager is the person with overall responsibility for incident management within the county program. This responsibility includes a review to ensure incidents are managed and reported by provider or county staff in accordance with the process described in this statement of policy. The incident manager can approve or not approve HCSIS Incident Reports submitted by the provider or by a county point person.
2. Identify a county incident point person(s). The point person has the ability to initiate an incident that comes to the attention of the county and has not been reported by a provider. A point person cannot approve or not approve HCSIS Incident Reports.
3. Identify a county incident reviewer(s). The county incident reviewer has the ability to review incidents but cannot initiate or change incidents already entered into the system.
4. Implement a county process for the review and analysis of incident report data. This bulletin does not direct any specific procedure for this review or analysis. However, it is recommended that county MH staff dedicate time each day to do the following:
  - a. Review prior day incident reports to assure they have been properly completed.
  - b. Assure follow-up actions have been taken by the provider to protect the consumer and prevent reoccurrence of any incident.
  - c. Assure that a thorough investigation has been conducted by the provider.
  - d. Monitor incidents needing to be finalized by provider or county staff.

- e. Ensure final approval of HCSIS Incident Reports filed by the county.
5. Analyze incidents. The county incident manager should conduct regular trend analysis to provide the agency, the county and OMHSAS with insights into specific issues that cannot be gained from the review of individual incident reports. It should be conducted across individual program locations as well as across providers.

### C. OMHSAS ROLE

The OMHSAS regional offices provide oversight of the process, including:

1. Review incident reports and final reports to assure that appropriate action and investigation of each incident is being conducted by the provider/county, with emphasis on the safety of the consumer.
2. Contact the county and provide direction when further investigation is warranted.
3. Review data to identify trends which may require administrative steps to support improved risk management.

The OMHSAS central office will review data on all reported incidents to identify any trends that may be developing statewide. OMHSAS will incorporate these findings into the Annual Quality Management Plan.