

## 7084 MANAGEMENT OF INCIDENTS

### 7084.3 FACILITY MANAGEMENT PLAN

Each facility shall have a risk management plan which includes:

1. Explicit assignment of responsibilities for the facility's risk management program. These responsibilities may be assigned to a risk manager and/or risk management/incident review committee. Assignment of tasks shall include at a minimum:
  - a. The review, investigation, and/or analysis of each incident report.
  - b. the review of aggregate incident data to determine any trends or patterns within the facility.
2. Incidents reportable to the Office of Mental Health and Substance Abuse Services:
  - a. Reportable incidents include:
    - 1) The AWOL occurrence of a forensic or other potentially high risk or dangerous patient;
    - 2) A suicide;
    - 3) A suicide attempt or physical assault involving serious physical injury to the patient requiring community hospitalization;
    - 4) Homicide and homicide attempts;
    - 5) Allegations of sexual assault which are medically substantiated or require community hospitalization, or which result in criminal charges or lead to community concern;
    - 6) All patient deaths;
    - 7) Any incident about which the chief executive officer anticipates adverse community, media or legislative concern;
    - 8) A threat or notice of litigation against the facility or any employee;
    - 9) Fire causing injury to a patient(s) or staff, or requiring relocation of patients due to damage in a living area;
    - 10) The death or serious injury (requiring at least emergency room or panel physician care) of a staff, visitor or volunteer on hospital grounds.
    - 11) Power outages, work stoppage, or other events which may affect patient care services.

- b. Incidents reportable to OMHSAS may initially be communicated by telephone or through other available media within 12 hours of the incident. Initial information should include a brief summary of facts surrounding the incident/death to enable OMHSAS to respond to inquiries and/or request further information/action. A copy of the completed SI-815 or other report, should be forwarded to OMHSAS as soon as practicable, but no later than five calendar days after the incident.
3. Employee responsibilities upon observing or discovering an incident:
  - a. to initiate any indicated emergency procedures responsive to the health and safety needs of the person;
  - b. to notify and/or seek assistance from the supervisor;
  - c. to insure that information, relevant material, and/or evidence are noted and preserved; and
  - d. to record required information on the Incident Report, SI-815 within prescribed time frames pursuant to facility policy.
4. Supervisor responsibilities:
  - a. to assess the incident to insure correct emergency procedures are followed and all persons affected receive any care indicated;
  - b. to follow facility policy for reporting the incident; and
  - c. to review documentation to assure information presented is as factually accurate and comprehensive as possible.
5. Management responsibilities:
  - a. to assure that all staff receive training on the concepts of a comprehensive risk' management program, and
  - b. use of the incident reporting system (SI-815), and
  - c. develop procedures for addressing the emotional needs of any person who is a party or witness to an incident.
6. Requirements for post mortem evaluations of all patient deaths:
  - a. An ad hoc post mortem committee is established as a standing committee of the medical staff to review all patient deaths whether such death results from suicide, homicide, sudden or unexplained reason, accident, or from medical disorders. Medical staff bylaws should describe the method for selecting a committee chair, when and by whom meetings of the committee are called, the committee's purpose, and reporting requirements.

- b. Post mortem review should include, at a minimum, participation by the chief of clinical services, medical director, physicians, the patient's attending physician, the director of nursing (or designee), the director of social and rehabilitative services (or designee), and the director of continuous quality improvement (or designee).
- c. Each report/minutes of committee review should include, at a minimum:
  - 1) Identifying data about the patient; i.e., age, date of birth, gender, date of admission, date of death, time of death, ward or community hospital in which the death occurred.
  - 2) All diagnoses, psychiatric and medical, at the time of death and any medications used in the treatment of those conditions.
  - 3) Cause of death and certificate of death, when available.
  - 4) Course of hospitalization - a summary of the reason(s) for hospitalization and treatment history (psychiatric and medical), including medications used.
  - 5) The date and time the patient's next of kin or legal representative was notified of the patient's death and, the name and position of the person who contacted the next of kin or legal representative.
  - 6) The presence or absence of any advance directive and/or do not resuscitate order.
  - 7) Narrative description of medical and/or psychiatric signs and symptoms leading to the patient's death including treatment provided and information from consultants. If the patient died in a community hospital, a summary of the treatment during the patient's stay shall be provided.
  - 8) Autopsy findings, when available. A psychological autopsy shall be conducted for all deaths by suicide, homicide, and deaths reported as a sentinel event.
  - 9) Recommendations for changes in policy, procedure, or patient management, when applicable.
- d. Follow-up review of information relative to quality improvement actions taken as a result of recommendations made per 7,c,7 above.