

7084 MANAGEMENT OF INCIDENTS

7084.3 Facility Management Plan

Each facility shall have a risk management plan that includes:

1. Explicit assignment of responsibilities for the facility's risk management program. These responsibilities may be assigned to a risk manager and/or a risk management/incident review committee. Assignment of tasks shall include at a minimum:
 - The review, investigation, and/or analysis of each incident report; and
 - 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 (OMHSAS):
 - a. Reportable incidents include:
 - 1) The AWOL occurrence of a forensic or other potentially high risk or dangerous person;
 - 2) A suicide
 - 3) A suicide attempt or physical assault involving serious physical injury to the person requiring community hospitalization;
 - 4) Homicide and homicide attempts;
 - 5) Allegations of sexual assault that are medically substantiated or require community hospitalization or result in criminal charges or lead to community concern;
 - 6) All consumer/resident deaths
 - 7) Any incident about which the CEO anticipates adverse community, media, or legislative concern;
 - 8) A threat or notice of litigation against the facility or any employee;
 - 9) Fire or other disaster causing injury to a consumer/resident or staff, or requiring the relocation of consumers/residents 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 member, visitor or volunteer on facility grounds.

11) Power outages, work stoppage, or other events which may affect services.

b. Incidents reportable to OMHSAS shall be initially communicated by telephone or through other available media within twelve (12) hours of the incident. Initial information shall include a brief summary of facts surrounding the incident/death to enable OMHSAS to respond to potential inquiries and/or request further information/action. A copy of the completed SI-815, or other report format, shall be forwarded to OMHSAS as soon as practical, but no later than five (5) calendar days after the incident.

3. Employee responsibilities upon discovering or observing an incident:

- to initiate any indicated emergency procedures responsive to the health and safety needs of the individual;
- to notify and/or seek assistance from the supervisor;
- to ensure that information, relevant material, and/or evidence are noted and preserved; and
- to record required information on the Incident Report (SI-815) within the prescribed time frames pursuant to facility policy.

4. Supervisor responsibilities:

- to assess the incident to ensure correct emergency procedures have been enacted and followed and all individuals affected receive the care indicated;
- to follow facility policy for reporting the incident; and
- to review documentation to ensure information presented is factual, accurate, and comprehensive as possible.

5. Management responsibilities:

- to ensure that all staff receive training on the concepts of a comprehensive risk management program and the use of the incident reporting system (SI-815); and
- to develop procedures for addressing the emotional needs of any person who is a party or witness to an incident.

NOTE: Attachment A (Incident Report Form – SI-815) is a template form. Revisions to the form may be made by any of the State hospitals and/or Restoration center to meet specific data collection needs or certification agency standards. Revisions may not adversely affect or compromise statewide data collection and comparison projects.

6. Requirements for post mortem reporting and evaluations of all consumer/resident deaths (individuals within the facilities at the time of death and any person who commits suicide within 72 hours of discharge):
- When a consumer/resident death occurs (or is discovered) the following report action steps shall be put into effect:
 1. Telephone notification to the facility Chief Executive Officer (or designee);
 2. Telephone notification to Director, Bureau of Community and Hospital Operations (or designee);
 3. Completion of the “OMHSAS Report of Patient Death” (Attachment F) within 24 hours of the death and submission via email or fax to the following individuals:
 - Director, Bureau of Community and Hospital Operations (or designee);
 - OMHSAS Medical Director;
 - Designated data collection/point of contact; and
 - The Disability Rights Network designated contact.
 4. Ensure information/facts relating to the death are accurately reflected on an Incident Report (SI-815);
 5. Completion of the State Hospital Mortality Database Abstraction Tool (Attachment G) within thirty (30) days of the death and submitted to the designated data collection/point of contact.
 - Post Mortem Committee – an ad hoc committee of the Medical Staff shall be established to review all consumer/resident deaths that occur (or are discovered) during the course of hospitalization/residence. The Medical Staff Bylaws shall describe the methods to be utilized to complete this task.

At a minimum the following individuals (or designees) shall be involved in the Post Mortem Committee review process:

- Chief Medical Executive
 - Medical Director
 - Chief Executive Officer
 - Attending Psychiatrist
 - Attending Medical Physician
 - Chief Nurse Executive
 - Chief Social and Rehabilitative Services Executive
 - Chief Performance Improvement Executive
 - Members of the Treatment Team
 - OMHSAS Medical Director
 - External Chief Executive Officer
 - External Chief Medical Executive or Medical Director
 - Disability Rights Network Representative
- Post Mortem Committee Report – a report/minutes of the Post Mortem Committee meeting shall be completed and reflect the following information:
 1. Identifying consumer/resident data (name, date of birth, gender, date of admission, date/time/location of death);

2. All psychiatric and medical diagnoses at the time of death and any medications used in the treatment of those conditions;
 3. Cause of death;
 4. Course of hospitalization – a summary of the reason(s) for hospitalization and treatment history (medical and psychiatric), including medications prescribed;
 5. The date and time the next of kin or legal representative was notified of the death and the name and position of the individual who completed the notification;
 6. The presence or absence of a physical health and/or mental health advance directive and/or do not resuscitate (DNR) order;
 7. Organ procurement organization contact information and outcome (for persons who expired within the State facilities);
 8. A narrative description of the medical and/or psychiatric signs and symptoms leading to the death including treatment provided and information from consultants. If the consumer/resident died in a community hospital, a summary of the treatment provided during their hospitalization shall be included;
 9. Autopsy findings, when available. A root cause analysis (RCA) shall be conducted for all deaths by suicide, homicide, and those required to be reported as a sentinel event; and
 10. Recommendations for changes in policy, procedure, or consumer/resident management, when applicable, and subsequent improvement activities undertaken.
- As an attachment to the Post Mortem Committee meeting report, a discussion is to be delineated regarding the following:
 1. Preventability - whether the person's death was preventable, and if so, what steps could have been taken to prevent this person's death.
 2. Risk Assessment – how many other people within our service may be at risk for the circumstances/conditions that may have contributed to the death of the person under review; and what steps are being initiated to identify others at risk and to reduce those risks for the persons identified.
 - The Post Mortem Committee meeting shall be conducted within fifteen (15) calendar days of the initial death notification and shall follow the guidelines as contained in Attachment H.
 - The original Post Mortem Committee Report shall be filed in the individual consumer/resident closed medical record.
 - Copies of the Post Mortem Committee meeting minutes shall be forwarded to the designated data collection/point of contact staff person for inclusion in the Mortality review database and to the OMHSAS Medical Director within seven (7) calendar days of the date the meeting was held.

7. Reporting of sentinel events to the Joint Commission:

- a. A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, unrelated to the natural course of the

patient's illness or underlying condition. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

- b. Such events are called "sentinel" because they signal the need for immediate investigation and response.
- c. The state mental hospitals and restoration center as Joint Commission accredited organizations are expected to identify and respond appropriately to all sentinel events. An appropriate response includes: conducting a timely, thorough, and credible root cause analysis (RCA); developing an action plan designed to implement improvements to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements.
- d. Sentinel events subject to review by the Joint Commission includes any occurrence that meets the following criteria:
 - The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition or
 - The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition) :
 1. Suicide of any patient receiving care, treatment and services in a state mental hospital or the restoration center or within 72 hours of discharge;
 2. Abduction of any patient receiving care, treatment, and services;
 3. Rape (as a reviewable sentinel event is defined as unconsented sexual contact involving a patient and another patient, staff member, or other perpetrator including oral, vaginal or anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ, or object. One or more of the following must be present to determine reportability:
 - Any staff-witnessed sexual contact as described above
 - Sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact
 - Admission by the perpetrator that sexual contact, as described above, occurred.
 - Additional examples of sentinel events that are reviewable under the Joint Commission's sentinel event policy:
 1. AWOL of any patient resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function;
 2. Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error;
 3. Any patient death, paralysis, coma, or other major permanent loss of function relating to a health care associated infection;

4. Assault, homicide, or other crime resulting in patient death or major permanent loss of function; or
5. A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

e. Reporting requirements:

1. Within five (5) days of discovery of the sentinel event, the hospital/center shall complete the Joint Commission online self report form entitled "Organization Sentinel Event Self Report" form and transmit the document electronically to the Joint Commission. NOTE: the instructions for completion of this form are contained on the Joint Commission extranet site.
2. Within forty-five (45) calendar days of the discovery of the sentinel event submit the completed root cause analysis and action plan to the Joint Commission for evaluation and review. The methodology for submission of the documents is outlined on the Joint Commission extranet site.
3. The Bureau of Community and Hospital Operations Director (or designee) shall be notified by the facility's Chief Executive Officer (or designee) that the steps outlined above have been completed. These actions shall be completed immediately following submission of the self reporting form and the transmission of the root cause analysis.