DBHDD Georgia Department of Behavioral Health & Developmental Disabilities	**Policy # 04-106** *(Replaces DMHDDAD Policies 6001-101 & 6001-201)* Page 1 of 11

Chapter: Administrative Issues Related to Behavioral Health & Developmental Disabilities Service Delivery
Subject: Reporting and Investigating Deaths and Critical Incidents in Community Services

References:

Official Code of Georgia Annotated (O.C.G.A):

31-8-81; 37-1-2; 37-1-20; 37-2-1 et seq.; 37-3-166; 37-3-2; 37-4-125; 37-4-3; 37-7-166; 37-7-2; 30-5-1 et seq.; 19-7-5; 16-6-5.1

Applicability:

- Public and Private Community Providers
- OTP & State-operated Community Programs
- State DBHDD Office
- Regional DBHDD Offices
- Self-directed DD Services

Attachments:

Attachment A – Definitions
Attachment B – Death Report Form
Attachment C – Critical Incident Report Form (CIR)
Attachment c1 – Critical Incident Report Form (CIR) (Supplemental)
Attachment D – Reporting to Other Agencies
Attachment E – Investigative Report Format
Attachment e1 – Investigative Report
Attachment F – Request for Extension
Attachment G – Corrective Action Plan

Effective Date: April 1, 2011
Scheduled Review Date: April 2012
Approved:

Beverly D. Rollins, M.P.A., Executive Director — Date
Division of Developmental Disabilities

Cassandra Price, Executive Director — Date
Division of Addictive Diseases

J. Bryce McLaulin, M.D., Executive Director — Date
Division of Mental Health

Frank E. Shelp, M.D., M.P.H., Commissioner — Date

I. POLICY

It is the policy of the Department of Behavioral Health and Developmental Disabilities (DBHDD) to maintain a safe and humane environment for individuals, and to prevent abuse, neglect and exploitation of individuals. DBHDD uses a standardized process for reporting and investigating deaths and critical incidents that involve individuals being served in all types of community services.

II. DEFINITIONS

Category I Incidents

- Death-Unexpected
- Suicide
- Alleged Individual Abuse-Physical
- Alleged Neglect
- Alleged Individual Abuse-Psychological
- Alleged Sexual Abuse

- Alleged Individual to Individual Sexual Assault
- Alleged Exploitation - Staff to Individual
- Medication errors with adverse consequences
- Seclusion or restraint resulting in injury requiring treatment
- Suicide attempt that results in medical hospitalization

Category II Incidents

- Death-Expected
- Alleged Individual Abuse-Verbal
- Individual who is unexpectedly absent from a community residential program or day program
- Vehicular accident with injury while individual is in an agency vehicle or is being transported by staff
- Incident occurring in the presence of provider staff which required the intervention of law enforcement services
- Criminal conduct by individual
- Aggressive act between individuals resulting in injury requiring treatment beyond first aid
- Hospitalization of an individual in a community residential program

Category III Incidents

- Death
- Individual injury requiring treatment beyond first aid (not related to possible staff misconduct)
- Staff injury caused by an individual and requiring treatment
- Aggressive act between individuals with injury requiring minor first aid

See **Attachment A: Critical Incident Definitions & Reporting/Investigating Requirements** for definitions of incidents.

Community Provider: Any person or entity providing community-based disability services through a contract with or authorized by DBHDD and/or providing Medicaid services authorized by DBHDD. "Community Provider" includes any state owned or operated community program. For purposes of this policy, community provider includes services provided through a subcontractor.

Community Residential Individual: An individual receiving services in a staffed home or a host home and/or an individual receiving community living support 24 hours/7 days a week.

Corrective Action Plan: A document which identifies and analyzes problems within the provider organization and prescribes corrective action steps which, when implemented, are likely to prevent the recurrence of similar problems and improve the quality of services. A corrective action plan must identify the person(s) responsible for ensuring that action steps are completed and reviewed for efficacy and establish a schedule for completion and follow-up of all action steps.

Crisis Support Home: A home that serves up to four (4) individuals diagnosed with a Developmental Disability and who are experiencing an emotional/behavioral change and/or distress that leads to a disruption of essential functions, which has not responded to Intensive-In-Home Support services.

Critical Incident: Any event that involves an immediate threat to the care, health or safety of any individual in community residential services, in community crisis home services, on site with a community provider, in the company of a staff member of a community provider, or enrolled in participant-directed services. Critical incidents that must be reported to DBHDD are listed in **Attachment A**.

Critical Incident Database: DBHDD web-based system for entering data about critical incidents.

High-Visibility Incident: Critical incidents as defined in this policy, which have system-wide impact, have impact upon, or relevance to, any ongoing litigation of DBHDD, or may have significant impact upon, or significant relevance to, issues of DBHDD public concern and/or are likely to be reported in the media.

Individual: For purposes of this policy, a person enrolled with a community provider or state-operated community service provider for disability services, or receiving community crisis services, or participating in self-directed developmental disabilities services.

Investigative Report: A written summary of an investigation conducted by the Office of Incident Management and Investigations or by a community provider regarding an alleged critical incident or death.

Participant-Directed Services: A model for service delivery in which individuals have the option to control and direct Medicaid funds identified in a personalized budget, and in which the individuals live in their own homes. The individual hires

and dismisses direct support staff, and works with a support coordinator to receive assistance needed with self-directing services.

Person of Interest: Staff accused of abuse, neglect or exploitation of an individual receiving disability services.

Senior Executive Manager: The individual authorized by the agency to review for accuracy and completeness incident reports, investigative reports and corrective action plans prior to submission to DBHDD.

Support Coordinator/Planning List Administrator: In DBHDD developmental disability services, the independent case manager for each individual.

Temporary Intermediate Support (TIS) Home: A home that serves up to four (4) children ages 10 thru 17 years of age, diagnosed with a Developmental Disability and who are undergoing an acute crisis that presents a substantial risk of imminent harm to self or others.

III. PROCEDURES FOR REPORTING INDIVIDUAL DEATHS AND CRITICAL INCIDENTS

A. Reporting Deaths (Category I and II)

1. Community providers will immediately notify parents/guardians, Regional Office, support coordinators and other stakeholders, as indicated.

2. For deaths in a residential or community crisis home setting, community provider requests that the coroner/medical examiner conduct an autopsy and provides sufficient facts to the coroner/medical examiner regarding the death.

3. In the event that the coroner/medical examiner decides not to perform an autopsy, the provider documents the coroner/medical examiner's decision, and if known, the rationale for the decision.

4. The provider submits the ***Death Report Form*** (Attachment B) to the Office of Incident Management and Investigations electronically. The report must be submitted on the same day as the individual's death or on the next business day if the death occurred after business hours or on a weekend or holiday.

5. The senior executive manager is responsible for ensuring that the ***Death Report Form*** (Attachment B) is submitted as required.

6. For deaths that must be reported to other agencies or offices as required by law or regulation, the community provider is responsible at all times for notifying such agencies and offices in a timely manner. (See Attachment D – ***Reporting to Other Agencies***)

7. The Office of Incident Management and Investigations obtains a copy of the death certificate from the Department of Community Health. This copy must not be reproduced or released outside DBHDD.

B. Reporting Deaths (Category III)

1. The provider submits the ***Death Report Form*** (Attachment B) to the Office of Incident Management and Investigations electronically. The report must be submitted on the same day as the death, or discovery of the death, or on the next business day if the death occurred after business hours or on a weekend or holiday.

2. The senior executive manager is responsible for ensuring that the ***Death Report Form*** is submitted as required.

C. Reporting all other Category I and II Critical Incidents (excluding deaths)

1. Upon discovery of a critical incident, providers immediately take any action necessary to protect individuals' health, safety and rights. These actions may include:

   - Removal of an employee from direct contact with any individuals when the employee is alleged to have been involved in physical abuse, neglect, sexual assault, verbal abuse or exploitation, until such time as the community provider has sufficiently determined that such removal is no longer necessary; and
   - Other measures to protect the health, safety and rights of the individual, as necessary.

2. The community provider immediately notifies:

   - The individual's guardian and/or next of kin, as appropriate with respect to confidentiality regulations;
   - The Office of Incident Management and Investigations if there is reasonable suspicion that a crime has been committed; and

- Law enforcement, as needed, subject to applicable rules, regulations and consideration of confidentiality.

3. For all other Category I critical incidents (excluding deaths), the community provider submits the ***Critical Incident Report*** form (Attachment C) electronically to the Office of Incident Management and Investigations on the same day as the Category I incident, or the discovery of the incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday.

4. For all other Category II critical incidents, (excluding deaths) the community provider submits the ***Critical Incident Report*** form (Attachment C) electronically to the Office of Incident Management and Investigations within 24 hours of the Category II incident, or discovery of the incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday.

5. When an individual has an assigned support coordinator, the provider notifies the support coordinator of the critical incident by giving them a copy of the Critical Incident Report.

6. For critical incidents that must be reported to other agencies or offices as required by law or regulation, the community provider is responsible at all times for notifying such agencies and offices in a timely manner (See Attachment D – ***Reporting to Other Agencies***).

D. Reporting Category III Critical Incidents (excluding deaths)

1. Upon discovery of a critical incident, providers immediately take any action necessary to protect individuals' health, safety and rights.

2. The community provider immediately notifies:

   - The individual's guardian and/or next of kin, as appropriate with respect to confidentiality regulations;
   - The Office of Incident Management and Investigations if there is reasonable suspicion that a crime has been committed; and
   - Law enforcement, as needed subject to applicable rules, regulations and consideration of confidentiality.

3. The community provider submits the ***Critical Incident Report*** form (Attachment C) electronically to the Office of Incident Management and Investigations within 48 hours of the Category III incident, or discovery

of the incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday.

4. When an individual has an assigned support coordinator, the provider notifies the support coordinator of the critical incident and provides a copy of the Critical Incident Report.

5. For critical incidents that must be reported to other agencies or offices as required by law or regulation, the community provider is responsible at all times for notifying such agencies and offices in a timely manner (See Attachment D – ***Reporting to Other Agencies***).

E. High Visibility Incidents

1. The community provider immediately reports all incidents that are high visibility to the Office of Incident Management and Investigations by telephone. This call must be made as soon as possible, but at least within two (2) hours of discovery of the incident.

2. A ***Critical Incident Report*** form (Attachment C) must be submitted electronically on the same day as the high visibility incident or on the next business day if the incident occurred after business hours or on a weekend or holiday.

3. The Office of Incident Management and Investigations notifies the Director of Communications, the Regional Coordinator, and the appropriate Division Director of high visibility incidents.

F. Reports of Incidents made by persons other than staff of community providers

1. Individuals, family members of individuals, support coordinators, or any other persons may initiate reports of critical incidents as needed.

2. In participant-directed services, the individual's support coordinator has responsibility for gathering information from the individual's support system about critical incidents as they occur. The support coordinator then reports critical incidents as required by this policy.

3. All support coordinators report critical incidents upon discovery, if the incident has not already been reported by the community provider.

4. If the support coordination agency submits a Critical Incident Report, they must notify the provider of the submission by giving them a copy of the report.

5. When information about a critical incident is received from any person other than support coordinators, the staff receiving the information completes and submits the applicable incident report form.

6. When information about a critical incident is received by the Office of Incident Management and Investigations, the staff receiving the information completes the applicable incident report form.

G. Agency Managerial Review of ***Death Report*** **and** ***Critical Incident Report*** Forms

1. Administrators of community providers or support coordination agencies perform a managerial review of all Death Report Forms and Critical Incident Reports. The reviewer at a minimum:

   - Reads the Death Report Form or Critical Incident Report;
   - Reads all statements and reports associated with the incident;
   - Requires and ensures the completion of any incomplete or missing documentation; and
   - Signs by attestation as the managerial reviewer on the ***Death Report Form*** (Attachment B) or ***Critical Incident Report*** form (Attachment C).

2. The Office of Incident Management and Investigations reviews all Death Report Forms and Critical Incident Reports for completeness and contacts the provider for additional information, as appropriate.

H. Responsibility for Investigations

1. The Office of Incident Management and Investigations reviews on the day received all incident reports of Category I incidents. If that office assumes responsibility for the investigation, the provider is notified the same day for reports received before 3 p.m. on a business day. If the Category I incident report is received after 3 p.m., the provider is notified on the next business day regarding responsibility of the investigation.

2. The Office of Incident Management and Investigations reviews all Category II incident reports. It is the responsibility of the provider to

complete the investigation for the Category II incident within timeframes established in section IV.

3. The Office of Incident Management and Investigations reviews all Category III incident reports. An investigation is not required unless the Office of Incident Management and Investigations determines that one is necessary. If this determination is made, the provider agency is notified by the Office of Incident Management and Investigations.

IV. PROCEDURES FOR INVESTIGATING INDIVIDUAL DEATHS AND CRITICAL INCIDENTS

A. For investigation of Category I and II Critical Incidents

1. The provider must designate staff who will be responsible for conducting any investigations pursuant to this policy.

2. The investigator, at a minimum:

- Interviews individuals, staff and other involved parties;
- Reviews all related documentation; and
- Collaborates with outside agencies, as applicable.

3. The individual served who is the subject of the incident must be offered an opportunity to speak with the investigator.

4. All investigations must be thorough and must address, at a minimum, those items identified in the **Investigative Report Format** (Attachment E).

5. If, at any time during the investigation, evidence of criminal conduct is discovered, the investigator immediately notifies the Office of Incident Management and Investigations and the senior executive manager. The senior executive manager will review applicable rules, regulations and confidentiality provisions, and notify law enforcement when appropriate.

6. If law enforcement authorities initiate an investigation regarding the incident, the community provider staff cooperates with law enforcement and ensures that such cooperation is in compliance with confidentiality laws and regulations.

7. If, at any time during an investigation, it appears that a community provider or its staff has failed to protect the health, safety and/or welfare of the individuals in its care, the Office of Incident Management and Investigations requests that the Regional Coordinator take immediate steps to protect such individuals, including the removal of the individual(s) to another community provider, if needed. The Regional Coordinator, or his/her designee, notifies the Office of Incident Management and Investigations of actions taken.

8. The investigator completes the investigation and submits the typed ***Investigative Report*** (Attachment e.1) to the Office of Incident Management and Investigations within thirty (30) calendar days following the date of the incident or discovery of the incident. The report may be submitted electronically with electronic signatures.

9. If there is a compelling reason why the investigation cannot be completed within thirty (30) days, a ***Request for Extension*** form (Attachment F) is completed and submitted electronically to the Office of Incident Management and Investigations outlining the reasons and giving an expected completion date. Such requests must be received by the Office of Incident Management and Investigations at least five (5) calendar days prior to report due date. In response to the request, the Office of Incident Management and Investigations will establish a new deadline, based on circumstances, but not beyond thirty (30) calendar days.

B. Corrective Action Plans and Follow-up

1. Upon completion and review of the Investigative Report, the Office of Incident Management and Investigations notifies the community provider/support coordination agency if there is need for a ***Corrective Action Plan*** (CAP) form (Attachment G).

2. A CAP must be submitted to the Office of Incident Management and Investigations within the timeframe established by the request.

3. The Office of Incident Management and Investigations accepts or makes recommendations for changes to the CAP and involves the Regional Coordinator as necessary.

4. For CAPs that are not completed successfully by contracted providers, the Regional Coordinator coordinates appropriate contract actions with DBHDD Legal Services.

C. Distribution of Investigative Reports and Corrective Action Plans

1. When an investigation is completed by the Office of Incident Management and Investigations, that report and any subsequent Corrective Action Plans are sent to the Regional Coordinator.

2. It is the responsibility of the Regional Coordinator to follow-up with the provider when necessary, and to ensure that the provider has taken the appropriate corrective steps to correct unsafe conditions.

V. DATA ENTRY AND ANALYSIS

A. Procedures for Data Entry

1. DBHDD maintains a critical incident database to identify patterns and to perform trend analysis.

2. Access to the critical incident database must be granted by the Office of Incident Management and Investigations and is limited to staff of providers or agencies operated by, or under contract or Letter of Agreement (LOA) with DBHDD.

3. Each provider agency designates one or more persons to be responsible for entering critical incident and death information into the database. Entries must be made within one business day of the incident or knowledge of the incident.

B. Procedures for Data Analysis

1. The critical incident reporting processes are monitored by the Office of Incident Management and Investigations for timeliness and accuracy.

2. Information about incidents is utilized in the Department's quality improvement initiatives to evaluate the quality of services.