Internal protocol for Department of Behavioral Health and Developmental Services Incident Management

Table of Contents

[Purpose 2](#_Toc21014530)

[Office of Licensing 2](#_Toc21014531)

[Regulatory Authority 3](#_Toc21014532)

[Applicability 3](#_Toc21014533)

[Procedures 3](#_Toc21014534)

[Training & Technical Assistance 7](#_Toc21014535)

[Audit 8](#_Toc21014536)

[Definitions 8](#_Toc21014537)

# Purpose

The purpose of this internal protocol is to establish the standards and guidelines by which the Department of Behavioral Health and Developmental Services (DBHDS) Office of Licensing (OL) will govern the design and implementation of the incident management system and reporting process. Incident management and reporting is necessary to protect the health and safety of the individual, mitigate reoccurrence, and to improve overall quality of services and supports. The Incident Management Unit (IMU) will review and triage reportable incidents. The overall goal of the IMU is to improve processes and to ensure the overall safety of all individuals served throughout the Commonwealth.

# Office of Licensing Authority

**Authority:** The Department of Behavioral Health and Developmental Services (DBHDS) is authorized by Chapters 3 (§ [37.2-300](http://law.lis.virginia.gov/vacode/37.2-300) et seq.) and 7 (§ [37.2-700](http://law.lis.virginia.gov/vacode/37.2-700) et seq.) of Title 37.2 of the Code of Virginia to operate DBHDS hospitals, training centers, and other facilities (state facilities) for the evaluation, treatment, training, or habilitation of individuals with mental health or substance use disorders or developmental disability (a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness). See [§](http://law.lis.virginia.gov/vacode/title37.2/chapter1/section37.2-100/)[37.2-100](http://law.lis.virginia.gov/vacode/37.2-100).

Section 37.2-404 of the Code of Virginia authorizes the commissioner to license providers subject to rules and regulations adopted by the State Board of Behavioral Health and Developmental Services. No provider shall establish, maintain, conduct, or operate any service without first receiving a license from the commissioner.

* The Office of Licensing’s Licensing Specialist/Investigator conducts announced or unannounced onsite review of all new providers and services to determine compliance with this chapter.
* The Office of Licensing’s Licensing Specialist/Investigator conducts unannounced onsite reviews of licensed providers and each service at any time and at least annually to determine compliance with regulations. The annual unannounced onsite reviews are focused on preventing specific risks to individuals, including an evaluation of the physical facilities in which the services are provided.
* The Office of Licensing’s Licensing Specialist/Investigator may conduct announced and unannounced onsite reviews at any time as part of the investigations of complaints or incidents to determine if there is a violation of this chapter.

**Role/Purpose:** The Office of Licensing is the regulatory authority for DBHDS licensed service delivery system through effective oversight.  This office provides consistent, responsive, and reliable regulatory oversight to DBHDS licensed providers by supporting high quality services to meet the diverse needs of its clients.  The Office of Licensing is the regulatory authority for DBHDS licensed services.

# Serious Incident Reporting Requirement

Office of Licensing (OL) regulation ***12VAC35-105-160 D.2*** states that Level II and Level III serious incidents shall be reported by all providers licensed by Department of Behavioral Health and Developmental Services (DBHDS) OL on the department’s web-based reporting application and by phone to anyone designated by the individual to receive such notice and to the individual’s authorized representative within 24 hours of discovery. Reported information shall include the information specified by the department as required in its web-based reporting application but at least the following: the date, place, and circumstances of the serious incident. For serious injuries and deaths, the reported information shall also include the nature of the individual's injuries or circumstances of the death and any treatment received. For all other Level II and Level III serious incidents, the reported information shall also include the identified solution to mitigate recurrence of incident when applicable.Deaths that occur in a hospital as a result of illness or injury occurring when the individual was in a licensed service shall be reported.

# Applicability

The following procedures apply to all DHBDS employees, subcontractors, providers/vendors, consultants, volunteers, and governmental agencies that provide services and supports on behalf of the individuals with disabilities receiving services as part of the DBHDS services.

Incident Review Process:

The following sections establish procedures and protocols for implementation of the Incident Management Unit (IMU). IMU meets daily to triage incidents that were reported within the last 24-hour period or the last business day in the case of a weekend or holiday.

1. IMU will review the incident to determine whether the incident meets the criteria of a reportable incident (Level II or Level III), documenting the Level and type within the Action Remarks. If the incident does not meet the criteria of a reportable incident, IMU will contact the provider by phone and provide technical assistance and direct the provider to the [DBHDS OL Guidance for Serious Incident Reporting](https://townhall.virginia.gov/L/GetFile.cfm?File=GuidanceDocs%5C720%5CGDoc_DBHDS_6415_v1.pdf). "Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident. "Level I serious incidents" do not result in significant harm to individuals, but may include events that result in minor injuries that do not require medical attention, or events that have the potential to cause serious injury, even when no injury occurs (12VAC35-105-20).
2. Providers are not required to report Level I serious incidents via CHRIS to the Office of Licensing.
3. During triage, if IMU determine an incident is a Level I, IMU will call or send an email to the provider notifying them the incident is a Level I and does not need to be reported in CHRIS according to the DBHDS Office of Licensing Guidance for Serious Incident Reporting. IMU will indicate in CONNECT that the incident is a Level I incident or non-reportable. Any technical assistance or resources provided will be documented in the Action Remarks.
4. If an incident is a duplicate the IMU staff will indicate this in CONNECT.
5. IMU will determine if the incident has sufficient information to be able to triage. The incident shall present a clear and complete picture of the incident and the provider’s response.
	1. If the incident does not present a clear and complete picture, IMU will follow up with the provider, provide technical assistance and request for the provider to update the incident with the required information.
	2. If the incident is clear and complete, IMU will accept the incident and continue in the triage process.

6. IMU will verify whether the incident is a DD death, other death or SIR.

1. If the incident is a DD Death IMU will record the information, change the status to refer to investigations and move the workflow to the Specialized Investigations Unit (SIU).
	1. The SIU will process the DD death through the SIU process.
	2. The Investigation number will be generated by the CONNECT system.

7. Each business day the IMU CAP Specialist will run the ***Death and Serious Incident Late Queue***report to determine if any providers have NOT reported Level II and Level III serious incidents through the CHRIS system within the 24-hour timeframe. NOTE that the 24-hour timeline for reporting incidents begins from the time that the provider discovers the incident. IMU will follow the **Final 160.D Protocol for DD Providers** and determine if a late report is excused or if a citation will be issued.

8. IMU will triage all level II and level III incidents including reviewing all incidents and identifying situations that meet care concern criteria. Incidents that meet the Care Concern Thresholds criteria will trigger the IMU referral and notification process in accordance with the **Incident Management Unit Care Concern Threshold Joint Protocol.**

9. IMU will conduct a desk review of the incident. If the incident meets established triage protocol, IMU will refer the incident for further review to the Licensing Specialist (LS)/Investigator.

10. The Licensing Specialist/Investigator is then responsible for reviewing the SIR and making a determination if an investigation is warranted based on protocol, the incident will be tied to the CHRIS incident within the CONNECT system.

Incident Management Unit On Incident correction and provider notification:

For incidents which are classified incorrectly or information not entered in correctly the following steps will be taken:

**Process:**

1. IMU will make two attempts via phone call to contact the provider to make corrections to the incidents. One attempt will be made to the individual who entered the incident and the other call to the Risk/Quality /Supervisor/designee/or CEO if needed.
2. IMU will leave a message after each attempt to contact the provider. If the phone services do not allow messages to be received, IMU will send an email to the provider’s CEO/ designee to correct the information identified in the CHRIS report.
3. After two attempts, IMU will send an email to notify the provider of what actions need to be taken to correct the incident. Providers must response back to IMU within 24-48 hours.

**Unifying narrative with data fields:**

Incident Management Unit triages each incident entered into CHRIS. During the triage process IMU will look to see if information in narrative fields corresponds with a designated checkbox.

1. During the triage process if IMU notices the provider entered in the narrative an item which has a checkbox related to it, IMU will select the corresponding checkbox for the purpose of data collection or contact the provider to make the appropriate selection.
2. If IMU makes selections in the corresponding checkbox, IMU will document, in the Action Remarks, any change made to the incident.
3. The provider has 48 hours to contact IMU if they have any concerns about the changes.

Incident Management Unit Office of Human rights notification:

The Office of Licensing Incident Management Unit (IMU) work collaboratively with the Office of Human Rights

**Procedure:**

1. IMU will triage all incidents.
2. When an incident appears like it may also be a case of Abuse/Neglect/Exploitation, the IMU will check CHRIS to determine whether OHR was notified. If yes, no further action is required.
3. If no, IMU will notify, via email, OHR director and Deputy Director who will determine what further action, if any, is needed in accordance with the human rights regulations and AIMs protocol (139). IMU Notifications will include individual's name; provider and SIR CHRIS #.
4. OHR director or Deputy Director will notify IMU that either the incident is 1) not a human rights issue-no action taken or 2) it is a human rights issue-provider notified to start the investigation process.

Incident Closure Process:

The purpose of the Incident Closure Process is to assure the health, safety and welfare of individuals with mental health and developmental disabilities through an active review process. A finding is required prior to closure of an incident.

**Key factors include:**

Clear and accurate details pertinent to the interaction of person, place, and time to determine root cause and factors that contribute to occurrence.

Adequate and appropriate corrective actions.

Follow- up actions/information (including training as necessary) will be made accessible in a timely manner.

**Closing Criteria**

The closing of incidents requires the following steps:

1. Complete a thorough review of the incident by IMU in accordance with applicable standards
2. Ensure there are relevant facts and findings regarding the incident.
3. IMU shall exercise final discretion to re-open an incident for additional information.
4. Required elements for closing an incident: Provider has entered corrective actions taken or to be taken to address the issues raised by the incident and/or to prevent a recurrence of the incident should be documented in the follow up report and follow up completed.

Supervisor Review of Incident Closure:

As part of ensuring the quality of the closing of issues, that staff are actively working on issues and ensuring appropriate timely closures are occurring; the IMU manager is responsible for reviewing open and closed issues with direct reports.

1. Manager will identify all the open, closed, and past due issue.
2. During monthly supervision with staff, the supervisor will review 10 % of closed issues to review for quality closure, and timeliness.
3. During monthly supervision with staff, the staff person will identify issues that are not resolving satisfactorily, and if the staff person is experiencing barriers. The supervisor will follow up with the Provider to ensure responsiveness, notify the assigned Licensing Specialist.

Tracking and Trending:

IMU is charged with tracking and trending incident and issue data to discover patterns, identify trends for individuals and providers and to inform DBHDS Senior Management of patterns and trends. Trending the data is an essential component of the Incident Management Unit (IMU). The IMU will compile State and Regional specific quarterly and yearly data analysis reports and submit it to the Risk Management Review Committee (RMRC), Regional Quality Committee (RQC), and the Quality Improvement Committee (QIC). The content must include at a minimum

1. Trend analysis relative to each incident will be documented in the Action Remarks by the IMU.
2. The data and information obtained from reporting systems (CHRIS and CONNECT) will be aggregated, analyzed and used to identify sources of and contributing factors to risk and/or evaluate existing systems. The data and information will be used to inform providers on potential, actual risk, or person’s safety incident.
3. Identify and trend specific incident types that would benefit from a systemic intervention.
4. A quarterly and annual narrative analysis of findings, patterns, areas of concern, and recommended actions for quality improvement.
5. Discuss state-wide and regional corrective actions for improving quality assurance.

# Training & Technical Assistance

Training & Technical Assistance primary goals are the transferring of information and knowledge to increase competence, compliance and skills.

Training and technical assistance tools:

* Department of Behavioral Health and Developmental Services website
* Guidance Documents
* Webinars
* OL External Memos
* Conferences
* CHRIS – Help Screen

# Audit

Incident Management audits improves efficiency of the process by assuring policies and procedures are followed. The auditing process will ensure timely reporting of incidents and review of incidents. The audit will be conducted quarterly based on the review of a sample of incident reports during the time period.

# Definitions

# **Care Concern Thresholds Criteria Categories**

* 1. Multiple (Two or more) unplanned medical hospital admissions or ER visits for falls, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a ninety (90) day time-frame for any reason.
	2. Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a bowel obstruction diagnosed by a medical professional.
	3. Any choking incident that requires physical aid by another person, such as abdominal thrusts (Heimlich maneuver), back blows, clearing of airway, or CPR.
	4. Multiple (Two or more) unplanned psychiatric admissions within a ninety (90) day time-frame for any reason.

**Imminent danger** - an immediate threat or harm that could reasonably be expected to cause death or serious physical harm. Requires immediate intervention to prevent unwanted outcome.

**Level I reported incidents-**"Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident. "Level I serious incidents" do not result in significant harm to individuals, but may include events that result in minor injuries that do not require medical attention, or events that have the potential to cause serious injury, even when no injury occurs (12VAC35-105-20).

**Level II Serious Incident**- defined as a serious incident that occurs or originates during the provision of a service or on the premises of the provider that result in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident. Level II serious incident includes a significant harm or threat to the health or safety of others caused by an individual. Level II serious incidents include: 1. A serious injury; 2. An individual who is or was missing; 3. An emergency room visit; 4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with the individual’s Wellness Recovery Action Plan shall not constitute an unplanned admission; 5. Choking incidents that require direct physical intervention by another person; 6. Ingestion of any hazardous material; or A diagnosis of: a. A Decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer; b. A bowel obstruction; or c. Aspiration pneumonia.

**Level III Serious Incident** means a serious incident whether or not the incident occurs while in the provision of a service or on the provider's premises and results in: 1. Any death of an individual; 2. A sexual assault of an individual; or 3. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.

**Triage** refers to the practice of dividing incidents by priority level so that the highest priorities are handled first. This requires assessment, prioritization, elucidation, negotiation, and delegation of workflow to ensure prompt assessment and investigation.

**Trend analysis** is the review and documentation of incident history relative to the incident being triaged. This includes assessment for Care Concern criteria, Imminent danger status and applicable regulatory violations. Documentation should include, but is not limited to: time frame reviewed, previous incident dates, the incident type, injury/illness/condition and/or cause; or when applicable the finding of no previous incident history. Other patterns that warrant referrals to OL, OHR and OIH should be documented.