Comprehensive & Integrated Incident Management Process
DBHDD State Hospital System
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It is the priority of DBHDD Hospitals to provide a safe environment for individuals being served and to protect all individuals from harm. This goal is accomplished by employing a comprehensive and integrated incident management process to address all contributing factors related to incidents. Currently there are three policies/procedures for incident management process: Risk Management, Incident Management, and Quality Management. This document provides guidelines for the hospitals to integrate the policies/procedures in managing incidents. It also sets up expectations for the hospitals and team members in this process.

I. Incident Management Policy (Policy #: 03-515)

Incident Management Policy is implemented AFTER incidents. The goal of the policy is to effectively identify and report incidents, conduct proper investigation and take adequate actions to protect consumers and to prevent future incidents. The major components of the policy include:

- Reporting Incidents: All incidents defined in Attachment A should be reported within 24 hours of the incidents by using the Incident Management database. Based on the categories of incidents, different levels of management as well as external agencies should be notified within the time frame defined by the policy.

- Three-level Reviews: All incidents are reviewed by three levels of management within the hospitals. The purpose of the reviews is to identify contributing factors and recommend actions to address problems and to prevent future incidents.

- Investigations: The policy sets standards for the investigation process and investigation report.

- Incident Review Committee: The Committee is responsible for reviewing investigations related to consumer abuse, neglect and exploitation, and to track corrective action plans.

- Performance Improvement: The Policy requires hospitals to track and trend incident management data to evaluate the effectiveness of the incident management system.

II. Risk Management Policy (Policy # 03-601)

Risk Management Policy is implemented both BEFORE and AFTER incidents. The goal of the policy is to detect risks that potentially could lead to incidents and to adopt interventions to prevent future or recurrent incidents. The major components of the Policy include:
• Risk Assessment (Attachment B): Attachment B is utilized to assess each individual for behavior, psychiatric and medical risk. The result of the assessment is the Clinical High Risk Profile (Attachment F).

• Reporting Triggers and Thresholds (Attachment A): Attachment A defines triggers and thresholds that should be reported, reviewed and actions taken.

• Multi-level reviews (Attachment C, D, and E): These reviews are conducted by the Recovery Planning Team (RPT) or Interdisciplinary Team (IDT), Hospital Review Committee (HRC), and hospital Quality Council (QC). The Policy defines the roles and responsibilities of each team.

• Performance Improvement: The Policy requires the hospitals to collect and analyze data, identify trends and patterns that indicate systematic issues, and take proper actions to improve performance.

III. Quality Management Manual (Draft)

Safety is a core measure of hospital quality. Hospital quality management department is responsible for collecting and analyzing data, performing quality management reviews of incident management, identifying systematic issues, and leading and monitoring correctives action plans. The major functions of quality management in incident management include:

• Data Collection & Analyzing: Quality management can routinely collect data from incident and risk management processes, and analyze data by using charts and graphs, such as Run Chart and Control Chart.

• Quality Management Review: Based on the data analysis or the nature of the incidents, quality management can perform reviews in two different dimensions: in-depth review to drill down the causes/contributing factors of incidents by using quality management tools, such as Root Cause Analysis and Fish-bone Chart; and broad review to identify system issues.

• Corrective Action Plan: Based on the data analysis and quality management reviews, hospital quality management staff should initiate, lead, assist, and monitor the corrective action plans by utilizing quality management model, such as PDSA.

IV. Decision Making Process & Responsibilities

• Reporting Incidents: Any employee who observes the incident or has initial knowledge of the incident should report the incident. If the employee has doubt if it is a reportable incident, he/she should report the incident anyway. In case that
there are more than one employee witnessed the incident, the supervisor in charge of the unit should get information from all witnesses and complete the incident report.

- Incident Notification: Different levels of management staff should be notified based on the categories of incidents. The notification can be done by e-mail. However, for immediate notification, a pager or cellular phone should be used. Here are the guidelines:

1. The employee who submits the incident report should notify the highest ranking supervisor of the unit immediately following the incident.
2. For 13 types of incidents listed in Incident Management Policy Attachment A, the supervisor should immediately notify the unit manager/department head, Campus Supervisor, Incident Manager, Risk Manager, Director of Quality Management, Hospital Security Chief, Nurse Executive, Clinical Director, Administrator on Duty, Program Director and RHA.
3. The death notification should follow the DBHDD Death Notification Policy.
4. The Risk Manager, Clinical Director or RHA should decide to call DBHDD Director of Hospital Operations, Medical Director, Director of Incident Management and Investigations, and State Forensic Director based on the nature of incidents, such as unexpected-death, elopement, physical or sexual assault, suicide, severe injuries, and high profile incidents.
5. The DBHDD Director of Hospital Operations, Medical Director, Director of Incident Management and Investigations, and Forensic Director should decide to notify General Counsel, Director of Quality Management, Deputy Commissioner, and Commissioner based on the nature of the incidents.
6. The Risk Manager or RHA should decide outside notification, such as local police and GBI. In case there are questions, the General Counsel should be consulted.
7. Family notification should be done under the directive of the Risk Manager, Social Work Chief, and Clinical Director.

- Protecting Consumers: After an incident, the unit supervisor in charge should make the decision to take immediate action to protect the consumer from further harm. The supervisor may seek guidance or directive from the unit manager, Campus Supervisor, department heads, and Risk Manager in taking proper actions.

- Reassignment of Employees Involved in Incidents: The unit manager or Campus Supervisor should decide to reassign employees involved in incidents. If there are questions, the department heads, Incident Manager, Risk Manager, Director of Human Resources and RHA should be consulted.
• Investigations: All Category I incidents will be investigated. The DBHDD Director of Incident Management and Investigations should decide if the incident is investigated by internal or external investigators. For Category II incidents, the Risk Manager, Service Chiefs, Incident Manager, Program Director, Clinical Director, and RHA may decide that an internal investigation is needed. In DD Program, the ICF/MR investigation rules should be followed.

• Quality Management Review: The hospital Director of Quality Management should decide if the incident is a reportable sentinel event and a quality management review, such as Root Cause Analysis, needs to be done.

V. Monitoring and Accountability

Hospitals should routinely monitor the incident management process to ensure that policies and procedures are followed. Employees who fail to follow the policies and procedures should be held accountable. At minimum, the hospitals should monitor the following processes for completion, timeliness, and quality:

• Reporting Incidents: The Department Assistant Chiefs/Mentors should audit incident reports as well as charts monthly to ensure that incidents are reported and are reported within 24 hours. The audit report should be sent to Incident Manager, Risk Manager, Director of Quality Management, and Nurse Executive.

• Three Level Reviews: The Department Assistant Chiefs/Mentors should audit the Three Level Reviews monthly for timeliness and quality. The audit report should be sent to related department heads, Risk Manager, Director of Quality Management, Nurse Executive, Program Director, Clinical Director, and CRIPA Coordinator.

• IRC Minutes: The Director of Quality Management should review the IRC Minutes monthly to ensure that they meet the requirements of the policy. The results should be sent to the Incident Manager, Risk Manager and CRIPA Coordinator.

• Investigations: The Risk Manager should review all internal investigation reports to ensure that they meet the policy standards. The Risk Manager can order new investigations and mentor investigators who have deficiencies.

• Reporting Triggers & Thresholds: The Department Assistant Chiefs/Mentors should audit charts and reported triggers and thresholds monthly to ensure that they are reported according to the policy. The result should be sent to the Risk Manager, Program Director, Director of Quality Management, Clinical Director, and CRIPA Coordinator.

• Risk Assessment: The Department Assistant Chiefs/Mentors should audit the High Risk Profiles monthly to ensure that they capture all risks. The result is sent to Risk Manager, Clinical Director, Director of Quality Management, and CRIPA Coordinator.

• Triggers & Thresholds Review: The Department Assistant Chiefs/Mentors should audit chart and HRC Minutes to ensure that triggers and thresholds are reviewed according to the policy. The result should be sent to Risk Manager,
Director of Quality Management, Program Director, Clinical Director, and CRIPA Coordinator.

- **Corrective Action Plan**: The Director of Quality Management should review all corrective action plans to ensure that they are implemented and achieved the desired outcomes. The result should be sent to Risk Manager, Program Director, Clinical Director, Nurse Executive, department heads, CRIPA Coordinator, and RHA.

VI. **Documentation and Record Keeping**

It is critical to document all activities related to incident management and audit/monitoring. Here are the basic requirements:

- **Medical Records**: Incidents, triggers and thresholds, IPT/IDT reviews, and corrective actions should be documented in medical records.
- **Three Level Reviews**: The Incident Management Department should keep the records of Three Level Reviews.
- **HRC Minutes**: The Risk Management Department should keep the HRC minutes.
- **Investigation Reports**: The Risk Management should keep all investigation reports and related evidences.
- **Corrective Action Plans**: The Quality Management Department should keep all Corrective Action Plans and the implementation records.
- **IRC Minutes**: The Incident Management Department should keep the minutes of IRC.
- **QC Minutes**: The Quality Management Department should keep the minutes of QC.
- **Performance Improvement Plans**: The Quality Management Department should keep all performance improvement plans.
- **Audit Reports**: The Quality Management Department should keep all audit reports related to incident/risk management.

When a surveyor/ auditor comes to a hospital, the hospital should be able to present the following records:

- Medical Records (Charts): documentation of incidents, IPT/IDT incident reviews, triggers/thresholds reviews, high risk profiles, high risk profile reviews, recommendations from HRC/QC, and actions/interventions taken.
- Incident Reports
- Investigation Reports
- Three Level Reviews
- IRC Minutes
- HRC Minutes
- QC Minutes
- Incident/Risk Management Audit Records
- Incident/Risk Management data and data analysis by Quality Management
• Corrective Action Plans and the monitoring records
• Performance Improvement Plans and outcomes.