CENTRAL CARE POLICY
REPORTING OF SERIOUS AND UNUSUAL INCIDENTS IN CENTRAL CARE

SUBJECT:	**REPORTING OF SERIOUS AND UNUSUAL INCIDENTS IN CENTRAL CARE**
ANNUAL REVIEW MONTH:	June
RESPONSIBLE FOR REVIEW:	Director of Central Care
LAST REVISION DATE:	August 2010

Policy: To define critical incidents and establish policies and procedures for reporting them in a timely manner to:

a. The CEO, Central Care Community Services Director, and other appropriate Central Care staff; and
b. The Division of Mental Health, Mental Retardation, and Substance Abuse (MHMRSA)

Central Care will follow all of the established procedures listed in the reference section below (as it relates to this policy).

1. Definitions and Reporting

a. A *critical incident* is an occurrence that results, or could result, in major harm to a consumer, staff member or the facility. Types of reportable critical incidents to be reported are:

- Death
- (Allegation of) Physical abuse
- (Allegation of) Neglect
- (Allegation of) Staff to consumer sexual assault or sexual exploitation
- (Allegation of) Consumer to consumer sexual assault or sexual exploitation
- Medication errors with adverse consequences
- Seclusion or restraint resulting in injury requiring treatment beyond first aid
- Suicide attempt that results in medical hospitalization
- (Allegation of) Verbal abuse
- (Allegation of) Financial exploitation
- Consumer who leaves the grounds of a state hospital without permission
- Consumer who is unexpectedly absent from a community residential program
- Seclusion or restraint resulting in injury requiring minor first aid
- Vehicular accident resulting in injury while consumer is in a state vehicle or is being transported by community or hospital staff
- Incident occurring at a provider’s site which required intervention of law enforcement services
- Criminal conduct by consumer

- Consumer to consumer assault resulting in injury requiring treatment beyond first aid
- Consumer to consumer assault with injury requiring minor first aid
- Medical hospitalization of a consumer
- Consumer injury requiring treatment beyond first aid

b. A *Sentinel Event* as defined by the JCAHO is an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase, “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Events which are considered sentinel events by the Division of MHMRSA are as follows:

1. Any suicide
2. Any rape or non-consensual sodomy.
3. Any unanticipated or unexpected death or major permanent loss of function associated with the treatment, or lack or treatment, or the natural course of the patient’s or client’s illness or underlying condition.
4. Any patient death, paralysis, coma, or other major permanent loss of function associated with seclusion or restraint.
5. Any patient or client death, paralysis, coma or other major permanent loss of function associated with a medication error.
6. Any elopement (AWOL) of a patient or client resulting in a death (suicide or homicide) or major permanent loss of function.
7. Assault, homicide, or other crime resulting in a patient or client death or major permanent loss of function.
8. A patient or client fall that results in death or major permanent loss of function as a result of injuries sustained in the fall.
9. Discharge of a patient or client to the wrong family/guardian or abduction.

c. *Major Permanent Loss of Function* means sensory, motor, psychological, or intellectual impairment not present on admission requiring continued treatment or lifestyle change.

d. *“All Deaths”* refers to the death of any community consumer client or patient of a state operated facility whether or not the death occurred at the hospital. Deaths of consumers on pass or leave or within two weeks of discharge must be reported. Consumers who die after being transferred to a medical facility as a result of an injury sustained in a state facility must be reported regardless of the time elapsing since discharge.

2. Central Care shall maintain a safe, humane environment for consumers and staff. All serious and unusual incidents are to be reported in compliance with procedures established in this procedure.

3. The Regional Director (and CEO) shall receive reports of any serious and unusual incidents. They shall coordinate reporting of such incidents to the Division of MHMRSA.

4. When critical incidents occur, staff is to provide aid within their capabilities to any injured person, obtain medical attention if required and take all appropriate actions to assure the safety and security of persons and property. All critical incidents shall be investigated. Appropriate action will be taken to substantiate the cause or extent of damage or injuries and to prevent the recurrence of such incidents.

5. The Facility Risk Manager (for the facility) and the Regional Director have the responsibility for sending all critical incidents to the Division Office, Chief Executive Officer, Clinical Director and others as appropriate.

6. The Clinical Director of CSH has responsibility for sending DHMRSA Critical Incident reports of death to the Division Office after review as deemed necessary with the Chief Executive Officer, Risk Manager and others as appropriate.

Procedure:

Responsible Person(s)	Action
General Procedure	
Assigned Staff	1. Reports incidents of a serious and/or unusual nature to Team Leader immediately. 2. Fills out appropriate form and sends to Team Leader.
QMRP	3. Upon receiving report of Critical Incident, takes immediate action as required by incident. 4. Reports incident immediately to Service Director and Central Care Director or if unavailable to Regional Director.
Central Care Community Service Director	5. Reviews immediate action taken and directs further action as necessary. 6. Informs CEO and ensures that 707 is delivered to CEO Office within 24 hours. 7. Reviews all Critical Incidents and reports to the Division. 8. Determines if incident should be considered a Sentinel Event. Proceeds in accord with MHMRSA Facility System Sentinel Event Protocol if required.
Central Care Director	1. Completes appropriate documentation, investigations and follow-up. 2. Notifies appropriate persons including family member/guardians, Support Coordination, and appropriate licensing agencies.

APPROVED: ___________________ **TITLE:** Director of Central Care **DATE:** __________
George Harris, LCSW