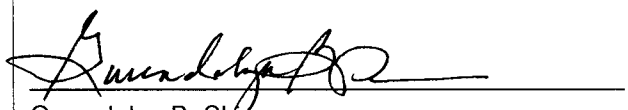
Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities & Addictive Diseases	DHR Online Directive Information System (ODIS) Directive # 6001-101 *Replaces DMHDDAD Policy #2.101* Page 1 of 10
ODIS Policy: Maintenance of Safety for Division of MHDDAD Consumers and Staff **Subject: Reporting of Consumer Deaths and Critical Incidents**	
Applicability: • State Hospitals • Public and Private community providers • OTP & State-operated community programs • State MHDDAD office • Regional MHDDAD offices	**Last Revised:** May 1, 2007 **Revised Date:** February 5, 2009 **Effective Date:** March 2, 2009  Gwendolyn B. Skinner Director, Division of MHDDAD 2/16/09 Date
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; DHR Rules and Regulations for Patients' Rights, Chapters 290-4-6; DHR Rules and Regulations for Clients' Rights 290-4-9. DHR Policy 1750	
Attachments: A - Critical Incident Definitions & Reporting Requirements B - Critical Incident Report form b.1 –Critical Incident Report form supplemental C - Reporting to other Agencies	

I. POLICY

It is the policy of the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) to maintain a safe and humane environment for consumers, and to prevent abuse, neglect and exploitation of consumers. The DMHDDAD uses a standardized process for reporting and investigating deaths and critical incidents that involve consumers being served by the DMHDDAD in state hospitals and by community providers. The process also includes critical incident procedures for consumers with developmental disabilities who are directing their own services and are not served by traditional provider agencies.

State Hospitals are also guided by DHR Policy 1750 which outlines the roles of the Office of the Inspector General and the Office of Investigative Services.

II. DEFINITIONS

Category I Incidents

- 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

Category II Incidents

- (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 or day program
- Seclusion or restraint resulting in injury requiring minor first aid
- Vehicular accident with 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 of a state hospital (including state operated community programs) or community residential program
- Consumer injury requiring treatment beyond first aid
- Staff injury caused by a consumer and requiring treatment (State-operated programs only)

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

Community Provider: Any person or entity providing community-based disability services through a contract with or authorized by the DMHDDAD and/or providing Medicaid services authorized by DMHDDAD. "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 Consumer: A consumer receiving MHDDAD services in a home that is staffed by a provider organization and/or a consumer receiving personal support 24 hours/7 days a week.

Consumer: An individual enrolled with a community provider for disability services, seeking services or admission at a state hospital or on the census of a state hospital or state operated community program.

Consumer-Directed Services: A model for service delivery in which consumers have the option to control and direct Medicaid funds identified in an individual budget, and in which the consumers live in their own homes. The consumer hires and fires direct support staff, and works with a support coordinator to receive assistance needed with self-directing services.

Critical Incident: Any event that involves an immediate threat to the care, health or safety of any consumer in community residential services, on site with a community provider or hospital, in the company of a staff member of a community provider or hospital, absent without leave from inpatient or residential services, or enrolled in consumer-directed services. Critical incidents include, but are not limited to, all incidents as listed in categories I and II.

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

Disability Services: Direct services to an individual, or services, which are designed to prevent or ameliorate the effect of a disability.

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 DHR or DMHDDAD, or may have significant impact upon, or significant relevance to, issues of DHR or DMHDDAD public concern and/or are likely to be reported in the media.

Senior Executive Manager: The supervisor administratively in charge at the time of the incident.

State Hospital: A state Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) hospital facility.

Support Coordinator/State Services Coordinator: In DMHDDAD developmental disability services, the independent case manager for each consumer.

III. PROCEDURES

A. Reporting deaths

1. Upon discovery of the death of a consumer, the state hospitals/community providers immediately take any actions necessary to respond to the medical emergency and to protect other consumers' health, safety and rights. These actions may include:

   - Immediate and ongoing medical attention, including notifying 911, as appropriate;
   - Suspension or reassignment of an employee from a position involving direct care pending the outcome of any investigation; and
   - Other measures to protect the health, safety and rights of other consumers, as necessary.

2. Upon discovery of the death of a consumer, the:

   - Community provider immediately calls 911 emergency services. State hospital notifies its law enforcement personnel to respond to the scene.
   - State hospital calls the coroner/medical examiner immediately;
   - State hospital or community provider calls the guardian, if any, and/or next of kin of the deceased after authorization from the coroner/medical examiner;
   - State hospital or community provider notifies the support coordinator, if applicable, within 24 hours; and
   - State hospital or community provider notifies the agency worker immediately after authorization from the coroner/medical examiner in instances when DFCS, DJJ, or APS has custodial or commitment responsibility,

3. In the case of a minor's death in a state hospital or state operated community program, the state hospital or community provider designates a staff person, who is qualified to provide crisis/grief counseling, to notify the parent/guardian in person of the death.

4. The Regional Hospital Administrator immediately reports the death of any state hospital consumer to the DMHDDAD Division Director by telephone.

5. The Regional Hospital Administrator or designee reports all deaths by email to the Director of Incident Management & Investigations Section, the Director of Hospital Operations, the MHDDAD Medical Director, and the Regional Coordinator. This report must be made as soon as possible, but at least within two (2) hours of the death or discovery of the death. The state hospital administrator or designee provides all information available at the time of the report, using as a guide the *Critical Incident Report* form (Attachment B).

6. The community provider immediately reports all deaths to the Incident Management & Investigations Section by telephone. This report is to be made as soon as possible, but at least within two (2) hours of the death or discovery of the death. The community provider will provide all information available at the time of the telephone report, using as a guide the *Critical Incident Report* form (Attachment B).

7. The Incident Management & Investigations Section notifies the Medical Director, Director of Hospital Operations (as applicable) and Director of Regional Operations of all deaths by the next business day.

8. The Incident Management & Investigations Section notifies the Division Director and Regional Coordinator of deaths of consumers of community providers on the next business day.

9. If a decision is made that it is necessary to contact the Georgia Bureau of Investigation (GBI) regarding possible commission of a crime, the Office of Investigative Services will make the notification.

10. For all consumer deaths, the state hospital, community provider submits the ***Critical Incident Report*** **(Attachment B)** to the Incident Management & Investigations Section electronic. The report must be submitted on the same day as the consumer's death or on the next business day if the death occurred after business hours or on a weekend or holiday.

11. In state hospitals and state operated community services, staff having knowledge of the death must complete their report of the death before leaving their shift/duty.

12. The senior executive manager is responsible for ensuring that both the telephone notification and the *Critical Incident Report* are submitted as required.

13. In all instances, the state hospital or community provider requests that the coroner/medical examiner conduct an autopsy and provides sufficient facts to the coroner/medical examiner regarding the death.

14. In the event that the coroner/medical examiner decides not to perform an autopsy, the state hospital or community provider ensures that the coroner/medical examiner's decision is documented, and if known, the rationale for the decision.

15. For consumer deaths that must be reported to other agencies or offices as required by law or regulation, the state hospital or community provider is responsible at all times for notifying such agencies and offices in a timely manner. (See **Attachment C**)

16. The Incident Management & Investigations Section obtains a copy of the death certificate from the Division of Public Health. This copy will not be reproduced or released outside the Division of MHDDAD.

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

1. Upon discovery of a critical incident other than a death, state hospitals or community providers immediately take any action necessary to protect consumers' health, safety and rights. These actions may include:

   - Contacting 911 or other emergency services as needed;
   - Immediate and ongoing medical attention, as appropriate;
   - Removal of an employee from direct contact with consumers when the employee is alleged to have been involved in physical abuse, neglect, sexual assault/sexual exploitation, verbal abuse or financial exploitation until such time as the state hospital/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 state hospital immediately notifies
   - Its law enforcement personnel (for state hospitals with assigned law enforcement personnel) or appropriate law enforcement authorities as well as the Incident Management & Investigations Section if there is reasonable suspicion that a crime has been committed; and

- The consumer's guardian or next of kin, as appropriate with respect to confidentiality regulations.

3. The community provider immediately calls:

   - Local law enforcement and the Incident Management & Investigations Section if there is reasonable suspicion that a crime has been committed; and
   - The consumer's guardian and/or next of kin, as appropriate with respect to confidentiality regulations.

4. If a decision has been made to contact the Georgia Bureau of Investigation regarding the possible commission of a crime, the Incident Management & Investigations Section consults with the Division Director before the GBI is contacted.

5. The state hospital or community provider immediately report all Category I critical incidents to the Regional Hospital Administrator/community provider administrator. Support coordinators of consumers in consumer-directed services immediately report all Category I critical incidents to the support coordination agency chief executive officer.

6. When a consumer has an assigned support coordinator, the state hospital or community provider notifies the support coordinator of the critical incident within 24 hours.

7. For critical incidents that must be reported to other agencies or offices as required by law or regulation, the state hospital or community provider is responsible at all times for notifying such agencies and offices in a timely manner (See Attachment C).

8. High Visibility Incidents

   - The state hospital or community provider immediately reports all high visibility Category I and II critical incidents to the Incident Management & Investigations Section by telephone. This call must be made as soon as possible, but at least within two (2) hours of the high visibility incident.

- A *Critical Incident Report* form (Attachment B) 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.
- The Incident Management & Investigations Section notifies the Director of MHDDAD, the Regional Coordinator, the Director of Regional Operations, the Director of Hospital Operations (as applicable) and the Department of Human Resources (DHR) Office of Communications of high visibility incidents.

9. For all other Category I critical incidents, the state hospital or community provider submits the *Critical Incident Report* form (Attachment B) electronically to the Incident Management & Investigations Section on the same day as the Category I incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday.

10. For all other Category II critical incidents, The *Critical Incident Report* (Attachment B) is electronically sent to the Incident Management & Investigations Section within 24 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend or holiday.

11. In state hospitals and state operated community services, staff having knowledge of the critical incident must complete their report of the critical incident before leaving their shift/duty.

C. Reports of Incidents by persons other than staff of state hospitals or community providers

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

2. In consumer-directed services, the consumer's support coordinator has responsibility for receiving information from the consumer's support system about critical incidents as they occur. The support coordinator then reports critical incidents in accordance with procedures outlined in section III, A. and B. pertaining to consumers served in community settings.

3. All other support coordinators report critical incidents in accordance with procedures outlined in section III, A and B upon discovery of incidents not already reported by community providers.

4. When information about a critical incident is received by a state hospital or community provider from any person other than support coordinators, the staff receiving the information completes the *Critical Incident Report* form and follows procedures outlined in section III, A and B.

5. When information about a critical incident is received by the Incident Management & Investigations Section, the staff receiving the information completes the *Critical Incident Report* form.

D. Agency managerial review of *Critical Incident Report* form

1. Administrators of state hospitals, community providers or support coordination agencies perform a managerial review of all *Critical Incident Reports*. The reviewer at a minimum:

   - Reads the *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 *Critical Incident Report* form (Attachment B).

2. The Regional Hospital Administrator, community provider administrator or support coordination administrator designates an executive staff to conduct the managerial review of all *Critical Incident Report* forms (Attachment B).

3. The Incident Management & Investigations Section reviews all *Critical Incident Reports* for completeness and contacts the state hospital/community provider or support coordination agency for changes and additional information, as appropriate.

E. Computer data entry

1. DMHDDAD maintains a critical incident database to identify patterns and to perform trend analyses.

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

3. Each state hospital and community 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.

F. Investigation of Critical Incidents

1. The Incident Management & Investigations Section may conduct investigations of Category I critical incidents that occur in the community, in accordance with the Investigating Consumer Deaths and Critical Incidents Policy #6001-201. If the Incident Management & Investigations Section determines that the state hospital, in the case of state-operated community programs, or community provider should conduct the investigation, the provider will be notified within 3 hours, if the report is received before 4 p.m., or on the next business day.

2. State hospitals and community providers conduct investigations of Category II critical incidents, in accordance with the Investigating Consumer Deaths and Critical Incidents Policy #6001-201. Support coordination agencies conduct investigations of Category II critical incidents for consumer directed services.

G. Procedures for Data Analysis

1. The critical incidents reporting processes are monitored by the Incident Management & Investigations Section for timeliness and accuracy.

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