Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities & Addictive Diseases	DHR Online Directive Information System (ODIS) **Directive # 6001-201** *Replaces DMHDDAD POLICY # 2.201* Page 1 of 9
ODIS Policy: Maintenance of Safety for Division of MHDDAD Consumers and Staff **Subject: Investigating 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 18, 2009 **Effective Date:** March 2, 2009 Gwendolyn B. Skinner, Director Division of MHDDAD 2/19/09 Date Signed
Reference: Official Code of Georgia 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 & Investigative Requirements B -Investigative Report Format –b.1-Investigative Report C - Medical Hospitalization Follow-up Report D - Consumer Injury requiring treatment beyond first aid Follow-up Report E - Administrative Review form F - Request for Extension G - Corrective Action Plan	

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 & Investigative 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.

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 consumer care. A corrective action plan must identify the person(s) responsible for ensuring that action steps are completed and reviewed for efficacy and establishes a schedule for completion and follow-up of all action steps.

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.

Investigative Report: A written summary of an investigation conducted by the Investigation Section, state hospitals or community providers of an alleged critical

incident or death and approved by the Director of the Incident Management & Investigations Section or designee.

Investigator: A trained staff person who is designated to perform investigations into critical incidents.

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. For investigation of Critical Incidents, other than medical hospitalization, consumer injury requiring treatment beyond first aid, consumer to consumer assault with injury requiring minor first aid and staff injury caused by a consumer and requiring treatment (State operated program only):

1. Designated staff who are trained and qualified conduct investigations.

2. The investigator, at a minimum:

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

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

4. If, at any time during the investigation, evidence of criminal conduct is discovered the investigator immediately notifies the senior executive manager who notifies law enforcement authorities.

5. If law enforcement authorities initiate an investigation regarding the incident, the state hospital/community provider staff cooperate with law enforcement authorities.

6. 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 consumers in its care, the Incident Management & Investigations Section requests that the Regional Coordinator take immediate steps to protect such consumers, including the removal of the consumer(s) to another community provider, if needed. The Regional Coordinator, or his/her designee, notifies the Incident Management & Investigations Section of actions taken.

7. The investigator completes the investigation and submits the typed *Investigative Report* (Attachment b.1) to the Incident Management & Investigations Section 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 or attestations.

8. 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 Incident Management & Investigations Section outlining the reasons and giving an expected completion date. Such requests are received by the Incident Management & Investigations Section at least five (5) calendar days prior to report due date. The Incident Management & Investigations Section will establish a new deadline, not to exceed thirty (30) calendar days.

9. As required by Federal regulations, the results of investigations of incidents involving the following consumers are reported to the Regional Hospital Administrator within five (5) working days of the incident:

    - Skilled nursing facilities- Allegations of abuse, neglect or exploitation; injuries of unknown origin; misappropriation of consumer property; or
    - ICF/MR-Allegation of abuse or neglect with injury requiring treatment beyond first aid; time-out or restraint resulting in injury requiring treatment beyond first aid; death not related to course of illness or underlying condition; allegation of rape or sexual assault.

B. Incident types with alternate reporting requirements:

1. The following Category II incidents require the hospital/community program to submit the *Critical Incident Follow-up Report* specific to that type of incident rather than conducting a formal investigation.

    - Medical hospitalization of a consumer of a state hospital or community residential program (see attachment C).
    - Consumer injury requiring treatment beyond first aid (see attachment D).

    a. The state hospital/community provider designates qualified staff to complete *Critical Incident Follow-up Reports.* (Attachments C and D)

    b. The investigator completes and submits the *Critical Incident Follow-up Report* to the Incident Management & Investigations Section 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 or attestations.

    c. If there is a compelling reason why the follow-up report cannot be completed within thirty (30) days, a *Request for Extension* form (Attachment F) is completed and submitted electronically to the Incident Management & Investigations Section outlining the reasons and giving an expected completion date. Such requests are received by the Incident Management & Investigations Section at least five (5) calendar days prior to report due date. The Incident Management & Investigations Section will establish a new deadline, not to exceed thirty (30) calendar days.

2. The Category II incident type "Consumer to consumer assault resulting in injury requiring minor first aid" is tracked by the provider. A narrative analysis regarding these incidents is submitted twice yearly by state hospital/community providers to the Incident Management & Investigations Section to include an analysis of trends, identification of opportunities for improvement and a description of changes in agency practice that are designed to reduce consumer injuries. These reports are submitted instead of individual *Investigative Reports* on each incident.

3. The incident type "Staff injury caused by a consumer and requiring treatment (state hospital-operated programs only)" does not require any report.

4. The Incident Management & Investigations Section may request an *Investigative Report* instead of or in addition to the above alternative report formats, such as, in cases of repeated incidents for individual consumers.

C. Agency Managerial Review

1. The administrators of state hospitals, community providers and support coordination agencies perform a managerial review of all the *Investigative Reports* and *Critical Incident Follow-up Reports* completed within that agency. The reviewer at minimum:

   - Reads the *Investigative Report* or *Follow-up Report*;
   - Reads all accompanying documentation;
   - Requires and ensures the completion of any incomplete or missing documentation; and
   - Signs off (electronically or by attestation) as the managerial reviewer on the *Investigative Report* or *Follow-up Report*.

2. The state hospital, community provider, or support coordination agency designates trained staff who are qualified to perform the review and sign as the agency representative.

D. MHDDAD Incident Management & Investigations Section Administrative Review

1. The Incident Management & Investigations Section reviews all *Investigative Reports* and *Critical Incident Follow-up Reports* completed by state hospitals, community providers and support coordination agencies for content, thoroughness of the investigation, and demonstration that conclusions are supported by evidence available. The reviewer, at a minimum:

   - Reads the *Investigative Report* or *Follow-up Report*;
   - Reads all accompanying documentation;
   - Requires and ensures the completion of any incomplete or missing documentation;
   - Evaluates whether the conclusions of the investigation or follow-up report are supported by the evidence documented;
   - Completes the Administrative *Review* form (Attachment E); and
   - Makes recommendations regarding the need for corrective action by the state hospital, community program and/or support coordination agency.

2. The Director of the Incident Management & Investigations Section or designee may overturn findings of investigations conducted by hospital or community providers.

3. Hospital administrators or community provider executive managers are contacted by telephone when findings are overturned.

4. For *Investigative Reports* or *Follow-Up Reports* completed by the state hospital, community provider or support coordination agency that are deemed inadequate, the Incident Management & Investigations Section requires corrections or additional information.

5. Corrections or additional information must be submitted within the timeframe established by the request.

6. The Director of Incident Management and Investigations Section or his/her designee reviews all *Investigative Reports* completed by the Incident Management & Investigations Section. The reviewer at a minimum:

    - Reads the *Investigative Report*;
    - Reads all accompanying documentation;
    - Requires and ensures the completion of any incomplete or missing documentation;
    - Signs off as the administrative reviewer on the Investigative Report; and
    - Makes recommendations regarding corrective action by the state hospital/community program as needed.

7. The Division Medical Director conducts and documents a review of all consumer death files within two (2) weeks of receipt of the death certificate.

E. Corrective Action Plans and follow-up

1. Upon completion and review of the Investigative Report the Incident Management & Investigations Section notifies the state hospital/community provider/support coordination agency if there is need for a Corrective Action Plan (CAP).

2. A CAP (Attachment G) must be submitted to the Incident Management & Investigations Section within the timeframe established by the request. The Cap may be submitted electronically.

3. The Incident Management & Investigations Section accepts or makes recommendations for changes to the CAP and involves the Regional Coordinator or Director of Hospital System Administration as necessary.

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

F. Review of Investigative Report by Regional Coordinator

1. The Incident Management & Investigations Section distributes *Investigative Reports* completed by DMHDDAD investigators, Administrative Reviews and Corrective Action Plans to the Regional Coordinator for Category I incidents in community provider organizations.

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

G. Distribution of Investigative Reports, Administrative Reviews and Corrective Action Plans

1. For investigations completed by DMHDDAD investigators, the Incident Management & Investigations Section notifies the Regional Hospital Administrator, Community Program Executive Director and/or Support Coordination Executive Director of approval of the CAP, and distributes the approved CAP to the Regional Coordinator for community incidents.

2. For investigations of Category I incidents completed by a community provider, the Incident Management & Investigations Section distributes Investigative Reports, Administrative Reviews and CAPs to the Regional Coordinator.