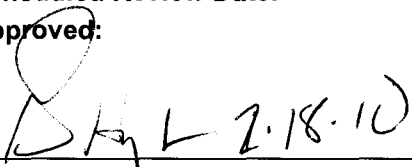
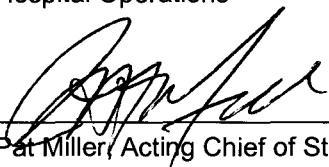
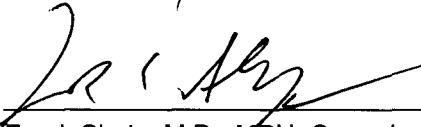




Chapter: Hospital Operations Subject: Incident Management		Full Implementation Date: June 1, 2010
Applicability: State Hospitals	Effective Date: March 1, 2010 CORRECTED Scheduled Review Date: March 2011	
References: Official Code of Georgia 31-8-81; 37-1-2; 37-1-20; 37-2-1 et seq.; 37-3-166; 37-3-2; 37-4-125; 37-4-3; 37-7-166; 37-7-2; 30-5-1 et seq.; 19-7-5; 16-6-5.1; Rules and Regulations for Patients' Rights - Chapters 290-4-6.	Approved:  <hr/> Gregory C. Hoyt, Director Date Hospital Operations	
Attachments: Attachment A: Definitions of Incidents Attachment B: Critical Incident Report (CIR) Form Attachment C: Corrective Action Plan (CAP)	 <hr/> Pat Miller, Acting Chief of Staff Date  <hr/> Frank Shelp, M.D., MPH, Commissioner Date	

I. POLICY

State Hospitals operated by the Department of Behavioral Health and Developmental Disabilities (DBHDD) shall establish an Incident Management system to identify, classify, document, report, track and trend events that have an adverse effect on the safety, care, treatment and rehabilitation of individuals served by each state hospital. The system includes a multi-level review process to ensure corrective actions are appropriate and effective, and to develop strategies to prevent recurrence. It establishes requirements for investigations of incidents that involves allegations of abuse, neglect, or exploitation, and for protecting individuals while the investigation is being conducted.

II. PRACTICE

A. Categories and Definitions

Each state hospital uses the categories and definitions of incidents to be reported and investigated as listed in **Attachment A - Definitions of Incidents**.

B. Documentation

Each state hospital shall utilize a standardized database defined by the DBHDD Office of Incident Management and Investigations to document and classify incidents, provide information on categories of incidents, document review findings, notify treatment teams and specific disciplines to support timely intervention, and transmit documentation of all **Critical Incident Reports (Attachment B)** to the DBHDD Office of Incident Management and Investigations. The database shall be revised as needed to expand its functionality.

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C. Multi-level Review Process

Each state hospital shall implement a multi-level review process to ensure the appropriateness and effectiveness of follow-up actions and safety of the individuals. This includes a mechanism for the Regional Hospital Administrator (RHA) or designee to review all Incident Reports.

D. Incidents that Involve Allegations of Abuse, Neglect, or Exploitation

1. Each state hospital shall take immediate and appropriate action to protect individuals involved, including removing the alleged person of interest from direct contact with individuals.
2. All incidents that involve allegations of abuse, neglect, and exploitation shall be investigated according to the requirements outlined in this policy and in the DBHDD Special Investigations Manual.
3. At each state hospital, the Incident Review Committee shall track investigations of incidents of abuse, neglect, and exploitation.

E. Performance Improvement

Each state hospital shall track, trend, and analyze data to identify and manage systemic trends and patterns.

F. Notifications and Reporting

All Incidents as defined in this policy shall be reported to the Director, DBHDD Office of Incident Management and Investigations. Incidents shall be reported to external agencies, as appropriate and required by law.

G. Retention of Incident Reports

Incident Reports shall be retained for seven years.

III. PROCEDURES FOR DOCUMENTATION OF INCIDENTS

A. Responsibility for Initial Documentation

1. Any occurrence of an incident as defined in **Attachment A – Definitions of Incidents** shall be documented in the Incident Management database within 24 hours of the incident. The person who observes the incident or has initial knowledge of the incident is responsible for completing the documentation prior to the end of their shift. During implementation of the system, allowance is made for Incident Reports to be entered and submitted within 24 hours of the event or the next business day if the incident occurs on a holiday or weekend.
2. All volunteers and contractors who interact with individuals at a state hospital who observe or are made aware of any incident shall immediately notify a staff person so the appropriate reports can be made.
3. Hospital staff shall be responsible for documenting the incident in the Incident Management database within 24 hours after it is reported by volunteers, contractors, the patients' rights advocate, or visitors to the hospital. During implementation of the system, allowance is made for Incident Reports to be entered and submitted within 24 hours of the event or the next business day if the incident occurs on a holiday or weekend.

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B. Documentation Requirements

1. Initial documentation shall include a synopsis of the incident, incident details, incident category, who reported the incident, related incidents, individual data relating to an incident, staff/other involvement, initial response, notifications, and contributing factors (See Attachment B - Critical Incident Report (CIR) Form).
2. All incidents meeting the definition of Incidents contained in this policy shall be entered in the database.

C. Accuracy of Documentation

1. All staff is to be aware of and use the correct incident definitions and codes as listed in **Attachment A - Definitions of Incidents**.
2. As part of the second level review described in this policy, the Program Directors/Department Managers or designee shall review all incidents occurring in their program or department as well as all incidents that occur elsewhere but pertain to the individuals in their area. It is their responsibility to ensure that **Attachment B - Critical Incident Report (CIR)** is complete and accurate prior to completing their review.
3. Risk Management department shall review all Critical Incident Reports for accuracy and completeness, and ensure that corrections are made, as necessary.
4. New employees are to receive training in the documentation and reporting of incidents as part of their orientation program.

IV. PROCEDURES FOR MULTI-LEVEL REVIEW OF INCIDENTS:

After unit staff documents an incident, it is subject to first and second level reviews completed by the Unit where the incident occurred. *For example, when a complaint is made by an individual in Unit 1 regarding care in Unit 2, the review would be completed by Unit 2.* If there are issues related to communication or other inter-unit issues, the involved units jointly perform the review.

The RHA conducts a third level of review of all incidents reportable to DBHDD Office of Incident Management and Investigations.

All review findings are documented in the Incident Management database.

A. First Level Review

1. The first level of review is to be completed by the Unit Supervisor within 24 hours and includes at a minimum the following information:
 - a. Precipitating events, known early warning signs, individual history impacting the incident, behavior of individual days prior to incident, and when and where the incident occurred.
 - b. Actions taken to protect the individual.
 - c. Unit acuity, staffing ratio and mix, location of staff, and staff changes.
 - d. If applicable, reaction of individual's guardian or conservator.
 - e. Staff actions related to incident (different from medical/nursing interventions).
 - f. Therapeutic milieu factors.
 - g. Environmental factors and equipment concerns.

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2. Physician Review (if an individual receiving services is involved):
 - a. If the incident occurs during the duty hours of the attending physician, the attending physician shall complete the physician's review before going off duty. If the incident occurs during Physician on Duty (POD) coverage, the POD shall complete the review before going off duty.
 - b. The review is to address necessary and appropriate changes to the individual's treatment plan including diagnosis, medications, and referrals.
 - c. The review shall also indicate whether or not injuries are consistent with the individual's explanation and describe any inconsistencies.

B. Second Level Reviews

1. The Program Director (whoever supervises the Unit Supervisor) shall complete a review within three business days that includes, at a minimum, the following information:
 - a. Additional information to Level I Review.
 - b. Analysis of contributing factors including staff actions, actions by other individuals, staffing ratio/mix, therapeutic milieu factors.
 - c. Action to prevent recurrence.
 - d. Recommendations and referrals.
2. Inform the Program Review Committee of findings (reference DBHDD Risk Management Policy)

C. Third Level Review

Within 30 days, the third level of review is to be completed by the RHA, or designee, for all incidents that are reportable to DBHDD Office of Incident Management and Investigations. The RHA or designee shall review the incident and the first and second level reviews, comment as appropriate, provide final approval, and notify the DBHDD Office of Incident Management and Investigations. The designee for RHA must be approved by the Director of Hospital Operations in advance of performance of duties.

V. PROCEDURES TO BE FOLLOWED FOR ALL INCIDENTS

- A. Staff members who observe or are aware of a reportable incident shall notify their supervisor and the supervisor shall notify security, as appropriate, initiate an Incident Report and forward to the Hospital Incident Management Section immediately, but at least by the end of the shift on which the incident occurred.
- B. The Risk Management Department enters the incident into the Incident Management database and submits it electronically to DBHDD Office of Incident Management and Investigations.
- C. The DBHDD Office of Incident Management and Investigations is responsible for conducting investigations to determine the validity of the complaints listed in **Attachment A - Definitions of Incidents** in the section titled Incidents Reportable to DBHDD Office of Incident Management and Investigation.
- D. Investigations shall commence within 24 hours of the incident being reported and be completed within 30 calendar days, except when material evidence is unavailable. In those cases, the investigation shall be completed within five business days of its

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availability. However, if an investigation cannot be completed within 30 calendar days, permission from the DBHDD Office of Incident Management and Investigations shall be needed to extend the deadline for completion.

- E. Federal regulations for Skilled Nursing Facilities and Intermediate Care Facilities require that investigations be completed within five business days.
- F. All victims are to be offered the opportunity to speak with an investigator.
- G. Investigators shall use appropriate hospital resources to address clinical implications and other issues that are not in their areas of expertise.
- H. Systemic issues that are identified but do not involve staff misconduct shall be referred to the Quality Council. The Quality Council shall address these issues and/or refer them to other performance improvement committees and workgroups.
- I. In cases where there is clear and compelling evidence of staff misconduct, such as the direct observation of a staff member asleep while assigned to monitor the status of individuals being served, it may not be necessary to conduct an investigation prior to proceeding with progressive discipline. The RHA, or designee, in consultation with the Human Resources Manager shall make the decision that an investigation is not warranted. These incidents shall be reviewed by the Incident Review Committee (IRC) for appropriateness of actions taken.
- J. Records Management System
 - 1. The DBHDD Office of Incident Management and Investigations shall use a standardized, computerized records management system to maintain records of all allegations, investigations, and findings, providing record retention commensurate with applicable state laws.
 - 2. The DBHDD Office of Incident Management and Investigations shall train responsible staff and monitor coding to ensure that it is accurate and consistent.

VI. SPECIAL PROCEDURES RELATED TO INCIDENTS THAT INVOLVE ALLEGATIONS OF ABUSE, NEGLIGENCE, OR EXPLOITATION

Each state hospital shall take immediate and appropriate action to protect individuals involved in allegations of abuse, neglect, or exploitation including removing alleged person(s) of interest from direct contact with the involved individuals pending the outcome of the facility's investigation.

- A. The Unit Supervisor is responsible for removing alleged person(s) of interest from direct contact with individuals as soon as the person(s) of interest are identified as such.
- B. If the allegations appear to be physically impossible or otherwise lack credibility, the Unit Supervisor may refer a case for administrative review.
 - 1. Each case shall be reviewed by the RHA, or designee, and the appropriate Discipline Chief within two business days. It is their responsibility to determine if the staff member may be returned to duties that involve direct contact with individuals before the investigation is completed.

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2. If both persons concur that the case lacks credibility, the alleged perpetrator may be returned to duties that involve direct contact with individuals prior to the close of the investigation. The decision should specify whether the staff member shall be returned to the same unit or assigned to a different treatment area.
 3. Factors that affect credibility include the plausibility of the allegation, consistency of allegations over time, motivation (e.g., retaliation), presence or absence of witnesses, corroborating evidence, prior allegations against the same person, lack of history of related allegations by the individual and physical evidence.
 4. The decision and rationale shall be documented in a memorandum and sent to the appropriate department or program, with a copy to the DBHDD Office of Incident Management and Investigations.
 5. The Unit Supervisor shall act upon the decision in a timely manner to ensure a safe environment.
- C.** If an individual has a history of two or more false allegations, the individual's treatment team shall document this in the individual's treatment plan, and include a goal, with objectives and interventions, to address the behavior.
- D.** Investigations must result in a written report, including a summary of the investigation and findings that includes the following:
1. Each allegation is investigated,
 2. Name(s) of all witnesses, alleged victims, and person(s) of interest,
 3. Names, and job titles where appropriate, of all persons interviewed and a summary of each interview,
 4. List of all documents reviewed,
 5. All sources of evidence considered, including previous investigations and results that involve the alleged victim(s) and person(s) of interest,
 6. Findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements, and
 7. Reasons for the conclusions, including a summary of how potentially conflicting evidence was reconciled.
- E.** The investigation report should include recommendations as appropriate. At minimum, the report should contain:
1. A recommendation that the case go forward to Human Resources for action when allegations are substantiated.
 2. Recommendations for corrective actions.
- F.** Each hospital is responsible for developing and implementing Corrective Action Plans and follow-up.
1. Upon completion and review of the investigative report, the DBHDD Office of Incident Management and Investigations shall notify the state hospital if there is need for a Corrective Action Plan (CAP).
 2. A CAP must be submitted to the DBHDD Office of Incident Management and Investigations utilizing Attachment C within the timeframe established by the request.
 3. The DBHDD Office of Incident Management and Investigations shall accept or make recommendations for changes to the CAP and shall involve the Regional Coordinator and/or Director of Hospital System Administration, as necessary.

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4. The hospitals shall maintain on site, in a distinct location, documented evidence for the DBHDD Office of Incident Management and Investigations that all CAP requirements are fully implemented.

VII. INCIDENT REVIEW COMMITTEE (IRC)

The Incident Review Committee shall track investigations of incidents of abuse, neglect, and exploitation that allegedly involve staff misconduct; this includes the following types of incidents as defined in Attachment A - Definition of Incidents: (i.e.,

- alleged individual abuse - physical (A8)
- alleged individual abuse - verbal (A10)
- alleged individual abuse - psychological (A9)
- alleged sexual abuse (A12)
- alleged neglect (A11) and
- exploitation - staff/individual (A22).

While they may be referred to local police or hospital security for investigation and possible pursuit of charges, other categories of incidents, such as serious or repeated aggressive acts or sexual assaults, patients' rights violations, individual/individual exploitation and victimization are reviewed by one or more of the Risk Management Committees as triggers or risk factors as specified in the DBHDD Risk Management Policy.

A. IRC Membership

At a minimum, the IRC member shall include the following:

1. Regional Hospital Administrator
2. Clinical Director
3. Nurse Administrator
4. Human Resources Director
5. Risk Manager
6. Director of QM/QI, and
7. Appropriate Discipline Chief

B. Quorum

Two clinical staff, one representative from Risk Management or QM/QI, and two additional members shall be present for all IRC meetings.

C. Meetings

The IRC shall meet monthly or more often, as needed.

D. Committee Functions

The functions and responsibilities of the IRC include:

1. Review all investigations concerning abuse, neglect, and exploitation to determine if they were conducted according to the DBHDD Special Investigations Manual guidelines and appropriate corrective actions were taken in response to investigation findings.
2. Identify and track disciplinary and programmatic corrective actions to ensure effective and timely implementation.
3. Tracks the timeliness of reports in the IRC minutes.

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4. Make referrals to the hospital's Quality Council on any items that require systemic performance improvement.

VIII. PERFORMANCE IMPROVEMENT

- A.** Each hospital shall track and trend incident management data to evaluate the effectiveness of the hospital's incident management system (e.g., timeliness of documentation and corrective actions) and identify and manage individual and systemic trends and patterns (e.g., changes in frequency, location, or severity of incidents).
- B.** For incidents that involve alleged abuse, neglect, or exploitation, trends shall be tracked in at least the following categories: type of incident, staff involved and staff present, individuals directly and indirectly involved, location of incident, date and time of incident, cause(s) of incident, and outcome of investigation.
- C.** The Quality Council is responsible for analyzing data and making recommendations for corrective action, as described in DBHDD Policy #03-601, Risk Management.
- D.** DBHDD shall create a feedback report with comparative statistical data among State hospitals. These reports shall be posted semi-annually for the hospitals to review.
- E. Semi-annual Reports**
 1. Each state hospital shall prepare a report on incidents twice per year.
 2. At a minimum, the report is to include the total number of incident types (as defined in Attachment A, Definition of Incidents, Section II.A), specific trends noted regarding program, units, incident locations, staff involved, shifts, days of week, and time of day, along with preventive and corrective actions taken, training or education needed, and modification to processes, procedures, and policies.
 3. It shall include incidents, the status of incidents that are pending, and the number of cases closed for those six months.
 4. The report shall be submitted to the Director, DBHDD Office of Incident Management and Investigations by February 15 (for incidents occurring July through December) and August 15 (for incidents occurring January through June).
 5. These reports shall be presented at the Governing Body meetings.