Georgia Department of Behavioral Health & Developmental Disabilities	Policy # 03-515 Page 1 of 8
Chapter: Hospital Operations **Subject: Incident Management**	
Applicability: State Hospitals	**Creation Date:** March 1, 2010 **Last Revision Date:** November 16, 2011 **Full Implementation Date:** March 1, 2012 **Next Review Date:** November 16, 2013 **Approved:**
Attachments: Attachment A: Definitions of Incidents Attachment B: Corrective Action Plan (CAP)	11/17/2011 Mona Givens, Ph.D. — Date Director, Incident Management & Investigations 11/17/2011 J. Bryce McLaulin, M.D., — Date Assistant Commissioner for Behavioral Health Services 11/18/11 Frank E. Shelp, M.D., M.P.H., Commissioner — Date

POLICY

DBHDD State Hospitals maintain 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 involve allegations of abuse, neglect, or exploitation, and for protecting individuals while the investigation is being conducted.

I. 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 incidents to the DBHDD Office of Incident Management and Investigations. The database shall be revised as needed to expand its functionality.

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.

II. PROCEDURES FOR DOCUMENTATION OF INCIDENTS

A. Responsibility for Initial Documentation

1. Any occurrence of an incident as defined in **Attachment A** 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 required documentation prior to the end of his/her shift.
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.

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 .

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 are to be aware of and use the correct incident definitions and codes as listed in **Attachment A**.
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.
3. Hospital staff shall review all data entry of critical incidents 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.

III. 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 or designee 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 48 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.

2. Physician Review: (if an individual receiving services has an injury with severity of Medical Treatment Required):
   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

The Program Director/Department Manager or designee shall complete a review within four business days that includes, at a minimum, the following information:

1. Additional information to Level I Review.
2. Analysis of contributing factors including staff actions, actions by other individuals, staffing ratio/mix, therapeutic milieu factors.
3. Action to prevent recurrence.
4. Recommendations and referrals.

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, and complete the final approval. The designee for RHA must be approved by the Director of Hospital Operations in advance of performance of duties.

IV. PROCEDURES TO BE FOLLOWED FOR ALL INCIDENTS

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

B. Federal regulations for Skilled Nursing Facilities and Intermediate Care Facilities require that investigations be completed within five business days.

C. All victims are to be offered the opportunity to speak with an investigator.

D. Investigators shall use appropriate hospital resources to address clinical implications and other issues that are not in their areas of expertise.

E. 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.

F. 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) and additional actions may be recommended to address system issues.

G. 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.

V. SPECIAL PROCEDURES RELATED TO INCIDENTS THAT INVOLVE ALLEGATIONS OF ABUSE, NEGLECT, OR EXPLOITATION

Each state hospital shall take immediate and appropriate action to protect individuals involved in allegations of abuse, neglect, or exploitation which may include removing alleged person(s) of interest from direct contact with the involved individuals pending the outcome of the 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 five 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.
2. If both persons concur that the case lacks credibility, the alleged person of interest 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 unsubstantiated 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) (Attachment B)**.
2. A CAP must be submitted to the DBHDD Office of Incident Management and Investigations utilizing Attachment B 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.
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.

VI. 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:

- 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 via the risk management process as specified in the DBHDD Risk Management Policy.

A. IRC Membership

At a minimum, the IRC membership 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

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. Track the timeliness of reports in the IRC minutes.
4. Make referrals to the hospital’s Quality Council on any items that require systemic performance improvement.

VII. 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, Section III.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. The report 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.

LEGAL 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

DEFINITIONS OF INCIDENTS

I. DEFINITION OF INCIDENT

An occurrence that is potentially or actually physically and/or psychologically harmful to an individual served at the hospital and/or is inconsistent with the individual's expected behavior, conditions, treatment, or plan of care.

II. INVESTIGATIONS

The DBHDD Office of Incident Management and Investigations will investigate those incidents that create a significant health hazard, put an individual's health and safety in immediate jeopardy, or create significant problems to hospital or psychiatric program operations. An investigation may also be conducted if the incident is a matter of public concern, of interest to the news media, to the Legislature or for pending legislation, or of sufficient concern to warrant the attention of DBHDD Office of Incident Management and Investigations.

The following types of incidents (at a minimum) shall be investigated by the DBHDD Office of Incident Management and Investigations:

a. Contraband (A15) when contraband involves staff or weapons
b. Alleged Abuse (A8, A9, A10, A12)
c. Alleged Neglect (A11)
d. Elopement (A37)
e. Alleged Exploitation (A21, A22)
f. Death-unexpected (A17)
g. Sexual Assault (A32)
h. Suicide (A34)
i. Suicide Attempt (A35)
j. Homicide/homicide attempt (A27)
k. Injuries of Unknown Origin (A28), with a severity level of C3 or C4
l. All Injuries requiring first aid or higher related to Seclusion and Restraint, (A14) and
m. Anything else determined by the RHA as needing to be reported to DBHDD.

Other incidents will require facility investigation, as referenced in the DBHDD Special Investigations Manual.

III. DEFINITIONS FOR TERMS USED

A. Incident Types :

A1 **Accidental Injury:** Injuries to individuals not resulting from aggressive acts to self or others. Examples include environmental hazards, work area injuries, medical devices, recreational or sports activities, or "horseplay."

A2 **Aggressive Act to Self:** Self-inflicted injuries without suicidal intent. For example burns, head banging, ingestion of foreign bodies, or potentially toxic substances.

A3 **Aggressive Act to another Individual - Physical:** Hitting, pushing, kicking or similar acts directed against another individual that could cause potential or actual injury; examples include attempts, such as throwing a chair but missing, and attempting to strike but another person intervenes.

A4 **Aggressive Act to Staff - Physical:** Hitting, pushing, kicking, or similar acts directed

against a staff person that could cause potential or actual injury; examples include attempts, such as throwing a chair but missing, and attempting to strike but another person intervenes. Also includes acts such as groping, grabbing, or touching intimate areas.

A5 **Aggressive Act to a Visitor/Family Member - Physical:** Hitting, pushing, kicking, or similar acts directed against a visitor/family member person that could cause potential or actual injury; examples include attempts, such as throwing a chair but missing, and attempting to strike but another person intervenes.

A6 **Aggressive Act to a Visitor/Family Member - Verbal:** Any language by an individual that may be threatening, demeaning, discriminatory, pejorative, derogatory, or aggressive directed at a visitor/family member.

A7 **Alleged Criminal Act:** Actions otherwise not defined in this policy that may result in criminal proceedings.

A8 **Alleged Individual Abuse - Physical:** Any interaction or physical contact, motion, or action that is directed toward an individual by someone other than another individual (peer), which may cause harm or pain. Examples include shoving, hitting, slapping, pinching, shaking, kicking, punching, misuse of seclusion or restraint, unreasonable confinement, misuse of medication or excessive force during the provision of care.

A9 **Alleged Individual Abuse - Psychological:** Any act by someone other than another individual (peer) that causes or could reasonably be expected to cause emotional distress to an individual. Examples include but are not limited to use of intimidation to achieve compliance, retaliation, purposely not intervening in a behavior that is demeaning to the individual, deliberately inflicting mental pain, anxiety, confusion, humiliation, harassment, or coercion.

A10 **Alleged Individual Abuse - Verbal:** Any language by someone other than another individual (peer) that may be threatening, demeaning, discriminatory, pejorative, derogatory, or aggressive.

A11 **Alleged Neglect:** Failure by an employee to provide care or service, for example personal hygiene, food, shelter or clothing, medical care for physical or mental health needs, protection from health and safety hazards, or prevention of malnutrition or dehydration.

A12 **Alleged Sexual Abuse:** An employee engages in sexual contact with an individual. An employee encourages or allows sexual contact between individuals, one of whom is not consenting.

A13 **Alleged/Suspected Violation of Individual/Patients' Rights:** A denial of those rights specified in the Official Code of Georgia Annotated (O.C.G.A.), Chapters 37-3, 37-4, and 37-7 and the Rules and Regulations for Patient's Rights, Chapter 290-4-6 without good cause. Examples include a denial of individual's rights without the benefit of due process, when the time frames for "good cause" denials of rights are not met, breaching an individual's confidentiality, purposely allowing an individual's privacy to be invaded or breached, denial of access to the Patients' Rights Advocate, and denial of legal representation.

A14 **All injuries requiring first aid or higher related to seclusion or restraint:** Seclusion or restraint includes manual and mechanical restraints. This would not include postural supports or restraints for medical or surgical procedures.

A15 **Contraband:** Any item or article of property that poses a threat to the security and safety of the hospital, individuals, employees, visitors or public, or other items prohibited by hospital policy or state law.

A16 **Death-expected:** Cause of death is attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation of outcome is death. It includes the death of an individual on the census of the state hospital, or within two weeks of being discharged or placed on conditional release.

A17 **Death-unexpected:** Death due to any cause except suicide (A34) and homicide (A27) where the cause of death is not attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation of outcome is death. It includes the death of an individual on the census of the state hospital, or within two weeks of being discharged or placed on conditional release.

A18 **Reserved**

A19 **Reserved**

A20 **Reserved**

A21 **Exploitation Individual/Individual:** Selfish or unethical advantage or gain of an individual by another individual (peer) to gain money, property, or services. Examples include strong-arming or sexual activity for money.

A22 **Exploitation Staff/Individual:** Selfish or unethical advantage or gain of an individual by staff.

A23 **Failure to Follow Policy/Procedure:** Failure of staff to follow hospital policy that results in a potential or actual security breach.

A24 **Failure to Return from Community:** Failure of a non-forensic individual to return to the hospital from an authorized visit to the community. This should not be confused with Elopement (which includes an unauthorized departure from the hospital).

A25 **Fall:** An uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows, other purposeful actions, stroke, fainting or seizures.

A26 **Fire Setting:** Incidents involving an individual starting a fire.

A27 **Homicide/homicide attempt:** Injury inflicted on an individual either having potential to, or resulting in death.

A28 **Injury of Unknown Origin:** Any injury that cannot be reasonably explained by either individual or staff. Any injury in which statements of victim or witness are contrary to the evidence or the explanation is inconsistent with the injury.

A29 **Other:** Any serious or unusual occurrence which threatens or is a danger to individuals and staff, and are not included in the other categories. Examples include major fires, floods, and bomb threats.

A30 **Property Damage:** Destruction or defacement of property that does not belong to the individual.

A31 **Pregnancy:** Pregnancy confirmed and conception is alleged to have occurred during hospitalization.

A32 **Sexual Assault:** Sexual contact by an individual involving using force or violence, or the threat of force or violence, including touching, rape or sodomy. The act may be against another individual, or against staff.

A33 **Sexual Contact Between Individuals**: Unwanted sexual contact which does not involve force or violence. Examples include groping, grabbing, or touching intimate areas.

A34 **Suicide:** The self-inflicted death of an individual on the census of the state hospital, or within two weeks of being discharged or placed on conditional release.

A35 **Suicide Attempt:** Deliberate act that may or may not result in injury with the potential to result in death made by an individual with suicidal intent. This includes but is not limited to ingestion of foreign bodies or potentially toxic substances.

A36 **Suicide Threat:** Any verbal indications that includes means, intent and/or plan signaling an individual at the hospital is going to make a suicide attempt.

A37 **Elopement**: Individual is not accounted for and is off the hospital grounds

A38 **Elopement attempt**: Individual is absent from a location defined by the individuals' level or legal status, but remains on hospital grounds.

A39 **Reserved**

A40 **Choking with intervention:** An incident of choking that required intervention (e.g., Heimlich) to clear the airway. Choking is defined as any episode of airway obstruction by food or foreign object as evidenced by one or more of the following: a) inability to speak when asked if choking (if individual is verbal), b) inability to breath or difficulty taking in adequate breaths; 3) movements indicating distress such as grasping for neck or throat; 4) turning blue.

A41 **Choking without intervention:** An incident in which an individual chokes, and is able to self-clear the airway. Choking is defined as any episode of airway obstruction by food or foreign object as evidenced by one or more of the following: a) inability to speak when asked if choking (if individual is verbal), b) inability to breath or difficulty taking in adequate breaths; 3) movements indicating distress such as grasping for neck or throat; 4) turning blue.

B. Alleged Involvement:

A person involved in an incident could be an individual in services, a staff person, family or a visitor. That person can have only one of the following roles:

B1 **Aggressor:** The individual who initiates the act/incident. For example, an individual who starts a hostile action or exhibits hostile behavior, including property damage.

B2 **Victim:** Recipient of an aggressive act or one who is taken advantage of, tricked, or swindled.

B3 **Subject:** Individual, other than an aggressor or victim, involved in an incident, for example a person who has fallen.

B4 **Witness:** One who can give an account of something seen, heard, or experienced; and/or one who furnishes evidence or information.

B5 **Person of Interest**: Staff accused of abuse, neglect or exploitation of an individual.

C. Injury Severity:

C1 **No Treatment Required:** The injury required examination or evaluation, but no first aid or medical treatment.

C2 **First Aid Required:** The injury received is of minor severity and requires the administration of minor first aid. This includes broken bones not requiring treatment (e.g. toe, nose). This is meant to include treatments such as the application of small adhesive bandages (Band-Aids), cleaning of abrasion, application of ice packs for minor bruises, and use of over-the-counter medications such as antibiotic creams, ibuprofen and acetaminophen.

C3 **Medical Treatment Required:** The injury received is severe enough to require the **treatment** of the individual by a licensed medical doctor (medical treatment **beyond** first

aid and other than diagnostic of assessment; i.e., sutures, broken bones requiring treatment, prescriptions beyond over-the-counter medication,) osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to warrant or require hospitalization; further, the treatment received may be provided within the facility or provided outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a general acute care hospital.

C4 **Hospitalization Required:** The injury received is so severe that it requires medical intervention and treatment as well as care of the injured individual at a general acute care medical ward within the facility or at a general acute care hospital outside the facility; regardless of the length of stay, this severity level requires that the injured individual be formally admitted as an individual to the hospital and assigned to a bed on a unit outside of the emergency room.

C5 **Death:** The individual died as a result of the injury or its complications.

C6 **Refused Treatment:** The individual refused assessment and/or treatment for an identified or suspected injury.

CORRECTIVE ACTION PLAN

Hospital ______________________________ **Date of Plan:** ______________________________

Individual: ______________________ **Incident #:** __________ **Date of Incident:** ______________________

Issue	Identified Problem	Corrective Steps	Target Date	Responsible Person

Person Responsible for CAP: ____

Contact Number: ____

ADMINISTRATIVE REVIEW OF CORRECTIVE ACTION PLAN

RHA/Designee: ____

Title: ______________________________ **Date:** ______________________
Typed signature verifies I have reviewed/approved the CAP