Policy and Procedures

Policy: Critical Incident Review	Effective: 7/1/2017	Policy #: 300
Original Date: 8/19/2011	Prepared By: Quality Management Committee	Approved By: Regional Advisory Council
Revised Date: 7/14/2017	Prepared By: Quality Improvement Coordinator	Approved By: Utilization and Care Coordinator Manager

Purpose:

1. To assure a timely review will be completed for 100% of critical incidents
2. To identify opportunities for systemic improvement of services to Members
3. To assure that a process is in place to consistently identify trends of critical incidents and to carefully examine factors leading to completed suicide

Policy:

Contracted mental health agencies serving Willamette Valley Community Health (WVCH) Members shall review all critical incidents internally and report their recommendations to the Mid-Valley Behavioral Care Network (BCN) – and other agencies - in accordance with the procedures discussed below.

BCN uses a continuous quality improvement process to identify issues within the Network in order to develop improved systems to prevent and address such incidents.

Mandatory Abuse Reporting:

Outside of this BCN process, there are a number of mandatory abuse reporting statutes and administrative rules applicable to vulnerable populations receiving behavioral health services:

- ORS 419B.005 to 419B.045 for child abuse
- OARS 430.735 through 430.765 for persons with mental illness or developmental disabilities served in facilities or in county mental health programs
- ORS 124.005 to 124.040 for elderly persons and persons with disabilities
- ORS 441.650 to 441.680 for residents of long term care facilities

The purpose of abuse investigations is to protect individuals at risk, and ensure appropriate action should there be substantiated findings of abuse. Agencies are expected to understand their mandatory reporting obligations and to ensure that staff make such reports as indicated. Most mandatory abuse reports do not fall under the definitions of critical incident.

Suicides of children and young adults (ages 0 to 24) are also reported to the county where the death occurred.

Definitions:

Critical Incidents are defined as followed:

1. Member Suicide: Completed suicide

2. Attempted Member Suicide: A serious action that would likely have resulted in death without intervention or that result in serious injury, regardless of whether the individual truly intended to die. Less lethal self-injurious behavior is to be reviewed at the supervisory level rather than being reported as a critical incident.

3. Member Death: Deaths which are violent, unexplained, or related to behavioral health disorders or treatment

4. Non-Natural Death: Includes motor vehicle accidents, falls, drowning, poisoning, complications from medical or surgical treatments, and exposure to smoke and fire

5. Allegation of Member Abuse or Neglect: Includes any allegation of physical or emotional abuse involving Provider Staff and/or Provider Contractors, and any Member to Member abuse occurring at the site of service.

    a. For children receiving *MV-Wrap* services, physical aggression between youth is a Critical Incident when it requires outside medical treatment beyond first aid.
    b. Cases of familial or acquaintance violence or abuse should be reviewed by persons knowledgeable about the dynamics of such situations. If issues are identified which could lead to systems improvement, the incident will be forwarded to the BCN for inclusion in the regional summary report.

6. Danger to Health and Safety: Includes any Member-related violence; Member injuries occurring on site; Member-to-Member threats that interfere with access to services, or unsafe conditions that have resulted in risk of imminent harm to Members or others. Accidental overdoses or other events with serious medical consequences are included in this category.

    a. For *MV-Wrap* services, violence or injuries to staff or Members which require outside medical treatment beyond first aid qualify as Critical Incidents.

7. Alleged homicide of or by Member: The organization will conduct or contribute to an incident review within the limitations of information available.

8. Police intervention: Involvement by law enforcement personnel in response to a crisis call from the agency, to control disruptive Member behavior at the contracted facility (including an BCN contracted foster home or other residential setting)

9. Medication Error involving medical intervention: A medication error is "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.

10. Other Issues encountered by agencies, when they believe that inclusion in the regional summary would yield information leading to systems improvement.

Procedures:

1. Each provider shall have a critical incident review policy and procedure consistent with the Integrated Services and Supports Rule or other applicable OAR, which includes reporting all critical incidents to the provider's Quality Management Committee (QMC), with the exception of (a) below.

    a. An incident in which staff is alleged to have abused a consumer may result in a referral to law enforcement and/or internal department for investigation and action.
    b. To ensure confidentiality within the agency for such abuse investigations, the agency administrator may choose to bypass the agency's QMC process and report the incident, plans for investigation, and follow-up directly to the BCN Quality Improvement Coordinator.
    c. In BCN's critical incident reporting of such incidents to the Clinical Quality Committee, the Quality Improvement Coordinator shall ensure that the confidentiality of the investigation is maintained.

2. Each provider's QMC shall send a completed Critical Incident Notification Report WITHIN 7 DAYS OF THE INCIDENT to the BCN Quality Improvement Coordinator. BCN staff will determine whether any other Network providers have recently provided services to the Member, and will notify the reporting agency whether there should be a multi-agency review.

    a. If the incident involves a consumer who is served by more than one BCN agency or program, the reporting agency is expected to invite the other agencies to participate in a joint review. Issues of transition and collaboration between agencies often lead to important systems improvement opportunities.

3. Each provider's QMC shall review the clinical context of the incident; the appropriateness of response to the incident; agency or system issues contributing to the event; and recommend changes, if any, which would reduce likeliness of future incidents.

4. Each provider's QMC shall submit a Critical Incident Follow Up Report for any critical incidents and to the BCN Quality Improvement Coordinator no later than the 15th of the month following the end of a quarter in which the incident occurred.

5. Following a completed suicide, the BCN Quality Improvement Coordinator shall convene an ad hoc committee to review the incident and report any system improvement recommendations to the Clinical Quality Committee. The review group shall be composed of BCN staff, including the Quality Improvement Coordinator, Peer Network Program Coordinator, and a Behavioral Health Care Coordinator. The review committee will meet with the reporting agency regarding systems improvement opportunities identified through the review.

6. The BCN Quality Improvement Coordinator shall summarize all incident reports received each quarter and provide a summary to Clinical Quality Committee with information to support:

    a. monitoring patterns of critical incidents in the provider Network
    b. making recommendations as necessary to improve services and reduce likeliness of further

incidents across the Network; and reviewing findings of BCN agency site reviews concerning the critical incident review process and agency follow-up on their own recommendations for improvement reviewing findings of BCN agency site reviews concerning the critical incident review process and agency follow up on their own recommendations for improvement.

c. The provider's QMC will be responsible for protecting the confidentiality of Members and provider staff members. Names of Members and provider staff involved in critical incidents will be edited out prior to any documents being routed to the BCN Quality Improvement Coordinator.

7. In addition to the above procedures, the following applies to children, birth through 17 years of age, in an approved Intensive Treatment Services (ITS) program, such as psychiatric day treatment services, and residential treatment who receive an "Emergency Safety Intervention". An emergency safety intervention is defined as the use of seclusion or personal restraint as an immediate response to an unanticipated threat of violence or injury to an individual, or others. Emergency safety interventions can only be used in approved ITS programs specified in OAR 309-022-0175.

    a. Reportable Incidents occurring within the ITS program are required to be reported within one working day to the Oregon Health Authority (OHA), BCN, and the legal guardian. Parents should be informed as soon as possible, and prior to any potential media coverage.

    b. Shared with MV Wrap Child and Family Team - The following events are to be shared with and discussed quarterly at the child and family team meeting following the event:

        I. Seclusion: Involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.
        II. Personal Restraint: The application of physical force without the use of any device, for the purpose of restraining the free movement of an individual's body to protect the individual, or others, from immediate harm. Personal restraint does not include briefly holding without undue force an individual to calm or comfort him or her, or holding an individual's hand to safely escort him or her from one area to another.
        III. Run away: Member has left agency supervision without permission, whether the Member later returns or is discharged as a runaway.

    BCN staff will collaborate with facility staff in problem-solving and selecting the most clinically appropriate responses to the problem behaviors leading up to these events. The BCN Behavioral Health Coordinator for Children should be consulted if there is a continued pattern of these events.