

	DIVISION OF CHILD AND FAMILY SERVICES Children's Mental Health
SUBJECT:	Incident Reporting and Management Policy
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SUPERSEDES:	10.81 DWTC Incident/Accident Reporting Policy dated October 2009 Oasis Incident Reporting Policy dated June 2012 FLH Incident Reporting Policy dated December 2009 ATC Incident Reporting Policy dated March 2007 All Incident Reporting Forms in use prior to the approval date of this policy
REFERENCES:	CODE OF FEDERAL REGULATIONS 42 CFR Parts 400 et al. 45 CFR Parts 160 & 164 42 CFR Part 2 NEVADA REVISED STATUTES (NRS) NRS 424 NRS 432 NRS 432A NRS 433.431-433.536 NRS 433.5476 NRS 449.774 DCFS CHILDREN'S MENTAL HEALTH POLICY CRR-1 Seclusion and Restraint of Clients March 2013 CRR-2 Client Rights Policy (pending approval) CRR-3 Consent to Treatment Policy (pending approval) SP-4 Documentation Policy (pending approval) 2.30 Reporting Suspected Abuse and Neglect of Clients April 2011 4.01 Performance and Quality Improvement June 2010 6.01 Patient/Medical Records Policy July 2010 7.05 Medication Administration and Management for Residential

	<p>Programs Policy May 2012</p> <p>JOINT COMMISSION STANDARDS Joint Commission Standards-CAMBHC</p> <p>DHCFP MEDICAID SERVICES MANUAL MSM 100 MSM 400 MSM 2500 MSM 3300</p> <p>LEGISLATIVE COUNCIL BUREAU Review of Governmental and Private Facilities for Clients</p>
ATTACHMENTS:	<p>Attachment A - Incident Reporting Form Attachment B - Seclusion and Restraint/Denial of Rights Form Attachment C - Denial of Rights Form</p>

I. POLICY

It is the policy of the Division of Child and Family Services (DCFS) Children’s Mental Health Programs that unusual and significant incidents (as defined below) involving clients, stakeholders and staff will be reported and investigated in a timely manner, with appropriate follow up and/or remedial action steps taken to prevent re-occurrence.

II. PURPOSE

The purpose of this policy is to provide guidance with regard to documenting, monitoring, reviewing and evaluating unusual and/or unexpected incidents which occur in the course of providing mental health services to DCFS clients and to ensure the timely reporting of pertinent information to appropriate programs and managers within DCFS.

The process described in this policy will allow for the monitoring of the appropriateness of care, aggregating and identifying opportunities for program improvement and ensuring treatment issues are tracked, trended, reviewed and reported for performance and quality improvement purposes. In this way, DCFS is better able to ensure lessons are learned from these incidents in order to minimize and/or prevent such events from occurring in the future.

III. DEFINITIONS

A. Client

Means a child who seeks, on his own or another’s initiative, and can benefit from care and treatment by DCFS.

B. Client Right(s)

Includes, without limitation, all rights provided to a [client] pursuant to NRS 433.456 to 433.536, inclusive, and any regulations adopted pursuant thereto.

C. Critical Incident

Any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a client, staff member or stakeholder. It is

also an event or situation which could have, or has had, a negative impact on the mental and/or physical well being of a client, staff member or stakeholder in the short or long term.

D. Critical Success Factor

An element that is necessary for an organization or system to achieve its mission. It is a critical factor or activity required for ensuring the success of an organization, system, or program.

E. DCFS or Division

Division of Child and Family Services.

F. DCFS Staff

A mental health counselor, clinical social worker, licensed psychologist, psychiatric caseworker, psychiatric nurse, treatment home provider, treatment home supervisor, mental health technician, psychiatrist, clinical program manager/planner, LPN/RN, developmental specialist or public service intern who assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's behavioral and mental health needs.

G. Emergency

A situation during which, within a reasonable degree of medical certainty, a delay in the initiation of emergency medical care or treatment would endanger the health of the clients (NRS 433.484).

H. Incident

An unusual or significant event that disrupts or adversely affects the course of treatment or care of a client.

I. Incident Report

A report form to be completed by DCFS staff whenever an incident occurs involving a client, staff, or stakeholder in a DCFS facility (Attachment A).

J. Legally Responsible Person

Persons responsible for child's welfare. A person is responsible for a child's welfare under NRS 432B.130 if the person is the child's parent, guardian, a stepparent with whom the child lives, an adult person continually or regularly found in the same household as the child, or a person directly responsible or serving as a volunteer for or employed in a public or private home, institution or facility where the child actually resides or is receiving child care outside of the home for a portion of the day (NRS 432B.130). (See the definition for Person Legally Responsible for the Psychiatric Care of the Child – Letter N. below).

K. Manual Guidance or Restraint

One method of restricting a client's freedom of movement for the client's safety or for the safety of others.

- L. Medical Director/Medical Supervisor
Medical Director means the chief medical officer of any division mental health or mental retardation program (NRS 433.134). A physician licensed to practice in the State of Nevada with at least two years experience in a mental health treatment setting who has the competency to oversee and evaluate a comprehensive mental health treatment program including rehabilitation services and medication management to individuals who are diagnosed as having a severe emotional disturbance or serious mental illness.
- M. Medication
A drug prescribed only for the purpose of controlling or preventing a specific condition or symptom.
- N. Medication Error
Any preventable event that may cause or lead to inappropriate medication use or client harm while the medication is in control of the health care professional, client, or caregiver.
- O. Performance and Quality Improvement
The complete process of identifying, describing and analyzing strengths and problems and then testing, implementing, learning from and revising solutions. Performance and Quality Improvement is not a time limited project or initiative. It is the ongoing process by which a system makes decisions, evaluates its progress and implements program improvement.
- P. Person Legally Responsible for the Psychiatric Care of the Child
A person, appointed by the court, who is legally responsible for the psychiatric care of a child who is in the custody of an agency that provides child welfare services and is responsible for the procurement and oversight of all psychiatric care for the child and shall make decisions relating to the psychiatric care and related treatment of the child, including, without limitation, the approval of all psychiatric services, psychiatric treatment, and psychotropic medication that may be administered to the child (NRS 432B Sec.4.1). (See the definition of Legally Responsible Person – Letter J above)
- Q. Physical Restraint
As defined in NRS 433.5476 and NRS 449.774, means the use of physical contact to limit a client's movement or hold a client immobile.
- R. Provider of Healthcare
Means a physician, nurse or physician assistant, licensed in accordance with state law (NRS 441A.334).
- S. Quality Assurance
A structured internal system for monitoring and evaluating aspects of a service or facility to ensure a standard of quality is being met. Quality assurance involves the identification of quality of care criteria, which establishes the indicators for program measurement and needed improvements.

T. Reportable Incident

Any event which results or may result in a major disruption to a program, results or may result in significant harm or death to a client, DCFS employees while on duty, stakeholder or any event which may have a negative impact on the DCFS.

U. Seven Rights of Medication Management

Standards for safe medication management – the right patient, right medication, right dose, right route, right time, right to refuse, and the right to be educated; any violation of these rights by DCFS staff is required to be reported as a medication error on an incident report.

IV. PROCEDURES AND PRACTICE GUIDELINES

A. NO BLAME CULTURE

DCFS is committed to developing and encouraging a reporting culture amongst staff, volunteers and contractors free from an assumption of blame. To this aim, no disciplinary action will result from complaints or the reporting of incidents except in the cases of acts of gross misconduct, criminal or malicious activities (including malicious reporting), clinical negligence and/or professional malpractice, and continual violations of DCFS policies and procedures. All reports will be dealt with in a confidential manner and where necessary the names of the originators of the report will remain confidential.

B. REPORTABLE INCIDENTS

Reportable incidents may include, but are not necessarily limited to, the following:

1. Incidents of suspected child maltreatment such as physical, sexual or emotional abuse and neglect. Any incident of suspected child maltreatment must be reported in compliance with the DCFS Reporting Suspected Abuse and Neglect of Clients Policy.
2. A child death or serious injury resulting in the need for emergency medical care by the Medical Director/Supervisor or other Provider of Healthcare or community emergency response.
3. A DCFS facility, including any DCFS facility residence, that compromises the health and safety of an client, staff member or stakeholder due to a significant interruption of a major utility, such as electricity, heat, water, air conditioning, plumbing, fire alarm or sprinkler system or structural problems including inappropriate sanitation, rodents, or damage caused by floods, earthquakes or other acts of nature.
4. Residential fire resulting in relocation, personal injury, property loss or other issues.
5. Missing clients, including those who go AWOL from DCFS residential programs or those who do not return from pass, school, work or community outings.

6. Any suspected criminal activity which occurs in DCFS facilities by DCFS staff, clients or others including but not limited to theft, illegal drug use, and arson.
7. Any medical or psychiatric treatments/services (including emergency room visits) that resulted from events that had a potential for causing significant harm or injury or that require medical follow-up.
8. Any medical services, including medication administration or an adverse medication event, which are determined by a physician to be a medical emergency.
9. Injuries of unknown origin.
10. Restraint or manual guidance or use of force especially those incidents of restraint/manual guidance or use of force which result in any significant injuries including but not limited to:
 - a. Fractures
 - b. Burns, including rug burns and burns that are greater than first degree
 - c. Choking
 - d. Areas of contusions or lacerations

All incidents of restraint are to be reported on the Seclusion and Restraint/Denial of Rights form (Attachment B). If an incident of seclusion and/or restraint results in an injury (i.e., either client or staff injury or both are injured) an Incident Report Form (Attachment A) is completed as well.

11. All incidents regarding a denial of client's rights (other than seclusion and restraint incidents) pursuant to NRS 433 and the CRR-2 DCFS Client's Rights Policy are to be reported on a Denial of Client's Rights Form (Attachment C).
12. Medication errors, including the violation of the Seven Rights of Medication Administration which result in:
 - a. Wrong medication given that places a client's health and safety in jeopardy as determined by the Medical Director/Supervisor or another provider of health care.
 - b. Wrong dose given that place a client's health and safety in jeopardy as determined by the Medical Director/Supervisor or another provider of health care.
 - c. Missed medication that places a client's health and safety in jeopardy as determined by the Medical Director/Supervisor or another provider of health care.
 - d. Medication given outside the prescribed administrative window that jeopardizes the client's health and safety as determined by the Medical Director/Supervisor or another provider of health care.
13. Inadequate medical support, including but not limited to failure to obtain needed follow up medical appointments, failure to obtain routine or special medical care, or failure to obtain or failure to attempt to obtain consent from the legally

responsible person and/or the person legally responsible for the psychiatric care of the child for medication, including changes in dosage of medications, and medication refills in a timely manner.

B. All employees, contractors, and volunteers who witness, discover, or are notified of unusual and/or reportable incidents are responsible for responding to these incidents as follows:

1. Take immediate action to protect, comfort, and arrange for emergency medical treatment of the client, staff member and/or stakeholder, as necessary.
2. Immediately verbally notify the appropriate DCFS supervisor and Medical Director and/or local community emergency response, if necessary, of the incident if there is an apparent serious injury, medication error, or unexplained injury.
3. Complete the Incident Report (IR) (Attachment A and Attachment B, as applicable) ensuring all information is filled in completely, and give the IR to the supervisor and/or Clinical Program Manager (I and II) as soon as possible, but no later than the end of the shift in which the incident occurred.

Only one IR should be completed per client/staff/stakeholder event. If other clients, staff or stakeholders were involved in the incident or were present at the time of the incident, this should be noted in the appropriate space on the IR form. The minimum information to be included in the “Description of Incident” section of the IR form by the most senior DCFS staff who observed the incident (if more than one DCFS staff observed the incident) is as follows:

- a. Who was impacted? (client, staff, stakeholder)
 - Describe all the individuals who were involved, including witnesses to the incident. Include each individual’s first and last name, title and role (if applicable).
- b. What happened?
 - Provide a detailed description of the incident, including the location of the incident, activities occurring immediately prior to the incident, and any injuries that were identified.
 - Describe the action taken to resolve or remediate the incident.
 - Describe any equipment that was involved.
 - Describe any treatment given or intervention provided.
- c. How did it happen?
 - Provide a description of the immediate cause of the incident; i.e., as best as the writer can determine, how did it happen?
- d. When and Where did it happen?
 - Provide a description of the location of the incident (i.e., in the bathroom, bedroom, yard, at school, during a home visit, location in the community, staff office, agency waiting room, etc.)
- e. Action taken

- Provide a description of both the immediate actions that have been taken and actions that are planned but not yet implemented.
4. Each IR Form is to include an incident number. The numbering convention for the incident number is as follows:
 - a. The acronym of the residential program or outpatient service as noted below:
 - 1) Adolescent Treatment Center (ATC)
 - 2) Family Learning Homes (FLH)
 - 3) Oasis On Campus Treatment Homes (OA)
 - 4) Early Childhood Mental Health Services, North (ECN)
 - 5) Early Childhood Mental Health Services, South (ECS)
 - 6) Children's Clinical Services (CCS)
 - 7) Outpatient Services (OS)
 - 8) Desert Willow Treatment Center (DWTC)

Followed by:
 - b. The date in the calendar year format (e.g., an incident occurs at ATC in January of 2013 would be written as ATC0113)
 Followed by:
 - c. The number of the incident. Incidents submitted during the calendar year are numbered sequentially based on submission of the IR.
 Using the numbering convention in b. above, this incident number would be ATC0113-1, given this was the first IR submitted by ATC in the calendar year of 2013.
 Each program will identify an administrative support staff member assigned the responsibility to number each IR based on this numbering convention and track IR's to ensure they are available for review and cross reference, if needed, based on this numbering convention system.
 5. If the incident involved a violation or denial of client rights, DCFS staff is required to comply with the CRR-2 DCFS Client's Rights Policy and to complete the Denial of Rights Form (Attachment C).
 6. The supervisor/Clinical Program Manager (I and/or II) or designee must notify the legally responsible person as soon as possible after the incident but not more than 24 hours after the incident. This notification must be included in the documentation on the IR.

If the legally responsible person is a public child welfare agency or youth parole, a copy of the IR is to be faxed, mailed, or delivered to the public child welfare agency/youth parole.

If the client is in parental custody but was placed in a DCFS residential program by a Probation Officer (PO), DCFS staff is to notify the PO as soon as possible but not more than 24 hours after the incident.

C. Supervisory and Clinical Program Manager Accountabilities in Incident Reporting and Management Practice

The supervisor/Clinical Program Manager (I and II) are responsible for the following:

1. Taking any further action necessary to assure treatment, protection and comfort of the client, staff and/or stakeholder.
2. Ensuring the appropriate staff and DCFS leadership is notified of the details of the incident as soon as possible. This includes providing a copy of the IR to the Safety Officer in the event the incident reported was a Class V Incident.
3. Within 24 hours of the Incident, the IR form must be completed. The supervisor/Clinical Program Manager (I and II) must review the IR to ensure documentation is complete and accurate, including a thorough description of the incident and the action taken. No client names are not to be included in the description of the incident.

The supervisor/Clinical Program Manager (I and II) will be responsible and accountable for ensuring the accuracy and thoroughness of the information being reported on the IR form. There are no exceptions to this requirement.

If the supervisor/Clinical Program Manager (I and II) determines the IR is incomplete or inaccurate, they are responsible for reverting the IR back to the author to address these issues. The Supervisor is responsible for providing direction and consultation to the author of the IR to ensure the information which is documented on the IR is complete and accurate.

The supervisor/Clinical Program Manager (I and II) is prohibited from signing the IR if it is not complete and accurate.

4. Completing the supervisory and Clinical Program Manager (I and II) sections of the IR with comments regarding actions needed or taken to remedy or prevent future recurrence of the incident is required.

If the incident report is of a critical nature (e.g. involves death, serious injury, or suspected child maltreatment), the supervisor/Clinical Program Manager (I and II) shall make a verbal report to the DCFS Deputy Administrator and/or DCFS Administrator. This report is to be made immediately whenever possible but not more than 24 hours after the incident.

5. Report any known or suspected denial or violation of client rights to the DCFS Deputy Administrator or DCFS Administrator pursuant to the CRR-2 DCFS Client's Rights Policy.
6. Once the IR is complete and has been reviewed and confirmed for completeness and accuracy by the supervisor/Clinical Program Manager (I and II) with recommendations for program improvement, a copy of the report is to be forwarded to the Planning and Evaluation Unit (PEU). The Clinical Program Manager II is responsible for ensuring all IR's from the last reporting month are submitted to the PEU not later than the last business day of the following month.

7. The PEU shall develop methods and processes for analyzing the IR reporting data and providing feedback to the Deputy Administrator for program improvement purposes. The Deputy Administrator shall determine the specific PEU reporting requirements for this purpose; e.g., written or narrative reports, verbal reports, timelines for submission of reports, report formats, etc.