WESTMORELAND COUNTY
MENTAL HEALTH
CRITICAL INCIDENT/ HCSIS POLICY AND PROCEDURES

This Critical Incident/HCSIS Policies and Procedures shall establish guidelines to be used in your agency's response to an incident or death connected with a mental health service, program, or activity.

The implementation of this "Critical Incident/HCSIS Policy and Procedure" will be the responsibility of your agency's designated employee. This employee will promote and protect the health and welfare of consumers, staff, visitors, and volunteers by minimizing the occurrence of incidents.

Your agency must realize its obligation to address and manage incidents when they occur and respond appropriately in a timely manner.

Please see attached flow chart.

HCSIS (Home and Community Services Information System)
All Providers shall adhere to the OMHSAS Community Incident Management & Report System Bulletin effective date August 1, 2006, Westmoreland County MH/MR HCSIS Reporting Procedures and the Westmoreland County Critical Incident Completion Instructions.
See attached HCSIS reporting procedures and HCSIS Bulletin.

Critical Incident

Incidents to be reported are those defined as unwanted, extraordinary, unexpected, or suspicious occurrences, which take place in connection with a mental health service, program or activity resulting in serious injury and/or otherwise listed below.

When an incident is known to have occurred, immediate attention/action by the staff member, supervisor, and director is required. All non-residential providers shall contact the Crisis Hotline to determine if the incident warrants submission into the HCSIS system for identified CHIPPS consumers. The Provider will then follow the instructions for Critical Incident Completion and or the HCSIS Reporting Procedures. See attached instructions.

Some examples of incidents are listed below. This list should not be considered as all-inclusive.

- program closure - unplanned/unexpected closing of a program providing services to consumers
- suicide attempt
- consumer rights violations - alleged and/or founded
- rape/sexual assault/abuse - alleged and/or founded
- missing client/consumer (24 hrs+)
- child/adolescent elopement from a residential program

- hospital admission (medical, 201's, 302's)
- misuse and alleged misuse of client funds or property
- outbreak of a serious communicable disease as defined in 28 PA Code, Section 27.2 (relating to reportable diseases)
- police department intervention
- physical assault/abuse - alleged and/or founded
- episodes creating major community disturbances
- the arrest of a client for a felony or for any capital offense
- an incident that would pose a danger to the consumer/client, to others in your facility or to the general public/surrounding community
- fire or other disaster rendering a site uninhabitable
- any incident, which a MH provider agency director deems serious enough in nature to notify the MH/MR Administrator's office

Death

A death, regardless of cause, is reportable whether it is the death of a consumer, visitor, or volunteer that occurs in connection with a mental health service, program, or activity.

When a death occurs, complete the death report only (Appendix B). For impending death, complete critical incident report form (Appendix A).

Management Plan

Each county MH/MR program is required to have an organized plan to deal with critical incidents or deaths. The plan should at a minimum:

1. Identify corrective necessary action to reduce, or eliminate conditions or factors, which permit or are identified as causing or contributing to the incidents:
   A. in the treatment/rehabilitation of consumers;
   B. in the physical environment;
   C. in the program or facilities policies, procedures, and/or documentation;
   D. created by deficits in staff training.

2. Include a comprehensive risk management training program which trains employees, volunteers, and consumers to insure knowledge of:
   A. Prevention, detection, investigation, documentation of incidents, reporting procedures, and evaluation/analysis.
   B. Procedures notifying the supervisor, provider/agency director, county administrator, or his/her designee, and informing parents, guardians, relatives, legal representatives, and law enforcement officials with respect to the incident or death;
   C. Disciplinary steps that may be imposed for failing to report an incident or death.

3. Establish a system for the investigation, analysis, and monitoring of individual incidents and deaths.

4. Include annual analysis of aggregated data to identify trends, patterns, and anomalies within the agency's MH program(s). Twice a year, quarterly, or even more often if your agency is having a high rate of critical incidents occurring. This analysis should include any preventative measures and corrective action.

5. Include procedures for:
   A. Dealing with the emotional needs of any consumer, staff member, visitor, or volunteer who is a witness or party to an incident or death.
   B. Responding to questions of persons notified about the incident.
   C. Incidents that are not required to be reported to the county office but should be kept in agency files. Examples are: medication, treatment, and procedural errors, accidents where there is property damage but no injury to a person.

6. Include consumer record documentation of treatment given as a result of an incident or death.

Notification and Report Completion Process

The factual information relative to an incident must be documented immediately on the incident form (See Attachment A). In the case of client death, the factual information is to be immediately documented on a Death Report (Attachment B).

It is a requirement:

1. For the provider/supervisor to;
   A. Assess the incident /death to insure that correct emergency procedures were followed.
   B. Follow provider procedures for reporting the incident or death; and
   C. Review documentation of the incident/death and note any comments so as to assure the report is as factually accurate and complete as possible.

2. For a provider employee observing or discovering an incident or death to:
   A. Initiate any indicated emergency procedures responsive to the health and safety needs of the person, taking prompt and effective action;
   B. Notify and/or seek assistance from a designated supervisor;
   C. Insure that information, relevant materials, and/or evidence are noted and preserved;
   D. Record required information within required timeframe.

3. The staff member who noted, was informed of, or had knowledge of the incident is responsible for notifying their immediate supervisor who will assess the situation and assist them with the reporting procedures.

All non-residential providers(except WCSI) must initially contact the Crisis Hotline to determine if submission into the HCSIS system for identified CHIPPS individuals is warranted. Once a person has been identified as a CHIPPS individual by a provider, the provider may call WCSI directly with any further critical incidents.

4. Immediately, upon receipt of a reportable incident or death, the supervisor (or their designee) must notify the following by telephone:
   A. Next of kin, nearest relative, or legal representative (if no relative exists) and follow up the telephone report with a written or personal contact, as appropriate.
   B. During normal working hours the County MH/MR Administrator's office shall be notified immediately by telephone upon knowledge when a death occurs or an extremely serious critical incident. After normal office hours or on weekends/holidays the county administrator's office is to be notified immediately by using the on-call MH delegate system for extremely serious critical incidents (such as murder or a high profile incident). The provider reporting the incident is to contact the Westmoreland County Crisis Hotline (800-836-6010) and give the crisis worker a contact name, accessible phone number and brief description of the incident. Crisis service will then contact the on-call delegate, who will then communicate with the reporting provider for more details and follow-up.

   C. If the individual is an enrolled member in Value Behavioral Health (V.B.H.-PA), the provider is to follow the VBH-PA Critical Incident Policy.
   D. Court or child-protection agency (If applicable).
   E. Appropriate MH Administrative Case Manager, Intensive Case Manager, or Resource Coordinator.
   F. Law enforcement officials. (If applicable)
   G. County coroner for sudden, violent, or suspicious death. Documentation should be made of the coroner's decision to conduct an autopsy.

5. The report must be objective, factual in nature, and written in an unbiased and professional manner. The "Description of Event" must specify (a) WHO was involved, (b) WHAT occurred, (c) WHERE it occurred and (d) WHEN it occurred.

6. The report for submission to the MH/MR Office must be typewritten (unless cursive writing is legible), signed and dated by all necessary individuals. The entire report must be completed. If a question does not pertain, enter N/A.

7. The Agency/Unit Director or identified person responsible for reporting the critical incident, having been assured the necessary procedures have been followed will:

   A. Submit a completed Westmoreland County Critical Incident/Death Report Form for (non-HCSIS) reports to the County MH/MR office within 24 hours or on the next working day by fax with original to follow.

   B. Submit a completed Westmoreland County Critical Incident/Death Report Form for any reportable HCSIS (non-residential) CHIPPS critical incidents to Westmoreland Casemanagement and Supports, Inc. for submission into the HCSIS system.

Please refer to Critical Incident Flow Chart

8. Each provider is responsible for forwarding on to the county all necessary follow-up documentation on the Follow-Up Form (Attachment C). For example: Missing person found, actions taken or needed. **A Follow-Up Form (Attachment C) is to be submitted within 14 days of initial report or as necessary when actions have been completed.**

The county Mental Health/Mental Retardation office will be responsible for notifying the Regional Western Office of Mental Health and Substance Abuse Services when necessary.