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<b>Title 1</b>	<b>Northern Lakes Policies</b>
<b>Part 104</b>	<b>Quality Assurance and Improvement</b>
<b>Subpart A</b>	<b>Quality Improvement</b>
<b>Policy No.</b>	<b>104.108</b>
<b>Subject</b>	<b>Critical Incidents</b>

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## Applicability

Policy applies universally during all NLCMH operations and to all Workforce Members at all directly operated sites or during any other activity performed for or on behalf of NLCMH. This policy also applies to any contracted provider that has elected to adopt and adhere to NLCMH policies and procedures pertaining to Recipient Rights protection under the terms of their Participating Provider Agreement.

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## Policy

To improve the quality of services, reduce and/or prevent the potential for injury or other harm to the people served, it is the policy of NLCMH that all workforce members and contracted providers take action to prevent, promptly report and take remedial action in response to all critical incidents. Critical incidents are unusual or unexpected occurrences that fall into one of the following categories listed below:

- **abuse or neglect** (Note: The various types of Abuse and Neglect are defined in greater detail in accordance with MDCH Administrative Rule 7001 in NLCMH Policy and Procedure 106.1303, "Recipient Abuse and Neglect.")
- **recipient abuse** – Recipient Abuse means any of the following by a Workforce Member: A non-accidental act or provocation of another to act that causes or contributes to the death, serious or non-serious physical harm, physical pain, or emotional harm to a recipient; Sexual abuse or Sexual Harassment of a recipient; The use of unreasonable force on a recipient; Exploitation of a recipient's property or funds; An action that presumes a competent recipient is incompetent and results in economic or material loss or emotional harm to the recipient, or; Verbal abuse of a recipient.
- **recipient neglect** – An act of commission or omission by a Workforce Member: 1) That is in non-compliance with a standard of care or treatment to which a recipient is entitled under the Mental Health Code or other law, rule, policy, procedure, written guideline or directive, or Individual Plan of Service and that causes, contributes to, places or potentially places a recipient at risk of death, serious or non-serious physical harm, physical pain, or emotional harm, or; 2) The failure to report any apparent or suspected abuse or neglect of a recipient.
- **child abuse or neglect** – A violation or an attempt or conspiracy to commit a violation of section 136b of Act No. 328 of the Public Acts of 1931.
- **vulnerable adult abuse or neglect** – A violation or an attempt or conspiracy to commit a violation of section 145n of the Michigan penal code, Act No. 328 of the Public Acts of 1931.

- **criminal abuse of a recipient** – criminal assault, homicide, or criminal sexual assault that is a violation or an attempt or conspiracy to commit a violation of sections 81 to 90 of the Michigan penal code, Act No. 328 of the Public Acts of 1931.

**arrest** – Initiation of criminal justice proceedings by law enforcement officers taking a consumer into custody and charging the consumer with a crime.

**biohazard accident** – Accidents involving medical waste that pose a threat to human health

**communicable disease** – A disease that spreads from person to person or that you can “catch” from someone or something else

**conviction** – A judge or jury determining a defendant guilty.

**elopement** – When a person, whose plan of service includes a restriction on freedom of movement or an intrusive level of supervision, leaves a facility or treatment environment unsupervised by staff or another responsible person.

**infection control** – Incidents that pose a significant risk for the transmission of infection or disease or failure to use universal precautions in response to those incidents

**EMT (emergency medical treatment) due to injury** – Unexpected physical harm which requires emergency medical treatment.

**EMT (emergency medical treatment) due to medication error** – An error in the delivery or administration of a medication to a person served that requires emergency medical treatment.

**hospitalization due to injury** – Unexpected physical harm which requires medical hospitalization.

**hospitalization due to medication error** – An error in the delivery or administration of a medication to a person served that requires medical hospitalization.

**physical management** - A technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan. The term “physical management” does not include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. Physical management involving prone immobilization of an individual for behavioral control purposes is **prohibited under any circumstances**.

**potential sentinel event** – An event which has resulted in an unanticipated death or major permanent loss of function, or the risk thereof, not related to the natural course of the person’s illness or underlying condition.

**suicide or attempted suicide** – Completion or attempting to self-inflict critical bodily injury causing death. Suicides are reported for any person actively receiving services at the time of death and anyone who received an emergency service within 30 days prior to death.

**unauthorized use or possession of legal or illegal substances** – The unauthorized use or possession of legal controlled substances or the use or possession of illegal controlled substances at a provider site.

**use of seclusion or restraint** – Seclusion is the temporary placement of a recipient in a room, alone, where egress is prevented by any means, while restraint is the use of a physical device to restrict an individual’s movement. Restraint does not include the use of a device primarily intended to provide anatomical support.

**use or possession of weapons** – Weapons include any instrument or implement which is capable of inflicting serious bodily injury, including but not limited to firearms, knives with blades larger than a folding pocket knife, striking instruments, martial arts weapons,

incendiary or explosive devices, devices which discharge chemical irritants, bows and arrows.

**violence or aggression** – The exertion of physical force so as to injure or abuse. Physical or verbal behavior that is intended to cause harm or pain.

Failure to attempt to prevent, report and take steps to remediate critical incidents as defined and in the manner and timeframes described by this policy and procedure may subject a Workforce Member to administrative action, up to and including dismissal. NLCMH will monitor and analyze all critical incidents to assure that preventive and/or corrective actions are identified and taken.

Critical Incident Report Forms are confidential professional peer review and quality improvement documents and are protected from disclosure pursuant to the provisions of MCL.330.1143a UNAUTHORIZED DISCLOSURE OR DUPLICATION IS ABSOLUTELY PROHIBITED. Across all service settings the Critical Incident Report Form shall never be made part of any person's clinical or facility record. However,

- As required by MDCH Administrative Rule 7046, a summary of the critical incident describing what happened, when, where and to whom as well as services provided in response shall be documented in the person's clinical record by a staff member who has personal knowledge of the incident.

Additionally,

- When a critical incident occurs in a licensed residential setting the Department of Human Services approved Incident/Accident Report Form will be used to document the incident and the incident shall be reported to all parties required to be notified as prompted on the Incident/Accident Report Form and as required by applicable law, rule, policy and procedure. Incident/Accident Report Forms shall be maintained as required by licensing rules.

The filing of a Critical Incident Report Form does not constitute or substitute for the filing of other mandated reports, as follows (refer to NLCMH Ancillary Reporting Summary Poster for more guidance):

1. Oral and Written Reports of Apparent or Suspected Rights Violations to the Office of Recipient Rights as mandated by MCL 330.1752 and NLCMH Recipient Rights Policies and Procedures:
  - Although not all critical incidents are recipient rights violations, some are both and require critical incident reporting as well as recipient rights violation reporting. Please refer to the attached "Critical Incidents and Rights Reporting Comparison" chart for additional guidance. Additionally, other types of incidents or events may occur that constitute recipient rights violations that do not require the filing of a Critical Incident Report Form.

To promote NLMCH's statutorily required obligation to the prompt, impartial, and thorough investigation and remediation of potential rights violations, all employees, volunteers, and contractual agents of NLCMH and contracted providers shall make an immediate oral report followed by a written Report of Apparent or Suspected Rights Violation Form within 24 hours, directly to the

Office of Recipient Rights, when they witness or receive any information about an incident, critical or otherwise, that is an apparent or suspected violation. The reporting of apparent or suspected recipient rights violations is mandatory and failure to report such incidents directly to the Office of Recipient Rights is a rights violation.

2. Report of Recipient Death to the Office of Recipient Rights as required by NLCMH policy and procedure.
  - Any death of a recipient must be immediately reported to the Office of Recipient Rights via the filing of a Report of Death form. Note: Deaths that constitute a potential sentinel event are critical incidents and also require the filing of a Critical Incident Report Form as required by this policy.
3. Other legally mandated reports to other public agencies, including a Report of Suspected Child Abuse and Neglect to the Department of Human Services, Child Protective Services, a Report of Suspected Vulnerable Adult Abuse to the Department of Human Services, Adults Protective Services, and a Report of Suspected Criminal Abuse of a recipient to Law Enforcement.

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## Procedures

### I. Determining What Constitutes a Critical Incident

Determining what constitutes a critical incident is not always straight forward. In general, to be considered a critical incident the situation must be an unusual or unexpected occurrence for the individual, which means in order to be considered critical, it should not be part of the individual plan of service or a behavior management plan. When in doubt consult with others or get input from a supervisor about whether a specific situation is reportable as a critical incident.

### II. Preventing Critical Incidents

Every effort should be made to prevent more common situations from elevating to critical incidents. For example, aggressive or violent actions can be prevented by recognizing and responding to early signs of elevating frustration, agitation or anger. Providing the person an opportunity to talk about their feelings, directing them away from others and responding to their expressed feelings with dignity and respect can avoid violent confrontations.

### III. Reporting Critical Incidents

- A. When an unexpected occurrence involving a consumer that adversely disrupts the normal routine of support, treatment, service management or facility administration, or that is not in compliance with the standard of care required by NLCMH a Workforce Member or contracted provider who witnesses or otherwise is the first to learn of the incident shall immediately take action as necessary to protect, comfort and assure the treatment and support of the person.

B. The Workforce Member shall do all of the following as applicable:

1. Verbally report the incident to the supervisor by the end of the work shift during which the incident occurred.
2. The Critical Incident Report Form is used to report critical incidents at all NLCMH directly-operated or contractual service sites except:

Licensed residential facilities - In licensed residential facilities the Department of Human Services approved Incident/Accident Report Form is used.

Nationally accredited contract providers - A contract provider with recognized national accreditation may use its own incident report form to document the incident attaching an NLCMH Critical Incident Report Form as a cover sheet and route to the case manager/ support coordinator for primary review.

In all settings the critical incident is reported no later than the end of the work shift during which the incident occurred. The Critical Incident Report Form or DHS Incident/Accident Report Form is to be completed as follows:

- a. Complete the identifying information and reporting person sections on the appropriate form. The form should be filled out according to the instructions on the form using descriptive and concise language and in legible handwriting, unless typewritten. It is the responsibility of the reporting person to document only the facts as observed or as told to them, without interpretation or speculation. Additional pages may be attached to the report if relevant.
- b. When two or more workforce members are involved in or witness a critical incident requiring a report, one report form may be filed and signed. Any workforce member unwilling to sign a joint report form, for whatever reason, shall submit a separate form;
- c. File other legally mandated reports as applicable, and ensure that a summary of the incident is documented in the recipient's clinical record.
- d. Submit the report(s) to the designated supervisor and reference the NLCMH ancillary reporting summary poster to be certain that additional required reporting is completed and documented when indicated.

#### IV. Remedial Actions in Response to Critical Incidents

A summary description of any critical incident and services provided in response shall be documented in the clinical record. In addition, the Critical Incident Report Form or in licensed residential settings the NLCMH Critical Incident Routing Form shall be used to ensure a progressive review process which thoroughly documents the incident, what was done in response and what has been done to prevent a recurrence. The progressive review

process includes primary, secondary and in some cases subsequent review as well as quarterly aggregate and annual summary review.

#### PRIMARY REVIEW

- A. When notified of a critical incident on a NLCMH Critical Incident Report Form, usually the supervisor of the reporting person, but occasionally another shall conduct the primary review by:
1. Take any further action necessary to assure treatment, comfort, and protection of the person including assuring that medical treatment is provided if needed;
  2. Assure that the witnessing Workforce Member or contracted provider has completed a Critical Incident Report Form or in licensed residential facilities the Department of Human Services required Incident/Accident Report Form;
  3. Take follow-up action as required, including action to prevent reoccurrence and assure that the case coordinator is informed, if necessary;
  4. Categorize the event.
  5. Review the Critical Incident Report Form for completeness, adding further information if necessary, including any program or administrative action taken to remedy and/or prevent reoccurrence of the incident, and sign and date the report; and
  6. Ensure that other legally mandated reports are filed as applicable and as listed on the NLCMH ancillary reporting poster.
  7. Provide timely debriefing to the reporting staff person or others who may have been involved in the situation. Debriefing may include a one-time, semi-structured conversation with an individual who has just experienced a stressful or traumatic event for the purpose of reducing the possibility of psychological harm by informing people about their experience or allowing them to talk about it. Debriefing may also include referral to an Employee Assistance Program.
  8. Forward the report to the applicable party for secondary review.
- B. When notified of an incident which occurred in a licensed residential facility and is documented on the Department of Human Services required Incident/Accident Report Form, the home supervisor will copy the form, staple the NLCMH Critical Incident Residential Routing Form on the front, complete the primary review and;
1. Take any further action necessary to assure treatment, comfort, and protection of the person including assuring that medical treatment is provided if needed;
  2. Assure that the witnessing Workforce Member has completed the Department of Human Services required Incident/Accident Report Form;
  3. Take follow-up action as required, including action to prevent reoccurrence and assure that the case coordinator is informed, if necessary;
  4. Categorize the event on the NLCMH Residential Routing Form;
  5. Review for completeness, adding further information if necessary, including any program or administrative action taken to remedy and/or prevent reoccurrence of the incident, and sign and date the report; and
  6. Ensure that other required reports are made as listed on the NLCMH ancillary reporting poster;
  7. Forward the report to the person's case manager for review. The case manager then forwards for secondary review.

#### SECONDARY REVIEW

- A. Applicable secondary reviewers may vary by the type of issue being reviewed, but generally includes:
- Chief Operations Officers (for direct-operated services and all contracted services except residential):
  - Residential Services Supervisor (for direct-operated residential services):
  - Residential Manager (for contracted residential services)
- B. The appropriate secondary reviewer shall conduct the next review of the Critical Incident Report Form to assure continued consumer safety, delivery of appropriate treatment, and compliance with agency policies and procedures. Having made such a review, they shall forward the Critical Incident Report Form with secondary review completed, for subsequent review if necessary, as follows:
1. Incidents involving serious injury or death of a person served or other incidents that constitute apparent or suspected Recipient Rights violations are routed to the Recipient Rights Officer.
  2. Potential Sentinel Events are routed to the Director of Quality Improvement.
- NOTE: some incidents may require reporting to more than one of the above listed parties, please reference the NLCMH Reporting Summary Poster for details.
- C. If there is no subsequent review necessary, the Critical Incident Report Form is routed to the respective data entry site in the NLCMH Cadillac or Traverse City offices. If subsequent review is indicated the form is routed to the appropriate reviewer.

#### SUBSEQUENT REVIEW

- A. Subsequent review is conducted in all situations where indicated through secondary review and is always conducted according to area of responsibility: Apparent or suspected recipient rights violations are reviewed by the Director of the Office of Recipient Rights; potential sentinel events are reviewed by the Director of Quality Improvement.
- B. The purpose of secondary review is to ensure that key staff is made aware of critical incidents that may require further investigation. As such, subsequent reviewers should document any summary comments and indicate whether further investigation will be undertaken.
- C. The Critical Incident Report Form is routed to the respective data entry site in the NLCMH Cadillac or Traverse City offices.

#### AGGREGATE REVIEW

- A. Aggregate summary reports of types of incidents reported will be presented for review to the Quality Improvement Committee on a quarterly basis.
- B. A comprehensive report of all critical incidents will be presented for review to the Quality Improvement Committee annually. The summary report will address:
1. Causes
  2. Trends

3. Actions for Improvement
4. Results of performance improvement plans
5. Necessary education and training of personnel
6. Prevention of recurrence and
7. Internal and external reporting requirements.

**ATTACHMENTS:**

NLCMH Critical Incident Report Form  
NLCMH Critical Incident Residential Routing Form  
NLCMH Ancillary Reporting Summary Poster

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