WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 5:	Improving Organizational Performance
PROCEDURE 5.8:	**Patient Safety Event and Incident Management**
Governing Body Approval:	April 30, 2018
REVISED:	June 5, 2018

PURPOSE: To establish a system to identify, classify, document, report, track and trend events with the potential for adverse effects on the safety, care, treatment and rehabilitation of patients served by Whiting Forensic Hospital (WFH). The system will include a multi-level review process to ensure that safety events are reviewed, appropriate corrective actions are implemented and the effectiveness of actions in preventing recurrence is monitored.

To establish requirements for investigations of incidents that involve allegations of abuse, neglect or exploitation and for protecting patients while the investigation is conducted.

SCOPE: All WFH Staff

POLICY:

1. ***Categories and Definitions of Incidents***: The hospital will use the categories and definitions of incidents to be reported and investigated listed in Appendix A of this procedure.

2. ***Initial Documentation on the Incident Report Form (WFH-494):*** The hospital will use a standardized form to document and classify incidents as well as review findings. The hospital will use the Risk Management and Notification System (RMANS) and other electronic systems to provide information on categories of incidents, as well as patient specific incidents, to support timely intervention by interdisciplinary treatment teams and committee(s).

3. ***Multilevel Review Process:*** The hospital will implement a multi-level review process to ensure the appropriateness and effectiveness of follow-up actions and safety of patients. This includes mechanisms for oversight of sentinel event and other critical incident reviews.

4. ***Incidents that Involve Allegations of Abuse, Neglect or Exploitation:*** The hospital will take immediate and appropriate action to protect patients involved, including removing alleged perpetrators from direct contact with patients, as specified in this procedure. All incidents that involve allegations of neglect, abuse or exploitation will be investigated according to the requirements outlined in this procedure. The Governing Body will oversee investigations of abuse, neglect and exploitation.

5. ***Performance Improvement:*** The hospital will track, trend, and analyze data to evaluate the effectiveness of its incident review and management functions and to identify and manage systemic patterns and trends.

6. ***Notifications and Reporting:*** Sentinel Events (as defined by The Joint Commission (TJC) and other Critical Incidents (as defined by the Department of Mental Health and Addiction Services) will be reported to the DMHAS Office of Health Care Systems as outlined in this procedure. These incidents will be reported to external agencies, as appropriate and required by law, as outlined in this procedure.

7. ***Retention of Incident Reports:*** Incident Report Forms will be retained for a minimum of 10 years and require permission from the Public Record Administrator to destroy, coordinated by the Director of Health Information Management (WFH Medical Record Supervisor). De-identified data will be maintained and available through **RMANS** and other electronic systems for review of aggregate patterns and trends.

PROCEDURE:

Definitions:

Incident: An occurrence or attending circumstance, which adversely affects or has the potential of adversely affecting an individual's health, safety, or well-being and/or the operation of the hospital. An incident may, or may not, be patient-related. (An alphabetic listing of incident types and definitions is located at the end of this procedure – Appendix A.)

Patient Safety Event: An event, incident or condition that could have resulted in harm to a patient.

Adverse Event: A patient safety event that resulted in harm to a patient.

Sentinel Event: A sentinel event is an adverse event (not primarily related to the natural course of the patient's illness or underlying condition) that results in one of the following – death, permanent harm or severe temporary harm.

Critical Incident: An incident that creates a significant health hazard, puts an individual's health and safety in immediate jeopardy, or may have a serious adverse impact on the hospital and the Department of Mental Health and Addiction Services (DMHAS) patients, staff, facilities, funded agencies, or the public or incidents that may bring about adverse publicity. The incident must have involved a hospital/DMHAS patient, or an on-duty staff member or visitor, and must have occurred within a DMHAS-operated or DMHAS-funded agency or program. (A listing of sentinel events and other critical incidents reportable to the DMHAS Office of Health Care Systems is located at the end of this procedure - Appendix B.)

I. **Initial Documentation of Incidents**

A. Responsibility for initial documentation

1. Any occurrence meeting the definition of an incident as listed in Appendix A will be documented on the Incident Report Form (WFH-494) prior to the end of the shift by the person who observes and/or has initial knowledge of the incident.

2. When an incident is reported by advocacy and grievance staff, family members, conservator, volunteers, contractors or visitors to the hospital, the unit staff will be responsible for documentation.

B. Documentation requirements

1. Initial documentation will include a synopsis of the incident, incident details, incident category, who the incident was reported by, related incidents, patient data relating to an incident, staff/other involvement, initial response, notifications, and contributing factors.

2. All incidents meeting the definition of a critical incident (which include *all* allegations of Abuse, Neglect and Exploitation) will be noted as such on the Incident Report Form (Section 8 – Investigation by RN Supervisor/Unit Director) and on the DMHAS Critical Incident Submission Form (DMHAS 601).

3. All pertinent information relative to incidents involving patients must be documented in the Progress Notes section of the Medical Record, including the Registered Nurse and physician assessment as indicated. Assessment of injury and potential trauma related to any incident should be documented per hospital procedure. The Incident Report Form and the DMHAS Critical Incident Submission Form are administrative forms only and do not substitute for the necessary clinical documentation in the Medical Record.

C. Accuracy of documentation

1. All staff are to be aware of and use the correct incident definitions and codes as listed in Appendix A of this procedure.

2. As part of the second level review described in this procedure, the Chief Executive Officer (CEO) or designee will review all incidents occurring in the hospital as well as all incidents that occur elsewhere but pertain to the individuals in the hospital. It is the responsibility of the CEO/designee to ensure that the incident report is complete and accurate.

3. The Performance Improvement Department will review all incident reports for accuracy and completeness, and make coding corrections as indicated.

4. The CEO will ensure that all Incident Report Forms are entered in **RMANS** as soon as possible, but no later than 14 days following the date of the incident.

5. New employees will receive training in the documentation and reporting of incidents as part of their orientation program.

II. Initial Documentation of Incidents on the Incident Report Form (WFH-494)

A. Basic Data

1. ***Unit:*** Enter the Unit to which the patient/staff is assigned.

2. ***Incident Date:*** Enter the date on which the incident occurred. (This date may or may not be the same date on which the incident becomes known and is entered in the system.)

3. ***Incident Time:*** Enter the time at which the incident occurred. If the exact time is unknown, use the best estimate available (and note that the time is estimated in the description of the incident).

B. Type of Incident

Select the one incident type that most closely reflects the factual account of the incident. A listing of incident type definitions is located at the end of this procedure – Appendix A.

C. Persons Involved

1. ***Patient/Staff/Visitor:*** Indicate the relationship of the person(s) to the hospital.
2. ***Name:*** Enter the last name, first name for patient(s), staff or other(s) involved in the incident. Enter the MPI number for patients and the employee identification number for staff; leave this blank for others.
3. ***Alleged Involvement:*** Identify the role of each person related to the incident as follows:
   a. *Aggressor:* Person who commits acts of hostility or assault. An aggressive act must have occurred for there to be an aggressor (e.g. sexual assault, alleged criminal act). Incident codes appropriate for aggressor as involvement type are denoted in italics on the Incident Report Form.
   b. *Victim*: Person against whom an aggressive act is committed. An aggressive act must have occurred for there to be a victim. Incident codes appropriate for victim as involvement type are denoted in italics on the Incident Report Form.
   c. *Primary Involved*: the one patient, staff member, or hospital visitor who is the primary reason for completing the incident report when an incident other than an aggressive act occurs.
   d. *Other Involved*: other patient(s), staff member(s), or hospital visitor(s) who are participants in the incident, more than simply observing the incident; there is no allegation of responsibility or culpability for individuals listed as involved in the incident.
   e. *Witness*: Person who has seen or heard something related to the incident but otherwise has no direct involvement in the incident; one who may be able to furnish evidence or information about the incident.
   f. *Undetermined*: level of involvement or role in the incident is not clearly identifiable.

   Note: *The alleged aggressor or primary involved person should be listed first when multiple persons are involved.*

D. Location of Incident

1. ***Unit/Building:*** The specific unit on which the incident occurred should be selected. In circumstances in which the incident occurred off the unit, the building name should be selected.

2. ***Other Locations:*** If the specific incident location is known and relevant, then also select the more specific location (e.g. patient fall that occurred in the unit restroom).

E. Summary Description of Incident

Enter a detailed, factual account of the incident, including who the incident was reported by, staff and/or other person involved, and contributing factors.

F. Immediate Correction Action(s) Taken

Note all immediate actions taken to care for the patient and/or manage the situation following the incident.

G. Notifications

Enter the names of persons notified and the date/time of notification.

The person initiating the Incident Report Form prints his/her name, signs and dates and times the Incident Report Form.

H. Physician Report

The physician will complete this section for each patient involved in an incident if an exam was required and performed. An exam is required for all patient injuries. If more than two patients are examined related to the incident Addendum A will be completed and attached to the Incident Report Form.

1. ***Injury Type:*** Select all injury types that apply. If there is no injury, no type should be selected.

2. ***Severity of Injury:*** Select the appropriate severity using the following definitions:

    a) No Injury.
    b) No Treatment Required.
    c) *First Aid Required:* The injury received is of minor severity and requires the administration of minor first aid. 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, aspirin and acetaminophen. *This is to be selected whether the nurse or physician administers the first aid.*
    d) *Medical Treatment Required:* The injury received is severe enough to require the medical treatment of the individual by a licensed medical doctor 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. This medical treatment goes beyond first aid and involves more than diagnostic assessment. Examples include sutures, setting broken bones, and prescriptions beyond over-the-counter medication.

e) *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 hospital; 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.

f) *Death:* The injury received was so severe that it resulted in – or complications from the injury lead to – the termination of the life of the injured individual.

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

The assigned severity rating is based on the information known by the physician at the time of the assessment. The severity of injury rating should be changed as appropriate based on subsequent information as it becomes available. This is addressed in the hospital leadership review process.

3. *Physician Summary and Treatment Ordered:* the physician briefly summarizes findings of the physical exam and treatment ordered for the patient.

The physician prints his/her name, signs, and dates and times the Incident Report Form.

I. ***Investigation by Unit Director/Registered Nurse Supervisor:*** The appropriate supervisor on duty completes a detailed summary of findings from his/her further investigation of the incident and documents any additional measures taken to manage the immediate situation and any further notifications that occur.

1. Critical Incident: Select *Yes* or *No* depending on whether or not the incident is a critical incident as defined above and/or as determined in consultation with the CEO, Chief Operating Officer (COO), Chief Medical Officer (CMO) or Nurse Executive..

If the incident meets criteria as a critical incident, the RN supervisor on duty initiates notification as outlined below.

The Registered Nurse Supervisor/Unit Director prints his/her name, signs and dates and times the Incident Report Form.

III. Critical Incident Reporting and Notification

A. Initial Report

The staff person who observes, is involved in, or becomes aware of any critical incident immediately notifies the supervisor on duty (Unit Director/Registered Nurse Supervisor). The supervisor on duty notifies the Attending Psychiatrist/On-Call Physician and initiates the verbal and written notification process. (Refer to attached Flow Sheet)

B. Special Notification Procedures

Special notification procedures are required for certain types of critical incidents as delineated below.

1. Elopement: Unauthorized Absence or Escape

Any staff person discovering that a patient has eloped will immediately notify the supervisor on duty (Unit Director/Registered Nurse Supervisor). The supervisor on

duty immediately notifies the DMHAS Agency Police at WFH. The DMHAS Police notify the CEO. Those involved in reporting the incident will need to know the client's legal status, mental status, level of dangerousness and circumstances surrounding the elopement. This information is necessary for the CEO to make a determination as to whether or not to request that the Agency Police issue a teletype and/or notify other police departments, agencies or law enforcement entities. Refer to *Operational Procedure 2.10 Elopement/Escape and Unauthorized Absence* for more detailed, specific information.

If indicated by the incident, the CEO requests a teletype from the APO and notifies the DMHAS Medical Director and/or other officials in the Office of the Commissioner.

Elopement is defined as:

a) The absence of any legally committed or voluntary patient from the unit, building, or grounds without permission;
b) The failure of any patient to appear at any activity, therapy assignment, work or other appointment, or the departure of such patient from those areas without permission; or
c) The failure of any patient to return to the unit at curfew or at another stipulated time from limited grounds privileges, therapeutic activities, or an authorized leave.

There are two types of Elopement:

a) Escape - the unauthorized absence of patients who are hospitalized under the jurisdiction of the Psychiatric Security Review Board (PSRB), 54-56d, transfer from the Department of Corrections, or 17a-566-567.
b) Unauthorized Absence – the unauthorized absence of patients who are hospitalized under voluntary commitment; Physician Emergency Certificate (PEC) or Probate.

2. Unexpected Death, Sexual Assault, or Other Major Offense

The Unit Director/Registered Nurse Supervisor immediately notifies the Agency Police if the incident involves an unexpected death, sexual assault or other major crime on hospital grounds. The Agency Police follow internal police policy and procedures for investigation, preservation of evidence and any required notification of external law enforcement agencies.

C. Internal Verbal Notification for all Critical Incidents

1. The Unit Director/Registered Nurse Supervisor, or other Departmental Supervisor as appropriate, immediately notifies the CEO or designee. The Agency Police and the Nurse Supervisors' Office maintain up-to-date contact information for the CEO and senior leaders.

The immediate notification to the CEO includes as much of the following information as possible:

a) A brief summary of what occurred, the date, time, place of the incident, and the assigned unit(s) of the persons involved;

b) The names of the person(s) involved and their relationship to the hospital (e.g., patient, staff, visitor, other);
c) The age, gender, legal status, privilege level, diagnosis, clinical status and the current level of dangerousness as determined by the Attending Psychiatrist/On-Call Physician at the time of the incident of the person(s) involved;
d) External notifications that may be needed (identified through consultation with the Attending Psychiatrist/On-Call Physician) such as next of kin, conservator, probation officer, significant others, other agencies, etc.; and
e) Immediate actions taken, follow-up steps in process and current location of the person(s) involved if they have been moved.

2. The Unit Director/Registered Nurse Supervisor, as appropriate, notifies the following individuals as soon as possible, and no later than the end of the shift in which the incident occurred:

a) CMO);
b) Facility Human Resources Director (if staff involved).

3. The CEO reviews all (potential) sentinel events and critical incidents in the morning risk management meeting.

D. External Verbal Notification

1. The CEO/designee notifies:

a) CMS Regional Office (617-565-3627) by close of the next business day of any patient death during restraint or seclusion, within twenty-four hours (24 hours) of removal from restraint or seclusion or within seven (7) days where it is reasonable to assume that the use of restraint or seclusion directly or indirectly contributed to a death. "Reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement, chest compression, and restriction of breathing or asphyxiation. Notification is documented on the Hospital Restraint/Seclusion Death Report (WFH-636), which is filed in the legal section of the patient's medical record.
c) The Executive Director of the Psychiatric Security Review Board for all patients under the jurisdiction of the Psychiatric Security Review Board, when treatment is obtained outside the hospital.
d) Public Safety and the Department of Corrections, as appropriate with information contained on form DMHAS 601.
e) The DMHAS Evaluation, Quality Management and Improvement Division (EQMI) for notification of Disability Rights Connecticut (860-990-0175, (toll free - 1-800-842-7303) of all injuries related to the use of restraint or seclusion requiring treatment beyond first aid or resulting in death, and for all inpatient deaths (expected and unexpected).
g. CONN_OSHA for any incident which results in a work related staff death or hospitalization of three or more staff from a work related incident. This reporting process must be completed within 8 hours of the incident. (860-263-6946, toll free 1-866-241-4060)

2. The Unit Director/Registered Nurse Supervisor consults with the Attending Psychiatrist/On-Call Physician to determine the need for any external patient-related notifications that may be needed, such as next of kin, significant others, conservator, probation or parole officer, third-party warnings, other agencies (Department of Children & Families, Department of Social Service, Department of Developmental Services), etc.

3. If the patient goes to the Emergency Room due to a serious (life-threatening) injury or illness after normal business hours, the On-Call Physician attempts to notify the Attending Psychiatrist for notification of the family. If the Attending Psychiatrist cannot be reached quickly, the On-Call Physician notifies the family. If the patient's injury is less serious (e.g., sutures), the On-Call Physician can directly notify the family and offer reassurance.

4. If a patient dies at an acute care hospital, a WFH Physician contacts the hospital, confirms what notifications have occurred and whether an autopsy has been requested. The WFH Physician calls the family to offer condolences, answers questions and requests an autopsy if one is not already being performed.

E. Written Notification/Reporting

1. The Unit Director/Registered Nurse Supervisor completes**:**

   a) The DMHAS Critical Incident Submission Form (DMHAS 601), which is located on all patient care units. (If the incident involves more than one patient, a separate DMHAS-601 Form must be completed for each patient.)
   b) The Report of a Hospital Death Associated with Restraint or Seclusion (CMS-10455) for patient deaths related to restraint/seclusion use.

2. The Unit Director/Registered Nurse Supervisor forwards copies of the WFH-601, and as necessary CMS form *Report of a Hospital Death Associated with Restraint or Seclusion* (CMS-10455) , as soon as possible, and no later than the end of the shift in which the incident occurred, to the:

   a) CEO;
   b) CMO;
   c) COO;
   d) Director of Compliance & Performance Improvement; and
   e) Director of Human Resources (if staff is involved).

3. The CEO forwards a copy of the Incident Report Form (WFH-494) and the DMHAS Critical Incident Submission Form (DMHAS 601) to the Director of Health Care Systems at the Office of the Commissioner within one (1) business day.

4. In the event of a patient's death related to restraint/seclusion use, the CEO/designee submits the Report of a Hospital Death Associated with Restraint or Seclusion (CMS-10455) by Fax to the CMS Regional Office in Boston MA.

IV. Multilevel review of incidents

After unit staff documents an incident, it is subject to two levels of review. There is a third level of review for sentinel events and other adverse events that are determined to be critical incidents. All review findings are documented.

1. First Level Review: The first level of review is to be completed by the Unit Director or RN Supervisor and documented on the Incident Report Form (Addendum B) within five working days and includes at minimum the following information:

    a) Precipitating events, known early warning signs, history impacting the incident, behavior of the individual days prior to the incident and where the incident occurred.
    b) Actions taken to protect victim, e.g., staff movement, patient movement.
    c) Unit acuity, staffing ratio and mix, location of staff and staff changes.
    d) If applicable, reaction of patient's conservator.
    e) Staff actions related to incident (different from medical/nursing interventions).
    f) Therapeutic milieu factors.
    g) Environmental factors and any equipment concerns.
    h) Review of relevant video recordings of the incident, and events prior to and following the incident.

2. Second Level Review: The second level of review is to be completed by the CEO or designee and documented on the Incident Report Form (Addendum C) within ten working days and includes at minimum the following information:

    a) Additional information to Level I Review by the Unit Director.
    b) Analysis of contributing factors including staff actions, actions by other individuals, staffing ratio/mix, therapeutic milieu factors.
    c) Actions to prevent recurrence.
    d) Recommendations and referrals.

    Incidents will remain "open" in RMANS until the second level review is completed.

3. Third Level Review: The third level of review is to be completed by the Governing Body and documented in committee minutes within 45 days for all sentinel events and within 60 days for all other adverse events determined to be critical incidents. The Governing Body will review the factual account of the incident, the comprehensive systematic analysis, including the identification of causal and contributory factors, and the resulting Corrective Action Plan (CAP). The Governing Body will ensure the analysis is thorough and credible and that the CAP identifies and implements timely actions to eliminate or control systems hazards and vulnerabilities for all patients served.

V. Critical Incidents that Involve Allegations of Abuse, Neglect or Exploitation (ANE)

All employees must report any evidence of the abuse, neglect or exploitation of patients to their supervisor immediately. This obligation extends to any employee who is directly involved, witnesses, or is made aware of an alleged incident of abuse, neglect or exploitation.

The employee who observes abuse, neglect, or exploitation (ANE), or has initial knowledge of an allegation is responsible for completing the Incident Report Form (WFH-494) by the end of the shift when the alleged violation occurred or was discovered in accordance with this procedure.

The supervisor or manager on duty who is made aware of an allegation of ANE must ensure the completion of the MHAS-20 Work Rule Violation Form and the DMHAS Critical Incident Submission Form (DMHAS 601), and the immediate notification of the Agency Police (assigned Police Lieutenant or designee) of allegations of physical and/or sexual abuse.

For allegations of ANE, the first two levels of review described above are conducted as part of the Phase One Investigation, as described below.

PHASE ONE INVESTIGATION

A. The RN Supervisor and/or Unit Director initiate Phase One of the investigation.

B. The hospital will take immediate and appropriate action to protect patients involved in allegations of ANE. The alleged perpetrator(s) is/are immediately removed from contact with the patient(s) involved in the allegation pending the outcome of the Phase One investigation. This will take the form of either 1) temporary reassignment to a non-patient care area; or 2) temporary reassignment to another patient care area. The criteria for this decision are described below in section G of Phase One Investigation. This decision will be made by the RN Supervisor and Manager on Duty, in consultation with the CEO/designee. For allegations of physical or sexual abuse that result in temporary reassignment to a non-patient care area, all other patients on the unit with a similar clinical symptom profile of the alleged victim are also assessed to determine their risk of victimization and actions are taken to protect any other patients determined to be at risk.

C. The RN supervisor and/or Unit Director immediately collects witness statements from all staff on duty that may have information relevant to or potentially witnessed the alleged violation no later than the end of the shift.

D. The RN supervisor and/or Unit Director reviews documented witness statements and ensures they are complete and signed by the witness/involved person. The supervisor instructs witnesses/involved persons to include the following in their documented statements:

- Where they were specifically at the time of the incident in question
- What they were doing specifically at the time of the incident in question
- Names of all other individuals present
- Whether or not they participated in or witnessed any portion of the incident in question
- A detailed statement of the sequence of the events immediately before, during and after the incident in question

E. The RN supervisor and/or Unit Director will document as much as possible about the probable chain of events, by studying physical features and objects, as well as the

names and placement of all involved persons, witnesses, victim, etc. at the time of the incident on the Incident Report. If the incident was captured on videotape, the RN Supervisor and/or Unit Director will observe the video of the incident with the onsite manager on duty as soon as possible following the incident. If an available video recording clearly demonstrates that no ANE was possibly committed by the alleged perpetrator, the RN Supervisor and/or Unit Director will confer with the onsite manager on duty (who will confer with the CMO, COO, Nurse Executive or CEO). The manager may return the staff member to regularly assigned duties after this consultation and with the agreement of the CMO, COO, Nurse Executive, or CEO. In such circumstances, the manager will request that the Agency Police save the relevant video.

F. The RN supervisor and/or Unit Director will submit the Incident Report Form (WFH-494), MHAS-20, the DMHAS Critical Incident Submission Form (DMHAS 601), and other relevant documents (witness statements, staffing sheet, assignment sheet, routine or special observation forms, incident report form), to the CEO by the end of the shift when the alleged violation occurred or was discovered.

G. The CEO will notify DMHAS Labor Relations of all incidents involving allegations of ANE.

The DMHAS Human Resources Office of Labor Relations and the CEO/designee will determine one of the following three outcomes for the alleged perpetrator: 1) administrative leave with pay; 2) temporary reassignment to a non-patient care area 3) temporary reassignment to another patient care area.

The employee may also be returned to duty prior to discussion with DMHAS Labor Relations as described above and defined below, if supported by the available evidence. The decision must ensure an optimum level of patient care, safety and welfare and to protect the employee from further allegations.

This determination is informed by the Phase One investigation giving consideration to the following:

- the fact pattern as presented in the allegation;
- the physical evidence;
- the content of witness statements;
- review of recorded video where available
- the feasibility of the circumstances as alleged;
- the history of allegations attributed to the patient;
- the history of allegations directed toward the staff.

The Investigation Review Committee (IRC) will conduct the final review of all Phase One investigations of ANE.

1) Administrative Leave With Pay is utilized when there have been serious allegations made against an employee, the employee's presence at work is deemed unsafe or disruptive and the employee's actions are such that they may lead to termination.

Criteria for the use of administrative leave with pay includes, but is not limited to, the following:

- Preliminary investigation determines there is witness confirmation and/or corroboration through physical evidence on the scene of an allegation of physical or sexual patient abuse;
- Employee's presence at work could be harmful to the public, the welfare, health and safety of patients, state employees or state property;
- Physical violence; and
- Suspected staff impairment.

The Facility Human Resources Office will notify the CEO and the affected employee in writing. The investigation proceeds to Phase Two, as described below.

2) Temporary Reassignment To A Non-patient Care Area is utilized when the fact pattern does not warrant placing the alleged perpetrator on administrative leave with pay, but where reassigning the employee to a non-direct care area is determined to be in the best interest of both the patient(s) and staff.

Criteria for the use of temporary reassignment to a non-direct care area includes, but is not limited to the following:

- Allegations of physical or sexual abuse where the preliminary investigation is unable to establish a fact-pattern to rule in or rule out the allegation(s);
- The preliminary evidence is such that the abuse could have occurred.

The investigation proceeds to Phase Two, as described below. The temporary reassignment will continue until the Phase Two investigation is completed, additional factual information deems temporary reassignment no longer necessary, or as allowed by the collective bargaining agreement.

3) Temporary Reassignment To Another Patient Care Area is utilized when the fact pattern does not warrant placing the alleged perpetrator on administrative leave with pay, or reassigning the employee to a non-direct care area, and is determined to be in the best interest of both the patient(s) and staff.

Criteria for the use of temporary reassignment of patient care responsibilities for possible reassignment to another patient care unit includes, but is not limited to, the following:

- Allegations of verbal abuse or neglect
- Allegations of physical or sexual abuse where the preliminary evidence does not support the allegation, but does not fully eliminate the possibility that the allegation could have merit

The Facility Human Resources Office will notify the CEO and the affected employee in writing. The investigation proceeds to Phase Two, as described below. The temporary reassignment will continue until the Phase Two investigation is completed,

additional factual information deems temporary reassignment no longer necessary, or as allowed by the collective bargaining agreement.

4) Return to Duty is utilized after the evidence gathered during the Phase 1 Investigation has indicated that the alleged ANE did not occur and it is determined to be in the best interest of both the patient(s) and staff.

In these instances the investigation is completed and all records are retained by the CEO. The supervisor of the employee will inform him/her verbally that the investigation is complete, there were no findings of ANE against the employee, and that he/she is being returned to duty. The CEO will notify the affected employee in writing, as soon as possible after such a finding.

If a patient has a history of two or more false allegations, the Treatment Team shall document this in the Integrated Treatment Plan with objectives and interventions to address the issue leading to this behavior.

PHASE TWO INVESTIGATION

For allegations of physical or sexual abuse that proceed to Phase Two, an assessment of possible victimization should be completed and documented for all patients with a similar clinical symptom profile of the alleged victim on the same unit, if not already completed in Phase One. Actions are taken to protect those patients determined to be at risk.

For any investigations referred to Phase Two, DMHAS Labor Relations will complete the Phase Two investigation within 60 business days, except when material evidence is unavailable. In those cases, the investigation will be completed within 5 business days of its availability.

A. Advocacy staff will attempt to interview a reported victim within 7 days after the case is reported. All patients are to be offered the opportunity to speak with advocacy staff. Patient interviews may be conducted jointly by Advocacy staff and DMHAS Labor Relations staff wherever appropriate.

B. The client rights officer will document interviews with involved patient(s) and any patient witnesses, and submit patient interview statements to DMHAS Labor Relations.

C. DMHAS Labor Relations Investigators will use appropriate hospital resources, including clinical management staff, in investigatory interviews to address clinical implications and other risk management issues that are not in their area of expertise.

D. Incidents that raise systemic issues but do not involve staff misconduct will be referred to the Governing Body for review and response.

E. The DMHAS Labor Relations investigator will maintain a written record of the investigatory interview, including the interviewed person's responses to questions and any additional statements provided.

F. Upon conclusion of the interview, the DMHAS Labor Relations investigator will ask the interviewed person to review the written record of the investigatory interview and to make and initial any changes necessary to ensure that it is accurate and complete. The interviewed person will then be asked to sign the record of the investigatory interview. If the interviewed person refuses to sign, the participating clinical manager will review the record of the interview for accuracy and sign it, indicating in writing that the interviewed person refused to sign and attesting as to whether it is an accurate record of the interview. In such instances the interviewed person who refused to sign the record of the interview will be required to write and sign his/her own self-written statement which responds to the areas of questioning.

G. The DMHAS Labor Relations investigator will ask all interviewed persons if they have any concerns related to retaliation or threats as a result of their statements. This is documented in the written record of the investigatory interview.

H. Investigations are a comprehensive, systemic analysis and must result in a written summary report that clarifies and/or reconciles information submitted at the time of the initial report (i.e. Incident Report Form, MHAS-20 Form, Witness Statements, etc.) with additional information gathered throughout the course of the investigation. Data elements that must be reconciled through the investigation, and included in the written summary report, include the following:

1. the incident/allegation type;
2. staff involved and the type of involvement (alleged violator, witness);
3. patients involved and the type of involvement (alleged victim, witness);
4. the location of the incident/allegation; and
5. the date and time of the incident/allegation.

I. The Investigation Summary Report includes a summary of the investigation and findings, to include the following information:

1. the name of the participating clinical manager and any relevant clinical data or observations provided;
2. Each allegation of wrongdoing investigated;
3. Name(s) of all witnesses, alleged victim(s), and alleged violator(s);
4. Names of all persons interviewed and a summary of each investigatory interview;
5. List of all documents reviewed;
6. All sources of evidence considered, including previous investigations and results that involve the alleged victim(s) and violators(s);
7. A brief synopsis of the alleged violator's employment history with DMHAS, including prior discipline as well as the outcome of previous investigations involving the same alleged victim(s) and alleged violator(s);
8. Cause(s) and contributing factors of the incident/allegation;
9. Findings related to the substantiation of the allegations as well as findings about staff's adherence to hospital policies and procedures;
10. Rationale for the conclusions, including a summary of how potentially conflicting evidence was reconciled; and
11. The outcome of the investigation and any recommendation(s) for follow-up, including a recommendation that the case go forward for action when allegations are sustained.

S. The clinical manager's corrective action plan documents his/her analysis and conclusions of administrative and/or clinical issues identified for further review as a result of participation in the investigatory interviews. Consideration is given to:

1. Staff supervision or education needs
2. Policy and/or procedure issues
3. Unit rules or practices
4. Interpersonal environment
5. Physical environment
6. Equipment or related procedures
7. Patient's clinical condition
8. Other causal and/or contributory factors

T. The clinical manager ensures that recommended follow-up action occurs and documented verification is sent to DMHAS Labor Relations for inclusion in the investigation file.

U. Records Management System

1. DMHAS Labor Relations will use a standardized records management system to maintain records of all allegations, investigations, and findings, providing record retention commensurate with the State of Connecticut Record Retention Schedule.

2. The Director of DMHAS Labor Relations will train staff and monitor adherence to the investigation manual.

V. The IRC will oversee investigations of incidents of abuse, neglect and exploitation that allegedly involve staff misconduct. The IRC membership shall consist of: the COO, CMO (or designee), Facility Labor Relations Representative, Director of Accreditation, Regulatory Compliance and Performance Improvement, the Director of Advocacy Services, and the appropriate supervisor for the alleged perpetrator(s) of abuse, neglect or exploitation under investigation. At least one clinical staff (e.g. CMO), one representative from Performance Improvement, and two additional members of the IRC will be present for all IRC meetings. The IRC will review ANE investigations as often as needed. The IRC will maintain minutes, including conclusions and recommendations, following each meeting, and forward to the Governing Body.

In performing this function, the IRC will:

a. Review all investigations concerning ANE to determine if they were conducted according to relevant policy and procedures, and that appropriate corrective actions were taken in response to investigation findings.
b. Monitor corrective actions recommended by investigators and/or clinical managers (including but not limited to, supervision, training, and discipline) to ensure timely implementation.
c. Ensure that documentation of corrective actions is forwarded to DMHAS Labor Relations for inclusion in the investigation file.
d. Identify and track programmatic corrective actions to ensure effective and timely implementation.
e. Track the timeliness of reports in the minutes.
f. Review and analyze data and trends related to ANE.

g. The CEO is responsible for overseeing the implementation of the Clinical Manager's Corrective Action Plan and the submission of all required documentation. The CEO determines the closure of a critical incident file for ANE. The CEO signs a closure notice, which is sent to the OOC-EQMI Office.

VI. Sentinel Event/Critical Incident Review Process and Methodology

A. Sentinel events and other adverse events deemed to be critical incidents are investigated and examined through a comprehensive systematic analysis. Critical incidents that involve allegations of ANE are investigated and examined through a comprehensive systematic analysis, as specified in Section V above. However, a critical incident involving ANE can be deemed a Sentinel Event if the event meets the definition of a Sentinel Event, such as death, permanent harm or severe temporary harm ~~(pg2~~). In these instances, the following steps will be implemented. The comprehensive systematic analysis results in the development of a corrective action plan to reduce the potential recurrence of a similar event. Reviews that involve patients (or have the potential for a significant impact on the clinical care of patients) are conducted under the auspices of the Peer Review Committee of the Medical Staff, and, as such, are entitled to the protections granted to medical review committees under Section 19a-17b of the Connecticut General Statutes.

B. A comprehensive systematic analysis is the methodology by which an in-depth investigation is conducted focusing on systems and processes to identify causal and contributing factors that underlie the event (any incidental findings may be noted for action). The comprehensive systematic analysis is documented and maintained in the sentinel event/critical incident file and in the Governing Body files for allegations of ANE.

C. A Corrective Action Plan is developed to eliminate or control system hazards or vulnerabilities that have been identified by the comprehensive systematic analysis. The plan must identify corrective actions directly related to causal and contributory factors, assign responsibility for implementation, include time lines for completion and identify strategies for evaluating the effectiveness of the actions and strategies for sustaining the changes.

D. The CMO and the Director of Compliance & Performance Improvement will direct all aspects of sentinel event reviews. An interdisciplinary review team, to include relevant clinical staff, will be charged by the CMO. The process should be completed as described in paragraph E (below), unless access to information or staff is restricted as part of a criminal investigation. Under those circumstances the review team should complete as many of the tasks as feasible, and complete the remainder of the process when the investigatory hold is lifted.

E. The CMO and the Director of Compliance & Performance Improvement are responsible for ensuring the following in relation to the sentinel event review:

1. The interdisciplinary team is convened within 72 hours of the determination of a sentinel event;

2. The Clinical Case Summary, which provides relevant patient-specific data and clinical background, describes the course of events leading up to the event and

summarizes any other relevant information, is prepared by the Attending Psychiatrist and submitted to the CMO within 72 hours of the sentinel event;

3. The Clinical Case Summary, incident report and critical incident report paperwork will be reviewed in the first meeting and an investigation work plan will be developed.
4. Participants will be given assignments to include investigatory interviews, review of the medical record and other relevant documents and forms, review of relevant procedures, visiting the involved unit/location and other activities as appropriate.
5. The goal of the investigation is to establish the facts and a timeline relevant to the incident under review.
6. The team will reconvene within 72 hours after the first meeting to review investigation findings, identify any discrepancies and identify additional information needed to complete the comprehensive systematic analysis.
7. The team will continue the investigation, meeting at least weekly, until the comprehensive systematic analysis is complete and accepted as thorough and credible by the CEO.
8. The team will develop a Corrective Action Plan identifying actions already implemented as well as those to be implemented that directly relate to the identified causal and contributory factors, assigning responsibility and time lines for implementation, and identifying strategies for evaluating effectiveness and sustaining changes.
9. Documentation of the comprehensive systematic analysis and correction action plan will be completed no later than 45 days following the event.
10. The Director of Compliance & Performance Improvement will ensure documentation of all aspects of the investigation, including interviews and other materials referenced and/or relied upon to determine the fact pattern and time line, are included in the sentinel event review file with the comprehensive systematic analysis and corrective action plan.
11. The documented comprehensive systematic analysis as stipulated under C.G.S. Statute Section 19a-17b is stamped "peer review" and maintained in the locked critical incident review files.

F. The CMO or Service Medical Director serves as the critical incident review (CIR) Manager for critical incidents involving patients or having a significant impact on the clinical care of patients that do not involve allegations of ANE. A Performance Improvement facilitator assigned by the Director of Compliance and Performance Improvement assists the CMO or Service Medical Director in a facilitative role. An interdisciplinary review team will include relevant clinical staff. Other participants in the review process include, as appropriate:

1. Staff involved in, or witnessing, the incident;
2. The attending psychiatrist;
3. The general medical services clinician;
4. The Unit Director and/or Program Manager;

5. The Nurse Executive;
6. The CEO and/or COO;
7. The Chair of the Pharmacy, Nutrition and Therapeutics Committee and/or a pharmacist for Level 4 to Level 6 medication events;
8. The Physical Therapist for fall related injuries; and
9. Plant Operations staff as indicated.

G. The CIR Manager is responsible for ensuring the following in relation to the Critical Incident review:

1. The Clinical Case Summary, which provides relevant patient-specific data and clinical background, describes the course of events leading up to the event and summarizes any other relevant information, is prepared by the Attending Psychiatrist and submitted to the Medical Director within 72 hours of the critical incident;
2. A meeting of the interdisciplinary review team is convened within 7 days of the incident to review the Clinical Case Summary, incident report and critical incident report paperwork and to identify the investigation team.
3. Participants in this meeting are given assignments to include additional investigatory interviews to be conducted, review of the medical record and other relevant documents and forms, review of relevant procedures, visiting the involved unit/location and other activities as appropriate.
4. The goal of the investigation is to establish the facts and a timeline relevant to the incident under review.
5. The investigation team reconvenes the following week to review investigation findings, identify any discrepancies and identify additional information needed to complete the comprehensive systematic analysis.
6. The investigation team continues the investigation, meeting at least weekly, until the comprehensive systematic analysis is complete.
7. A Critical Incident Review session is convened no later than 30 days after the incident to gather additional information and validate findings of the investigation.
8. The investigation team develops a Corrective Action Plan identifying actions already implemented as well as those to be implemented that directly relate to the identified causal and contributory factors, assigning responsibility and time lines for implementation, and identifying strategies for evaluating effectiveness and sustaining changes.
9. Documentation of the comprehensive systematic analysis and correction action plan is completed and submitted for approval to the Governing Body no later than 60 days following the event.
10. Clinical case summaries, attendance at the CIR session and documented comprehensive systematic analysis, as stipulated under C.G.S. Section 19a-17b, are stamped “peer review” and are maintained in the locked critical incident review files.

H. The assigned Performance Improvement facilitator is responsible for the following:

1. Assisting the CMO or Service Medical Director with recording the comprehensive systematic analysis and developing the subsequent Corrective Action Plan;
2. Ensuring documentation of all aspects of the investigation, including interviews, materials referenced and/or relied upon to determine the fact pattern and time line and attendance at the CIR session, are included in the critical incident review file with the comprehensive systematic analysis and corrective action plan.
3. Maintaining documentation of outcome measures related to implementing Corrective Action Plan items necessary for the closure of the CIR file;
4. Submitting Section C of the DMHAS Critical Incident Review Closure Form to the DMHAS Office of Health Care Systems within 45 days of the Critical Incident;
5. Ongoing monitoring of the implementation of the corrective actions approved by the CIR Action Plan Subcommittee of the Quality Risk and Safety Committee.
6. Ensuring the critical incident file is complete prior to submission to the CEO for closure.

I. The CEO is responsible for ensuring that the corrective actions identified on the Corrective Action Plan are implemented.

J. The CMO, upon implementation of all corrective actions and the submission of all necessary documents, recommends "closure" of a critical incident file to the hospital's CEO.

K. The CEO authorizes the closure of the CIR with his/her signature. (All closure notices are sent to the OOC, EQMI Office)

L. An *Administrative* Critical Incident review is conducted for incidents involving staff members only and having no significant impact on the clinical care of patients.

M. An appropriate designated manager serves as the Administrative Review Manager and convenes a group to include the staff member(s) involved in, or witness to, the incident; the staff member(s)' supervisor(s) and other personnel as determined by the manager in consultation with the CMO. A Performance Improvement Manager will be available to facilitate the review.

N. The manager is responsible for ensuring the following in relation to the Administrative Review:

1. Timely scheduling of the review session and notification to participants;
2. Preparation of a succinct factual description of the incident, including persons involved, date, time, location, actions taken, and impact;
3. Recording attendance;
4. Documentation of a thorough and credible comprehensive systematic analysis;
5. Development of a Corrective Action Plan that incorporates risk reduction strategies based on the findings of the comprehensive systematic analysis and identifies parties responsible for action items, target dates for completion and measures of success/outcomes;

6. Submission of the completed and signed comprehensive systematic analysis, record of attendance, documentation relative to the investigation and the Corrective Action Plan to the CMO within 60 days of the critical incident;
7. Ongoing monitoring of the implementation of the corrective actions approved by the Governing Body;
8. Maintaining documentation of the outcome measures related to implementing Corrective Action Plan items necessary for the closure of the CIR file; and
9. Ensuring the critical incident file is complete and accurate prior to submission to the CEO for closure.

Administrative Critical Incident Review proceedings are not peer-protected due to the absence of patient-related information/issues.

I. Performance Improvement

A. The hospital will track and trend data to evaluate the effectiveness of the Incident Management System (e.g., timeliness of documentation and corrective actions) and to identify and manage individual and systemic patterns and trends (e.g., changes in frequency, location, or severity of incidents).

B. For incidents that involve alleged ANE, trends shall be tracked in at least the following categories: type of incident, staff involved and staff present, patients directly and indirectly involved, location of incident, date and time of incident, cause(s) of incident, and outcome of investigation.

C. The Governing Body is responsible for analyzing data and making recommendations for corrective action.

D. Semi-annual Reports:

1. The Performance Improvement department will prepare summary reports on Key Indicators twice per year for presentation to the Governing Body.
2. Trends will be noted regarding divisions, units, and incident locations. Further drill down analysis will be conducted as indicated with a summary provided to the Governing Body.
3. The Performance Improvement department will prepare a semiannual report for presentation to the Governing Body to include the number and types of sentinel events and critical incidents, timeliness of investigation and corrective actions, and an analysis of causal and contributory factors and corrective actions taken for those six months.
4. A summary report of significant findings will be presented to the Governing Body.

Incident Management Procedure
Appendix A
Alphabetic Listing of Incident Types

Accidental Injury (303): Injuries to individuals not resulting from aggressive acts to self or others, potential infection control exposures or the use of restraints. Examples include environmental hazards, work area injuries, medical devices, recreational or sports activities or "horseplay."

Aggressive Act to Self (100): Self-inflicted injuries without suicidal intent. For example burns, head banging, ingestion of foreign bodies or potentially toxic substances.

Aggressive Act to Other – Physical (101): Hitting, pushing, kicking or similar acts directed against a peer, staff person or visitor to the hospital to cause potential or actual injury.

Aggressive Act to Other – Verbal (102): Any language by a patient that may be threatening, demeaning, discriminatory, pejorative, derogatory, or aggressive directed at a peer, staff person or visitor to the hospital.

Alleged Neglect (204): Failure 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.

Alleged Patient Abuse – Physical (200): Any interaction or physical contact, motion, or action that is directed toward a patient by someone other than a peer, which may cause harm or pain. Examples include shoving, hitting, slapping, pinching, shaking, kicking, punching, misuse of seclusion or restraint, misuse of medication or unnecessary roughness during the provision of care.

Alleged Patient Abuse – Psychological (201): Any act by someone other than a peer that causes or could reasonably be expected to cause emotional distress to a patient. 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 patient, deliberately inflicting mental pain, anxiety, confusion, humiliation, harassment or coercion.

Alleged Patient Abuse – Verbal (202): Any language by someone other than a peer that may be threatening, demeaning, discriminatory, pejorative, derogatory, or aggressive.

Alleged Sexual Abuse (203): An employee engages in sexual contact with a patient. An employee encourages or allows sexual contact between patients, one of whom is not consenting.

Alleged Criminal Act (900): Actions otherwise not defined as an incident type that may result in criminal proceedings.

Alleged/Suspected Violation of Patients' Rights (206): A denial of those rights specified in "Your Rights as a Client or Patient of the Connecticut Department of Mental Health & Addiction Services" (DMHAS) without good cause. Examples include a denial

of patients' rights without the benefit of due process; when the time frames for "good cause" denials of rights are not met; breaching a patient's confidentiality; purposely allowing a patient's privacy to be invaded or breached; denial of access to the Patients' Rights Advocate; and denial of legal representation.

Confidentiality – Unauthorized Disclosure (901): Disclosing protected health information of a patient for other than for the purposes of treatment, payment or healthcare operations, without the patient's authorization and/or disclosing information in a manner other than in accordance with hospital procedures.

Contraband (902): Any item or article of property that poses a threat to the security and safety of the hospital, patients, employees, visitors or public; or other items prohibited by hospital policy or state law.

Death: Termination of life, categorized as one of the following:

> **Expected (600):** The cause of death is attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation of outcome is death.
>
> **Unexpected (601):** The cause of death is not attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation of outcome is death.
>
> **Suicide (602):** Self-inflicted injury resulting in death.
>
> **Murder (603):** Injury inflicted on an individual resulting in death and determined by DMHAS Police to meet CT Penal Code Section 53a-54a.

Elopement Attempt (800): Attempted, but unsuccessful elopement from unit or other designated area.

Elopement from Unit/Remained in Building (801): Left unit or other authorized area, but returned to authorized area before leaving the hospital building.

Elopement from Building/Remained on WFH Campus (802): Left authorized hospital building but was returned to authorized area before leaving WFH Campus.

Elopement from Campus; Returned to Hospital within 24 Hours (803): Left hospital campus unauthorized, but returned within 24 hours of own accord or with assistance of police.

Elopement from Campus; Did Not Return within 24 Hours (804): Left hospital campus unauthorized and did not return within 24 hours. This includes patients who return, but not within the first 24 hours.

Elopement from Authorized Off-Campus Activity; Returned to Hospital within 24 Hours (805): Left from authorized off campus activity, including an off campus leave or pass, but returned within 24 hours of own accord or with assistance of police.

Elopement from Authorized Off-Campus Activity; Did Not Return within 24 Hours (806): Left from authorized off campus activity, including an off campus leave or pass,

but did not return within 24 hours. This includes patients who return, but not within the first 24 hours.

Elopement from Campus during Admission Process; Discharged After Inquiry (807): Left from Admission/Screening Unit prior to admission to the patient care unit and subsequently discharged based on physician assessment and determination that patient does not present a risk to self or others.

Elopement; Discharged ACA/AMA/NCR after Inquiry (808): Left hospital campus unauthorized, or from authorized off-campus activity, and subsequently discharged Against Clinical Advice, Against Medical Advice or Noncompliant with Rules based on a physician assessment and determination that patient does not present a risk to self or others.

Elopement; Discharged after Inquiry (809): Left hospital campus unauthorized, or from authorized off-campus activity, and subsequently discharged based on a physician assessment and determination that patient does not present a risk to self or others.

Equipment Failure/Malfunction, non-medical (914): Cessation of proper or effective functioning of a non-medical machine or equipment, such as elevator, key pad, door, alarm, or locking mechanism.

Exploitation of Peer (105): Selfish or unethical advantage or gain of a patient by a peer to gain money, property, or services. Examples include strong-arming or sexual activity for money.

Exploitation by Staff (205): Selfish or unethical advantage or gain of a patient by staff.

Fall (400): 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.

Fire Setting (903): Incidents involving patients starting fires.

Infection Control Exposure (302): Any situation where a patient, staff, or visitor has actual or potential contact with any communicable disease and/or blood or body fluids from another person.

Injury of Unknown Origin (301): Any injury that cannot be reasonably explained by either patient or staff. Any injury in which statements of victim or witness are contrary to the evidence or the explanation is inconsistent with the injury.

Medical Device Failure/Malfunction (904): Cessation of proper or effective functioning of a medical machine, such as suction, dialysis and bed or chair alarms.

Medical Condition: A medical condition requiring immediate attention that has the potential to be life threatening or cause serious harm to the individual, categorized as one of the following:

Choking – A transient blockage of normal breathing by obstruction of the airway. A patient who is choking may not be able to talk or breathe and the face may turn gray, blue or red. The patient may also use the "universal sign" for choking. The

patient may self clear airway or require assistance.

Choking - Individual able to self-clear airway (500)
Choking - Individual requiring Heimlich (501)
Cardiac (502)
Respiratory (503)
Seizure (504)
Trauma (505)
Other (506)

Missing Keys/Key Card (905): The absence of keys or key cards issued to an individual, unit, or department that is discovered through self-report, being found and reported by another individual, or discovered through an inventory process.

Missing Sharps (906): The absence of any item notated as a "sharps item" without proper record of disbursement or disposal.

Murder Attempt (106): Injury inflicted on an individual having the potential to result in death and determined by DMHAS Police to meet CT Penal Code Sections 53a-54a and 53a-49.

Other Incident (912): 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.

Property Destruction: Destruction or defacement of property that does not belong to the patient being served, categorized as one of the following:

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Patient Property (700)
Staff Property (701)
State Property (702)
Other Property (703)

Restraint Related Injury (300): Any injury that occurs during a restraint situation which includes physical holds, escorts and the application of mechanical restraints to patients.

Security Breach (907): A lapse in the integrity of the security mechanism of the hospital, including but not limited to, unauthorized entry on hospital premises, doors found unlocked and unauthorized access to a secure area.

Serious Threat/Threatening Behavior (908): An expression of intent to inflict injury on another person or to endanger the environment, characterized by verbal or physical actions deemed to be of a serious nature.

Sexual Assault (103): Sexual contact involving patients using force or violence, or the threat of force or violence, including touching, rape or sodomy.

Sexual Contact (104): Unwanted sexual contact between patients which does not involve force or violence. Examples include groping, grabbing, or touching intimate areas.

Smoking Violation (909): Possession of lighters or matches or an instance of smoking on hospital grounds that places patients, staff or others at risk.

Suicide Attempt (910): Self-inflicted injuries or ingestion of foreign bodies or potentially toxic substances with suicidal intent or with a potential lethal outcome.

Suicide Threat (911): Any verbal or behavioral indications that signal a patient at the hospital is going to make a suicide attempt.

TLP Unauthorized Leave (913): Voluntary resident of the Transitional Cottage left the cottage without authorization.

Incident Management Procedure
Appendix B
Sentinel Events/Critical Incidents

1. Sentinel Events (reviewable by The Joint Commission)

   Sentinel Events are defined as patient safety events (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

   - Death
   - Permanent Harm
   - Severe Temporary Harm[1] (as determined by the CMO)

   An event is also considered sentinel if it is one of the following:

   a. Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED).

   b. Unanticipated death of a full-term infant.

   c. Discharge of an infant to the wrong family.

   d. Abduction of any patient receiving care, treatment, and services.

   e. Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient.

   f. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups).

   g. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital.

   h. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital.

   i. Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure.

   j. Unintended retention of a foreign object in a patient after an invasive procedure, including surgery.

   k. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter).

[1] *Severe temporary harm* is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition. **Source:** Throop C, Stockmeier C. *The HPI SEC & SSER Patient Safety Measurement System for Healthcare*. 2011 May.

l. Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose.

m. Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care.

n. Any intrapartum (related to the birth process) maternal death.

o. Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm.

2. Other Critical Incidents

a. Any serious or significant injury requiring medical intervention outside the hospital to a patient that occurred during the use of seclusion or restraint. The determination of "serious or significant" for injuries requiring medical intervention, but not hospitalization, is made by the CMO.

b. Any serious suicide attempt, including suicide attempts that occur up to 30 days after discharge, if known.

c. A medication event that resulted in the need for admission to an acute care hospital, but was not life threatening and resulted in no permanent or severe temporary patient harm**.**

d. Any serious or significant injury requiring medical intervention outside the hospital to a patient, on-duty staff member, or visitor, resulting from an accident, unexplained/suspicious circumstances, or possible criminal activity. The determination of "serious or significant" for injuries requiring medical intervention, but not hospitalization, is made by the CEO in conjunction with the CMO.

e. The death of an on-duty staff member or visitor to the hospital related to accident, unexplained circumstances or suicide.

f. The unexpected death of a patient including death that occurs up to 30 days after discharge, if known.

g. Escape or elopement of a patient under the jurisdiction of the Psychiatric Security Review Board (PSRB), a patient confined under Section 54-56d C.G.S., a patient transferred from the Department of Corrections (DOC), a patient admitted under a Physician's Emergency Certificate (PEC), a patient legally deemed incompetent, or a voluntary patient deemed dangerous to self or others or gravely disabled.

h. Serious behavior committed or allegedly committed on or by a patient, or a staff member, or a visitor to the facility that resulted in or may result in a felony arrest, such as arson, assault, armed robbery, bomb threat, hostage taking, or sale of illegal substances or sexual assault/rape of a staff member or visitor while on the grounds of the hospital.

i. Rape defined as coerced sexual contact involving a patient and another patient, staff member or other perpetrator while being treated or on the premises of the grounds of the hospital.

j. Alleged or suspected patient abuse or neglect, non-accidental injury

k. Patient rights violation, including confidentiality breaches having serious consequences or potentially serious consequences for the patient.

l. Threats by a patient who has been assessed to represent a serious risk to staff, other patients, or others.

l. An incident involving a patient or staff member in which it appears reasonable that media coverage or adverse publicity will be or is likely to occur.

m. Major environmental event that requires emergency evacuation or relocation of patients (other than for the purpose of a drill) for a duration of at least two (2) hours, such as a fire or flood.

n. Significant loss or allegation of theft of property or property damage that compromises or could compromise staff or patient safety.

o. Significant ($1,000 or greater) loss or theft of state property or property damage; and emergency situations that result in the notification of any government agency (e.g., FBI, U.S. Secret Service, Board of Examiners, Protection and Advocacy, etc.), in conformance with the incident reporting requirements of the respective agency.

p. Any other incident determined by the CEO as needing to be reported.