DEVELOPMENTAL DISABILITIES ADMINISTRATION

POLICY ON REPORTABLE INCIDENTS AND INVESTIGATIONS

Audrey Waters, Acting Director
Developmental Disabilities Administration
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Effective Date: October 1, 2007

TABLE OF CONTENTS

BACKGROUND AND INTENT

To protect the rights of individuals with developmental disabilities, community agencies that are licensed by the Developmental Disabilities Administration (DDA) and State Residential Centers (SRCs) that are operated by DDA are required to identify, report, investigate, review, correct and monitor situations and events that threaten the health, safety or well-being of individuals receiving services (individuals). The purpose of these activities is to protect individuals from harm and enhance the quality of services provided to them.

The purpose of this policy is to inform community agency, SRC, DDA, and Office of Health Care Quality (OHCQ) staff of problems, to insure that corrective measures are taken and to minimize the potential for recurrence of similar problems. For example, the prompt reporting and investigation of the alleged abuse of an individual can ensure that immediate steps are taken to protect that individual and others from being exposed to the same or similar risk. Uniform reporting of incidents assists in identifying trends in community agencies or SRCs across the service delivery system. This information can be used to develop preventive strategies.

This policy applies to all community agencies licensed by DDA, regardless of funding source and SRCs. It describes the types of incidents that the community agency/SRC is required to review internally, as well as those that shall be reported to external entities, such as DDA's regional office, OHCQ, etc. It includes specific time frames for reporting and investigating certain incidents. This policy also briefly outlines the respective roles of OHCQ and the DDA with regard to incident investigations.

This policy does not mandate that OHCQ or DDA investigate every incident, event or problem involving an individual in a community agency or SRC. However both OHCQ and DDA have the prerogative and authority to investigate any incident, including those which are not officially reported to OHCQ and/or DDA.

The requirements that are set forth in this policy pertain to any incident that harms or has the potential for harming an individual. This may include incidents which have not been specifically described in the policy. Each community agency/SRC shall develop and implement internal operating procedures for identifying and addressing any situation that has or could have an undesirable outcome for the individuals it serves.

GENERAL REQUIREMENTS

1. Appendix 1A - K of this policy contains the most common types of incidents that the community agency/SRC shall report. There may be other unusual events or situations that have not been described in the policy. Therefore each community agency/SRC shall determine if there are other incidents that should be reported and investigated. The failure to identify a specific type of incident within this policy does not relieve the community agency/SRC of its reporting responsibilities.

2. Every community agency/SRC shall develop an internal protocol to ensure compliance with this policy. The protocol shall establish operating procedures, to include the definition of responsibilities of employees, interns, volunteers, consultants and contractors with regard to identifying, reporting, investigating, reviewing, addressing and monitoring the follow-up of incidents. The protocol shall also include provisions for a standing committee and identify what trainings, in addition to the Policy on Reportable Incidents, will be provided for standing committees. The agency's protocol shall also include the use of the Agency Investigation Report "Appendix 7" form to investigate incidents that are reportable externally and internally. Additionally, the agency's protocol shall include the use of the Standing Committee Review form "Appendix 7 Addendum" to document follow up and review of all incidents by the standing committee.

3. Every community agency/SRC director shall provide a copy of this policy and the community agency/SRC's internal protocol on handling incidents to employees, interns, volunteers, consultants and contractors, members of the standing committees, as well as individuals receiving services, their parents or guardians and advocates. The community agency/SRC shall also provide telephone numbers for emergency contacts within the community agency/SRC as well as the appropriate DDA regional office and the OHCQ to the above-listed persons.

4. Each community agency/SRC shall institute measures to reduce the potential for retaliation against any person reporting an incident.

5. For the purpose of this policy, working days are Monday through Friday, excluding State holidays.

6. This policy reflects a three-level approach to reviewing, reporting and investigating incidents.

A. REPORTABLE INCIDENTS

(1) Reportable incidents are significant events or situations that, because of the severity or the sensitivity of the situation, shall be reported within prescribed time frames to OHCQ and the DDA regional office. The community agency/ SRC shall notify family and/or advocates as identified by the interdisciplinary team for all reportable incidents. Some reportable incidents shall also be reported to other external entities such as Maryland Disability Law Center (MDLC), law enforcement, etc.

(2) Appendix 1 includes examples of events and situations categorized as reportable incidents.

(3) The community agency/SRC director shall be advised of all incidents in this category immediately upon discovery. The director shall immediately assure the health, safety and/or well-being of any involved individuals. The director shall also assure that all required parties are notified of the incident as defined by the policy.

(4) Reporting requirements for reportable incidents are defined in Appendix 2.

(5) As specified in Appendix 2, some types of incidents shall be reported to OHCQ and the DDA regional office immediately either verbally or by e-mail. Within 1 working day of the discovery of the incident, the community agency/SRC shall e-mail a completed Appendix 4 for each reportable incident to OHCQ and the DDA regional office. **Please note, verbal notification is not a substitute for the completed Appendix 4.**

(6) The community agency/SRC shall investigate each incident following their internal protocol. The licensee shall confirm with the outside authorities, when applicable, i.e., law enforcement, fire department, Protective Services, etc. if the licensee should initiate/continue its investigation. The community agency/SRC shall complete its investigation and e-mail its Appendix 7 to OHCQ and the regional office within 21 working days of the discovery of the incident. It should be noted that an Appendix 7 is required even if the licensee is instructed by the outside agency not to initiate/continue its investigation.

(7) The community agency/SRC shall provide follow-up and any actions necessary to resolve the incident. This may include corrective, preventive or disciplinary actions, as indicated by the community agency/SRC investigation and/or OHCQ and/or outside agency (i.e., law enforcement, Protective Services).

B. INTERNALLY INVESTIGATED INCIDENTS

(1) Internally investigated incidents are those significant events or situations that shall be reported to designated authorities within the community agency/ SRC. The community agency/SRC is responsible for reviewing and investigating each of these incidents.

(2) Appendix 1 includes examples of events and situations categorized as internally investigated incidents.

(3) The community agency/SRC director shall take whatever action is necessary to assure the health, safety and/or well-being of any involved individuals.

(4) Internally investigated incidents shall be reported to the community agency/ SRC director, or designee, within 1 working day of discovery. In addition, the community agency/SRC shall immediately investigate each incident. The method for reporting and investigating shall be in accordance with the community agency/SRC's internal protocol. Within 21 working days, an internal final report shall be completed by the community agency using the Appendix 7 form included in this policy. For SRC's, the ICF-MR standard for reporting the results of investigations shall be followed using the Appendix 7 form. The completed internal investigation final report form shall be forwarded to the community agency/SRC's standing committee for review. Upon completing their review, the standing committee shall complete the Appendix 7 addendum form and attach it to the Appendix 7 form.

If the investigation reveals that an injury was the result of abuse, neglect, or restraint, this information shall be reflected in the Appendix 7 form and must be reported as a reportable incident following Appendix 2 reporting procedures for abuse, neglect or restraint.

(5) Each incident shall be resolved by the community agency/SRC.

(6) Each community agency/SRC shall submit to DDA and OHCQ a listing of all internally investigated incidents which occurred during the prior quarterly period. The report is due January 15, April 15, July 15, and October 15.

(7) The report shall be in the DDA format, Appendix 5. The report due January 15 shall include a listing of all internally investigated incidents occurring during the time period from October 1 through December 31; the report due April 15 shall include internally investigated incidents occurring during the time period from January 1 through March 31; the report due July 15 shall include internally investigated incidents occurring April 1 through June 30; and the report due October 15 shall include internally investigated incidents occurring during the time period from July 1 through September 30.

(8) In the event that 3 or more internally investigated incidents occur within a 4 week time frame for the same individual, the most recent incident must be treated as a reportable incident and investigated accordingly. Documentation regarding the other incidents shall be included in this report.

(9) Files containing incident reports, any investigatory materials, meeting minutes, records of interviews, documented disciplinary actions, etc. shall be kept on file by the community agency/SRC for a minimum of 5 years.

C. INTERNALLY REVIEWED INCIDENTS

1) The **Planned Use of Restraints** defined as, the use of a mechanical device or physical intervention that is approved as part of an individual's behavior plan which has been reviewed and approved by the standing committee may be an internally reviewed incident.

   A. As an internally reviewed incident, each occasion of planned restraint use, as part of an approved behavior plan, must be documented in the individual's record. All documentation must contain, at a minimum, the individual's name, date of restraint use and type of restraint used.

   B. If a physical intervention is used documentation must also include the reason for the restraint use and the length of time used.

   C. If a mechanical device is used documentation must also include a record of:
      1. Staff checks of the individual every 15 minutes
      2. Staff escorting the individual to the bathroom and offering of fluids at least every two hours.
      3. Staff providing the individuals the opportunity for motion and exercise for a period of not less than 10 minutes during each 2 hours in which the restraint is used.
      4. Staff providing the individual meals at regularly scheduled hours.
      5. Review by a licensed health care practitioner who authorized the use of the mechanical device at a minimum of every 90 days documenting the effectiveness and whether continuation is indicated.

   D. The Community Agency/SRC shall submit their internal reviews of planned use of restraints to their standing committees for review at least quarterly.

   E. The Community Agency/SRC shall document on the Appendix 5, Quarterly Incident Report for Internally Investigated/Reviewed Incidents, and submit to OHCQ and the DDA Regional Office the type of restraint used for each individual and the number of times the restraint was used during that quarter. If an individual's behavior plan utilized more than one type of restraint each type of restraint would be listed and the number of times that each restraint was used would be listed for that individual.

   F. Additionally, for planned use of restraints only, the Community Agency/SRC shall submit a copy of the standing committee's review of planned restraint use, with the Appendix 5, Quarterly Incident Report for Internally Investigated/Reviewed Incidents, for each individual whose behavior required the use of planned restraint during that quarter.

2) **Chemical supports** defined as the use of medication as an intervention to support an individual for a medical appointment that would not typically require sedation may be an internally investigated incident.

A. The use of chemical supports must be approved by the team as part of an individual's plan and reviewed and approved by the standing committee.

1. The rationale for utilizing chemical supports must be documented.

2. The team must ensure that the chemical support is the lowest effective dose and is only being implemented after other methods have been systematically tried and objectively determined to be ineffective. This must be done before the team can approve the use of chemical support.

3. The team must specify the type of medical appointment(s) for which the chemical(s) have been approved and the name of the licensed health care practitioner (LHCP) who has approved the chemical support.

4. The LHCP must review any chemical support that has been prescribed at a minimum of every ninety days.

5. The LHCP must document that the possible outcomes of continually missed medical appointments or lack of treatment outweighs any potential side effect from the chemical support.

B. Each occasion of the use of a chemical support for a medical appointment, must be documented in the individual's record. All documentation must contain, at a minimum:

1. The individual's name

2. The date chemical support used.

3. The type of chemical support used.

4. The individual's response to the chemical support and

5. What are the potential side effects of the chemical support?

6. The appointment for which it was used.

7. Whether the chemical support is successfully accomplishing the purpose for which it is approved.

IRREGULAR SITUATIONS

If an incident is alleged for an individual that: a) is living with a community agency/SRC; b) attends a DDA-licensed day program; and/or c) receives a support service from a DDA licensed provider, ***but the incident did not occur while the individual was under the direct supervision of the agency providing the service,*** e.g., during a family visit, visit at a relative or friend's home, at another facility, in school, at a camp or while on a vacation trip:

a. the community agency/SRC shall report to authorities and community resources, as indicated, e.g., law enforcement authorities, Protective Services, etc. and investigate per their direction.

If an incident is alleged for an individual who is receiving services from a community agency/SRC while the individual was under the supervision of another community agency/SRC e.g., if day program staff allege that an incident occurred at a residential site or residential staff allege that an incident occurred at a day program site:

a. the discovering community agency/SRC shall document the allegation using the method determined in their internal protocol;

b. the discovering community agency/SRC shall notify the other community agency/ SRC of the allegation;

c. the community agency/SRC where the alleged incident occurred shall report the incident, and shall investigate, correct and monitor the situation and inform the discovering community agency/SRC of the progress and outcome of those activities. The Appendix 4 and the Appendix 7 are to be submitted to OHCQ, the DDA regional office, and other authorities as dictated by the requirements of this policy. If the discovering community agency/SRC is not satisfied that the event/situation is being handled appropriately, it shall bring the event/situation to the attention of OHCQ and the appropriate DDA regional office. OHCQ and DDA shall follow-up and take steps to assure appropriate action by the community agency/SRC.

If an incident involves more than one individual receiving DDA services, it shall be considered as one event, e.g., if John Doe hits Joe Smith and Joe Smith hits John Doe, it is not two separate incidents.

If there is disagreement between the two agencies as to the location of the incident and which agency is required to report the incident, both agencies are required to report and investigate the incident.

INVESTIGATION, FOLLOW-UP AND RECORDS MAINTENANCE REQUIREMENTS

1. The primary concern of the community agency/SRC regarding reportable incidents shall be the health, safety and/or well-being of the individual. The director shall always assure prompt treatment and care and the protection of all individuals from further harm.

2. No one may participate in an investigation of an incident in which there is a conflict of interest, such as an incident in which (s)he was directly involved or in which a spouse or other family member was involved.

3. No member of a standing committee of a community agency/SRC may participate in the decision making process for any incident in which there is a conflict of interest, or in which the committee member was involved.

4. All documentation regarding incidents shall be retrievable by the complete name of the individual and, if used, by a file number or other identification code. When an event/situation involves more than one individual, records shall also be retrievable by incident in addition to being retrievable by each individual's name.

5. Any incident report and/or documentation of an investigation shall be maintained confidentially except when reporting to appropriate internal community agency/SRC staff and external authorities as indicated in this policy.

6. All relevant records, including but not limited to, reports, investigations, interview notes and meeting minutes shall be available to OHCQ and/or DDA staff upon request. Any appropriate internal or external authorities may interview any individual, staff or other relevant parties regarding an internal or reportable incident. Reviews and/or investigations conducted by OHCQ and/or DDA shall assure confidentiality, except when reporting to other authorities as indicated in this policy.

7. All records relevant to an internally investigated or a reportable incident, including but not limited to, reports, investigations, meeting minutes, interview records and documentation of corrective, preventive and/or disciplinary action or any other follow-up activity shall be submitted to the community agency/SRC 's standing committee within 7 calendar days of the closure of the matter. For internally investigated incidents, closure means the completion of the agency investigation; for reportable incidents, this means the completion of the OHCQ investigation. The community agency/SRC should also share any information regarding unusual incidents not addressed in the policy and follow-up actions to inform the standing committee how the community agency/SRC addressed those matters.

Appendix 1A

ABUSE

The mistreatment or mishandling of an individual that results in physical or emotional injury of the individual or endangers the physical or emotional well-being of the individual. A perpetrator may be an employee, intern, volunteer, consultant, contractor, visitor, another individual receiving service or any other person. Abuse can occur whether or not the victim is or appears to be harmed. The failure to exercise one's duty to intercede on behalf of an individual that is being abused also constitutes abuse.

INTERNALLY INVESTIGATED INCIDENTS	***REPORTABLE INCIDENTS***	
Any suspected or confirmed incident of abuse is a reportable incident, with the exception noted in Appendix 2A # 8 and 9 which says: **Reporting History of Unsubstantiated Abuse** **#8** For an individual who repeatedly alleges unsubstantiated abuse, which is documented by the interdisciplinary team and addressed in a behavior plan, allegations of abuse may be treated as internally investigated incidents. **Physical Aggression** **#9** An incident involving physical contact or alleged physical contact between two or more individuals that does not result in injury or if an injury is sustained, it is defined as a mild injury* may be treated as an internally investigated incident. * *See Appendix 1E – Mild Injuries* ***Even though an incident may meet the requirements to be treated as internally investigated, the scope (frequency of occurrence), severity, and/or evidence of a pattern of the incident occurring may indicate that the incident instead be treated as a reportable incident.***	Any suspected or confirmed incident of the following involving **staff and individuals**, such as: **PHYSICAL ABUSE** - Physical contact, which may include, but is not limited to, hitting, slapping, pinching, kicking, biting, strangling, pushing, shoving or otherwise mishandling an individual; physical contact that is not necessary for the safety of the individual and causes discomfort to the individual; the handling of an individual with more force than is reasonably necessary. **SEXUAL ABUSE** - Any sexual activity between an individual and an employee, intern, volunteer, consultant, or contractor of an SRC/community agency; any touching or fondling of an individual directly or through clothing for the arousing or gratifying of sexual desires; causing an individual to touch another person for the purpose of arousing or gratifying sexual desires; **PSYCHOLOGICAL ABUSE** - The use of verbal or nonverbal expression or other actions in the presence of one or more individuals that subjects the individual(s) to ridicule, humiliation, scorn, contempt or dehumanization or is otherwise denigrating or socially stigmatizing. **USE OF AVERSIVE TECHNIQUES** - The application of painful or noxious stimuli to the body which is intrusive upon an individual's physical, mental or emotional well-being in order to terminate challenging behavior. **INHUMANE TREATMENT** - Any deliberate act of cruelty that endangers the physical or emotional well-being of an individual; the deliberate and willful determination of an SRC/community agency to follow treatment practices (a) that are contraindicated by the individual plan, (b) that violate an individual's human rights or (c) do not follow accepted treatment practices and standards in the field of developmental disabilities. **SECLUSION** - The involuntary placement o f an individual alone in a room. **VIOLATION OF INDIVIDUAL RIGHTS -**Any action or inaction that deprives an individual of the ability to exercise his or her legal rights, as articulated in state or	Any suspected or confirmed incident of the following involving **two or more individual**s, such as: **PHYSICAL ABUSE** - An incident involving physical contact or alleged physical contact between two or more individuals that results in a mild/moderate or severe injury. **SEXUAL ABUSE** - Any sexual activity between an individual and others or among individuals is sexual abuse unless the individuals involved are consenting adults with the cognitive ability to make a judgment; any touching or fondling of an individual directly or through clothing for the arousing or gratifying of sexual desires; causing an individual to touch another person for the purpose of arousing or gratifying sexual desires; **INHUMANE TREATMENT** - Any deliberate act of cruelty that endangers the physical or emotional well-being of an individual. **VIOLATION OF INDIVIDUAL RIGHTS -**Any action or inaction that deprives an individual of the ability to exercise his or her legal rights, as articulated in state or federal law. * *See Appendix 1E - Mild/Moderate/Severe Injuries*

	federal law.	

Appendix 1B

NEGLECT

The failure to provide proper care and attention to an individual that results in significant harm or jeopardy of harm to the individual's health, safety, or well-being; failure to provide necessities such as food, clothing, essential medical treatment, adequate supervision, shelter or a safe environment.

INTERNALLY INVESTIGATED INCIDENTS	*REPORTABLE INCIDENTS*
N/A	Any suspected or confirmed incident of neglect as per the above definition, e.g., weight loss due to denied nutritional food, lack of weather appropriate clothing, wearing same clothing everyday with no opportunity for cleaning, lack of timely follow-up regarding professional recommendations, lack of supervision.

Appendix 1C

DEATH

INTERNALLY INVESTIGATED INCIDENTS	*REPORTABLE INCIDENTS*
N/A	All loss of life, regardless of cause is considered a reportable incident.

Appendix 1D

HOSPITAL VISITS

INCIDENTS THAT ARE NOT REPORTABLE	*INTERNALLY INVESTIGATED INCIDENTS*	*REPORTABLE INCIDENTS*
A planned hospital admission e.g., scheduled surgery, planned treatments such as chemotherapy, dialysis, testing such as CT scan, ultrasound, colonoscopy, etc….	An unexpected and/or unplanned hospital admission for a medical or a psychiatric problem of an individual whose IP **documents** a need for frequent/repeated hospitalizations because of a chronic condition. e.g., neurological, mental health, respiratory, cardiac, impaction An emergency room visit that does not result in a hospital admission and /or may be the result of a mild/moderate or severe injury, not related to abuse, neglect or restraint use. **Refer to Appendices 1E and 2E*	An unexpected and/or unplanned hospital admission or in-patient service for an individual whose IP **does not document** the need for frequent/repeated hospitalizations because of a chronic condition. e.g., sudden and acute, car accident, injury. An emergency room visit that is the result of a severe injury.

Appendix 1E

INJURY

Any physical harm hurt or damage to an individual caused by an act of that person or others, whether or not the cause can be identified

NOTE: IN THE TEXT OF THIS POLICY, INJURIES HAVE BEEN CATEGORIZED AS TO LEVEL OF SEVERITY FOR THE PURPOSE OF PROVIDING A GUIDELINE TO COMMUNITY AGENCIES /SRC'S IN DETERMINING THE APPROPRIATE REPORTING AND INVESTIGATING REQUIREMENTS. HOWEVER, NOT ALL INJURIES HAVE BEEN ITEMIZED, AND, UNDER CERTAIN CIRCUMSTANCES, EVEN THOSE INJURIES THAT HAVE BEEN SPECIFICALLY ITEMIZED MIGHT BE OTHERWISE CATEGORIZED. THE COMMUNITY AGENCY/ SRC SHOULD THEREFORE BE ALERTED TO EXERCISE CAUTIOUS JUDGEMENT IN DETERMINING THE EXTENT OF MEDICAL ATTENTION THAT IS REQUIRED FOR ANY INJURY IN DETERMINING THE APPROPRIATE REPORTING AND INVESTIGATING REQUIREMENTS.

INCIDENTS THAT ARE NOT REPORTABLE	***INTERNALLY INVESTIGATED INCIDENTS***	***REPORTABLE INCIDENTS***
MILD INJURIES	MILD / MODERATE INJURIES	SEVERE INJURIES
Injuries that may or may not require minor routine treatment Minor Abrasions Blisters - intact, unopened Skin Irritation Minor Bruises Sunburn with no peeling or blisters Insect bites, stings, or other bites (with no evidence of allergic reaction) Minor scratches Shaving nicks Paper cuts	Injuries that may or may not require medical treatment Strains Blisters - open Contusions Insect bites/stings (with evidence of allergic reaction) Sprains Human/animal bites not as the result of abuse or neglect * Sunburn with peeling and blisters Abrasions Loss of fingernail/toenail due to trauma Loss of teeth due to trauma First and second degree burns not as the result of abuse or neglect * Lacerations not as the result of abuse or neglect * Puncture wounds **** Refer to Appendices 1A and 1B***	Injuries that result in medical emergencies. These injuries require immediate assessment and intervention. Virtually any injury in the extreme, including those in other categories, should be considered a severe injury. Fractures, dislocations Third degree burns (destruction of tissue) Electric shock Loss or tearing of body part All eye emergencies Ingestion of toxic substance, sharp or dangerous objects Any injury with loss of consciousness

Appendix 1F

INCIDENTS REPORTED TO/REQUIRING SERVICES OF A LAW ENFORCEMENT AGENCY OR FIRE DEPARTMENT

POLICE	
INTERNALLY INVESTIGATED INCIDENTS	***REPORTABLE INCIDENTS***
Police visits to a licensed site/service that **did not result** in a police report being taken. Incidents where the police are responding to the individual exhibiting out of control behaviors at the licensed site/service, there is a BP in place to address the behaviors, the BP was implemented, and/or the individual is judged **not to be** a safety risk to self or others. In these incidents the police usually have a brief discussion with the individual and leave without further intervention. Incidents where the individual calls the police as a means of attention getting and there are no safety risks identified.	Police visits to a licensed site/service that **resulted** in a police report being taken. These visits may have resulted in the police responding to a possible crime at the licensed site/service and/or at another location in the community (e.g. in response to an individual exhibiting out of control behavior.) Some police visits will result in the individual being taken to the police station. (Incidents where the police are responding to theft are to be reported under **Reportable – Theft.** Incidents where the police are responding to the individual exhibiting out of control behaviors at the licensed site/service, there is no BP in place to address the behaviors, the BP was not implemented, and/or the individual is judged **to be** a safety risk to self or others.

FIRE DEPARTMENT

INTERNALLY INVESTIGATED INCIDENTS	***REPORTABLE INCIDENTS***
N/A	Any incident*, including a crime, reported to/requiring the services of a fire department is a reportable incident. ****For ambulance service provided by the fire department, which is not related to a fire, refer to appendix 1D – Hospital visits.***

Appendix 1G

THEFT OF AN INDIVIDUAL'S PROPERTY OR FUNDS

Any suspected or confirmed misappropriation of an individual's personal property or money

INTERNALLY INVESTIGATED INCIDENTS	*REPORTABLE INCIDENTS*
Any suspected or confirmed incident of theft of an individual's property or funds valued at less than $50 per incident.	Any suspected or confirmed theft of an individual's property or funds valued at $50 or more per incident or $100 or more over the course of a 30-day period.

Appendix 1H

MEDICATION ERROR

The administration of medication in an incorrect dosage, in an incorrect specified form, by incorrect route of administration or which has not been prescribed or ordered; the administration of a medication to the wrong individual or the failure to administer a prescribed medication for one or more dosage periods.

INCIDENTS THAT ARE NOT REPORTABLE	*INTERNALLY INVESTIGATED INCIDENTS*	*REPORTABLE INCIDENTS*
Medication errors which do not result in marked adverse effects, e.g., medication administered correctly, but not documented.	Any medication error that results or could result in an individual evidencing marked adverse effects which require SRC/agency nurse consultation, but not requiring professional medical attention. e.g. a missed dosage of thyroid or seizure medication.	Any medication error that results or could result in an individual requiring medical or dental observation or treatment by a physician, physician's assistant or nurse; any medication error that results in the admission of an individual to a hospital or 24-hour infirmary for treatment or observation. e.g., the wrong dosage given to an individual over a period of time causing side effects to occur.

Appendix 1I

LEAVE WITHOUT NOTIFICATION (ELOPEMENT)

The unexpected or unauthorized absence of an individual

INTERNALLY INVESTIGATED INCIDENTS	*REPORTABLE INCIDENTS*
The unexpected or unauthorized absence of an individual for less than 4 hours.	The unexpected or unauthorized absence of an individual for more than four hours; The unexpected or unauthorized absence of any duration for an individual whose absence constitutes an immediate danger to that individual or others, e.g., an individual who has brittle diabetes missing while on an outing, an individual who has a history of sexual predation, and individual with Alzheimer's Disease, an individual who is court committed, an individual leaving house in 20° weather in a t-shirt, an individual not able to cross street independently.

Appendix 1J

RESTRAINTS

Any physical, chemical or mechanical intervention used to impede an individual's physical mobility or limit free access to the environment and /or to control acute, episodic behavior including those that are approved as part of an individual's plan or those used on an emergency basis.

INCIDENTS NOT REPORTED	*INTERNALLY REVIEWED INCIDENTS*	*REPORTABLE INCIDENTS*
MECHANICAL SUPPORTS- The use of a mechanical device to support an individual's proper body position, balance or alignment, such as splints, wedges, bolsters or lap trays, or to protect an individual with a continuing medical condition from sustaining an injury. ***(Internally reviewed per COMAR regulations 10.22.10.09C)***	**PLANNED USE OF RESTRAINTS** - The use of a mechanical device or physical intervention that is approved as part of an individual's behavior plan which has been reviewed and approved by the standing committee. ***(Internally reviewed per guidelines in section C of this policy.)*** **CHEMICAL SUPPORTS –** The use of medication as an intervention to support an individual for a medical appointment that would not typically require sedation. ***(Internally reviewed per guidelines in section C of this policy.)***	**UNAUTHORIZED/ INAPPROPRIATE USE OF RESTRAINTS-** - The use of mechanical devices or physical interventions to restrain an individual **without** having a behavior plan which has been reviewed and approved by the standing committee. -The use of physical interventions that are **not** part of the DDA approved curriculum – Behavioral Principles and Strategies. -The use of mechanical devices, physical interventions or psychotropic medication to restrict the movement of an individual for the convenience of staff, as a substitute for programming or for disciplinary/punishment purposes. **CHEMICAL INTERVENTION-** The use of any medication as an intervention that is not considered a chemical support to sedate, calm or manage acute, episodic behavior, even if part of an approved plan, which restricts the movement or function of an individual. **USE OF RESTRAINTS THAT RESULT IN ANY TYPE OF INJURY -** The use of a mechanical or physical restraint that is approved as part of an individual's behavior plan which has been reviewed and approved by the standing committee, which results in an injury, of any level, to the individual.

Appendix 1K

OTHER

Any incident not otherwise defined in this policy that impacts or may impact the health or safety of an individual

INTERNALLY INVESTIGATED INCIDENTS	*REPORTABLE INCIDENTS*
	Examples of incidents in this category are: Suicide threat/attempt An outbreak of a communicable disease Family/domestic issues that overflow into community agency/SRC

Appendix 2A

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
ABUSE - Physical and sexual between staff and individuals or sexual abuse between two or more individuals **Physical abuse between two or more individuals that results in a mild/moderate or severe injury.** **Any action or inaction that deprives an individual of the ability to exercise his or her legal rights, as articulated in state or federal law.**	Law enforcement, OHCQ, DDA regional office, family/legal guardian/advocate(s), case manager/ resource coordinator, State protection and advocacy agency (MDLC). SRCs must also report all incidents to Resident Grievance System (RGS).	Initial report - may be verbal, or e-mail using Appendix 4, reported immediately. Completed Appendix 4 - must be received by OHCQ, State protection and advocacy agency (MDLC), and DDA regional office within 1 working day of discovery. Appendix 7 - must be received by OHCQ, State protection and advocacy agency (MDLC), and DDA regional office within 21 working days of discovery.	1. Evaluate the Agency/ SRC's initial verbal or written report and determine whether OHCQ will investigate. (OHCQ may refer the matter to other agencies, e.g., law enforcement, protective services, etc., initially or at any time during their review and/or investigation, as indicated.) 2. Notify the DDA regional office as to which agency will investigate. 3. If OHCQ investigates, investigation must be completed, whenever possible, within 21 calendar days and the written report with findings and conclusions submitted to the DDA regional office within 3 working days of completion.	1. Assure that the Agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	1. THE SAFETY OF ALL INDIVIDUALS IS OF PARAMOUNT CONCERN. RELOCATION OF THE STAFF OR INDIVIDUAL MAY BE NECESSARY. 2. Other individuals who may have had contact with the alleged perpetrator should be evaluated to determine if they, too, may have been abused. 3. Any sexual activity between individual receiving services and an employee, intern, volunteer, consultant or contractor of an Agency/SRC, whether consensual or not, is considered to be sexual abuse AND IS PROHIBITED. 4. Any sexual activity between individuals receiving services and others or between individuals receiving services is considered sexual abuse unless the involved individuals are consenting adults. 5. If the Agency/SRC is aware of a confirmed diagnosis of a sexually transmitted disease in an individual, it is incumbent upon the Agency/SRC to investigate the possibility of sexual abuse. 6. Any allegation of sexual contact between an individual receiving services and a minor must be reported to a law enforcement agency and the Department of Social Services, Child Protective Services. 7. Any allegation of an incident of sexual abuse that occurred when an individual with a developmental disability is not under the care or supervision of an Agency/SRC must be reported to the Department of Social Services, Adult Protective Services. 8 For an individual who repeatedly alleges unsubstantiated abuse, which is documented by the interdisciplinary team and addressed in a behavior plan, allegations of abuse may be reported as internally investigated incidents. 9. An incident involving physical contact or alleged physical contact between two or more individuals that does not result in injury or if an injury is sustained, it is defined as a mild injury* may be reported as an internally investigated incident. . * *See Appendix 1E - Mild Injuries*
ABUSE – Psychological abuse, use of aversive techniques or inhumane treatment involving staff and individuals or inhumane treatment involving two or more individuals.	OHCQ, DDA regional Office, family/legal guardian/advocate (s), case manager/ resource coordinator, state protection and advocacy agency (MDLC) SRCs must also report incident to Resident Grievance System (RGS).	Same as above	Same as above	Same as above	

Appendix 2B

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
Neglect	OHCQ, DDA regional office, family/legal guardian/advocate(s), case anager/Resource coordinator, state protection and advocacy agency (MDLC), law enforcement. SRCs must also report incident to Resident Grievance System (RGS).	Initial report - may be verbal or e-mail using Appendix 4, reported immediately. Appendix 4 - must be received by OHCQ, State protection and advocacy agency (MDLC), and the DDA regional office within 1 working day of discovery. Appendix 7 - must be received by OHCQ, State protection and advocacy agency (MDLC), and DDA regional office within 21 working days of discovery.	1. Evaluate the Agency/SRC's initial and/or written report and determine whether OHCQ will investigate. (OHCQ may refer the matter to other agencies, e.g., law enforcement, protective services, etc., initially or at any time during their review and/or investigation, as indicated.) 2. Notify the DDA regional office as to which agency will investigate. 3. If OHCQ investigates, investigation must be completed, whenever possible, within 30 calendar days and the written report with findings and conclusions submitted to the DDA regional office within 3 working days of completion.	1. Assure that Agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	

Appendix 2C

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
DEATH – Unusual, suspicious or due to unnatural causes **DEATH – natural causes** **DEATH – expected due to terminal illness**	OHCQ, DDA regional office, DDA headquarters, family/legal guardian/advocate(s), case manage/ resource coordinator, State protection and advocacy agency (MDLC), local health departments, law enforcement. * Please refer to Appendix 3 and 3A for additional information. SRCs must also report incident to Resident Grievance System (RGS).	Initial report - may be verbal or e-mail using Appendix 4, reported immediately. Completed Appendix 4 - must be received by OHCQ, State protection and advocacy agency (MDLC), and the DDA regional office, and DDA headquarters, within 1 working day of discovery. Appendix 7 must be received by OHCQ, State protection and advocacy agency (MDLC), and DDA regional office within 21 working days of discovery.	1. Evaluate the Agency/SRC's initial verbal and/or written report and investigate all deaths. (OHCQ may refer the matter to other agencies initially, e.g., law enforcement, coroner, etc., or at any time during their review and/or investigation, as indicated.) 2. Upon completion of each investigation, the Office of Health Care Quality submits to the Mortality Review Committee its final report for each death, Health General Article § 5-805.	1. Assure that Agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	If an individual's death occurs in the hospital the agency shall inform the hospital that the individual was receiving services from or residing in a state-funded and/or state operated facility. Appendices 3 and 3A discuss additional reporting requirements.

Appendix 2D

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
Hospital visits – an unexpected and/or unplanned hospital admission or in-patient service for an individual whose IP does not document the need for frequent/repeated hospitalizations because of a chronic condition. E.g. sudden and acute, car accident, injury. **An emergency room visit that is the result of a severe injury.**	OHCQ, DDA regional office, family/legal guardian/advocate(s), case manager/resource coordinator, State protection and advocacy agency (MDLC). SRCs must also report incident to Resident Grievance System (RGS).	Appendix 4 - must be received by OHCQ, State protection and advocacy agency (MDLC), and the DDA regional office within 1 working day of discovery. Appendix 7 must be received by OHCQ, State protection and advocacy agency (MDLC), and DDA regional office within 21 working days of discovery**.**	1. Evaluate the agency/SRC's initial or written report and determine whether OHCQ will investigate. (OHCQ may refer the matter to other agencies, e.g., law enforcement, protective services, etc., initially or at any time during their review and/or investigation, as indicated.) 2. Notify the DDA regional office which agency will investigate. 3. If OHCQ investigates, investigation must be completed, whenever possible, within 45 calendar days and the written report with findings and conclusions submitted to the DDA regional office within 3 working days of completion.	1. Assure that agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	An unexpected and/or unplanned hospital admission for a medical or a psychiatric problem of an individual whose IP **documents** a need for frequent/repeated hospitalizations because of a chronic condition must be internally investigated and the agency/SRC must complete an Appendix 7 form for their files, e.g., neurological, mental health, respiratory, cardiac, impaction An emergency room visit that does not result in a hospital admission and /or may be the result of a* mild or* mild/ moderate injury must be internally investigated and the agency/SRC must complete an Appendix 7 form for their files. **Refer to Appendices 1E and 2E*

Appendix 2E

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
INJURY	OHCQ, DDA regional office, family/legal guardian/ advocate(s), case manager/resource coordinator, State protection and advocacy agency (MDLC). SRCs must also report incident to Resident Grievance System (RGS).	Appendix 4 – must be received by OHCQ, State protection and advocacy agency (MDLC), and the DDA regional office within 1 working day of discovery. Appendix 7 must be received by OHCQ, State protection and advocacy agency (MDLC), and DDA regional office within 21 working days of discovery.	1. Evaluate the Agency/SRC's initial and/or written report and determine whether OHCQ will investigate. (OHCQ may refer the matter to other agencies, e.g., law enforcement, protective services, etc., initially or at any time during their review and/or investigation, as indicated.) 2. Notify the DDA regional office as to which agency will investigate. 3. If OHCQ investigates, investigation must be completed, whenever possible, within 45 calendar days and the written report with findings and conclusions submitted to the DDA regional office within 3 working days of completion.	1. Assure that Agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	1. Any injury that results from a suspected or confirmed abuse, whether or not it results in a hospitalization, should be reported as an incident of abuse. 2. Any injury that results from a suspected or confirmed neglect, whether or not it results in a hospitalization, should be reported as an incidence of neglect. 3. As part of the internal quality assurance plan, an annual report must be sent to DDA from the Agency/SRC which documents injuries of unknown origin, identifies and analyzes trends and outlines a plan of action to reduce or eliminate the possibility of similar future injuries.

Appendix 2F

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
Incident, including a crime, reported to/requiring services of a law enforcement agency or a fire department	OHCQ, DDA regional office, family/legal guardian/advocate(s), case manager/resource coordinator. If incident is the result of abuse or neglect, MDLC must be notified. SRCs must also report incident to Resident Grievance System (RGS).	Appendix 4 - must be received by OHCQ and the DDA regional office within 1working day of discovery. Appendix 7 – must be received by OHCQ and DDA regional office within 21 working days of discovery**.**	1. Evaluate the Agency/SRC's initial and/or written report. Determine whether law enforcement agency, fire department or OHCQ will investigate. (OHCQ may refer the matter to other agencies at any time during their review and/or investigation as indicated.) 2. Notify the DDA regional office as to which agency will investigate. 3. If OHCQ investigates, investigation must be completed, whenever possible, within 45 calendar days and the written report with findings and conclusions submitted to the DDA regional office within 3 working days of completion.	1. Assure that Agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	1. The Agency/SRC must submit to OHCQ the police report # or preferably the report if received. 2. The Agency/SRC must submit to OHCQ the report from the Fire Marshall, if received.

Appendix 2G

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
Suspected or confirmed theft or misuse of an individual's property or funds valued at $50 or more per incident or $100 or more over the course of a 30 day period.	Law enforcement agency, OHCQ, DDA regional office, family/legal guardian/advocate(s), case manager/resource coordinator. If theft or misuse of an individual's property or funds is the result of abuse or neglect, MDLC must be notified. SRCs must also report incident to Resident Grievance System (RGS).	Appendix 4 - must be received by OHCQ and the DDA regional office within 1 working day of discovery. Appendix 7 - must be received by OHCQ and DDA regional office within 21 working days of discovery.	1. Evaluate the Agency/SRC's initial and/or written report. Determine whether law enforcement agency or OHCQ will investigate. (OHCQ may refer the matter to other agencies at any time during their review and/or investigation as indicated.) 2. Notify the DDA regional office as to which agency will investigate. 3. If OHCQ investigates, investigation must be completed , whenever possible, within 45 calendar days and the written report with findings and conclusions submitted to the DDA regional office within 3 working days of completion.	1. Assure that Agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	

Appendix 2H

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
Medication Error	OHCQ, DDA regional office, family/legal guardian/advocate(s), case manager/resource coordinator, State protection and advocacy agency (MDLC) . SRCs must also report incident to Resident Grievance System (RGS).	Appendix 4 – must be received by OHCQ, State protection and advocacy agency (MDLC), and the DDA regional office within 1 working day of discovery. Appendix 7 – must be received by OHCQ, State protection and advocacy agency (MDLC), and DDA regional office within 21 working days of discovery.	1. Evaluate the Agency/SRC's initial and/or written report and determine whether OHCQ will investigate. (OHCQ may refer the matter to other agencies, e.g., law enforcement, nursing board, as indicated, initially or at any time during their review and/or investigation, as indicated.) 2. Notify the DDA regional office as to which agency will investigate. 3. If OHCQ investigates, investigation must be completed, whenever possible, within 45 calendar days and the written report with findings and conclusions submitted to the DDA regional office within 3 working days of completion.	1. Assure that Agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	1. All medication errors, whether or not there are effects, must be reported to the Agency/SRC licensed heath care practitioner for his/her review. 2. Any medication error that results in the admission of an individual to a 24-hour infirmary or a hospital for observation and/or treatment should be reported as a medication error.

Appendix 2I

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
Leave without notification (elopement)	Law enforcement, OHCQ, DDA regional office, family/legal guardian/advocate(s), case manager/resource coordinator. If elopement is the result of abuse or neglect, MDLC must be notified. SRCs must also report incident to Resident Grievance System (RGS).	Appendix 4 – must be received by OHCQ and the DDA regional office within 1 working day of discovery. Appendix 7 – must be received by OHCQ and DDA regional office within 21 working days of discovery.	1. Evaluate the Agency/SRC's initial and/or written report and determine whether OHCQ will investigate. (OHCQ may refer the matter to other agencies, e.g., protective services, law enforcement, etc., initially or at any time during their review and/or investigation, as indicated.) 2. Notify the DDA regional office as to which agency will investigate. 3. If OHCQ investigates, investigation must be completed, whenever possible, within 45 calendar days and the written report with findings and conclusions submitted to the DDA regional office within 3 working days of completion.	1. Assure that Agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	If elopement is result of abuse or neglect, it must be reported as abuse or neglect. The agency shall contact the DDA triage staff at OHCQ upon the individual's return to the program or the home.

Appendix 2J

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
Restraints **-Unauthorized/ inappropriate use of restraints** **-Chemical intervention that is not considered a chemical support.** **- Use of restraints that result in any type of injury**	OHCQ, DDA regional office, family/legal guardian/advocate(s), case manager/resource coordinator, State protection and advocacy agency (MDLC) . SRCs must also report incident to Resident Grievance System (RGS).	Appendix 4 – must be received by OHCQ, State protection and advocacy agency (MDLC), and the DDA regional office within 1 working day of discovery. Appendix 7 must be received by OHCQ, State protection and advocacy agency (MDLC), and DDA regional office within 21 working days of discovery.	1. Evaluate the Agency/SRC's initial and/or written report and determine whether OHCQ will investigate. (OHCQ may refer the matter to other agencies, e.g., protective services, law enforcement, initially or at any time during their review and/or investigation, as indicated.) 2. Notify the DDA regional office as to which agency will investigate. 3. If OHCQ investigates, investigation must be completed, whenever possible, within 45 calendar days and the written report with findings and conclusions submitted to the DDA regional office within 3 working days of completion.	1. Assure that Agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	**INTERNALLY REVIEWED INCIDENTS: PLANNED USE OF RESTRAINTS:** 1. As an internally reviewed incident, each occasion of planned restraint use, as part of an approved behavior plan, must be documented in the individual's record. All documentation must contain, at a minimum, the individual's name, date of restraint use and type of restraint used. 2. If a physical intervention is used documentation must also include the reason for the restraint use and the length of time used. 3. If a mechanical device is used documentation must also include a record of: a)staff checks of the individual every 15 minutes; b)staff escorting the individual to the bathroom and offering of fluids at least every two hours; c) staff providing the individuals the opportunity for motion and exercise for a period of not less than 10 minutes during each 2 hours in which the restraint is used; d) staff providing the individual meals at regularly scheduled hours; e) review by a licensed health care practitioner who authorized the use of the mechanical device at a minimum of every 90 days documenting the effectiveness and whether continuation is indicated. 4. The Community Agency/SRC shall submit their internal reviews of planned use of restraints to their standing committees for review at least quarterly. 5. The Community Agency/SRC shall document on the Appendix 5, Quarterly Incident Report for Internally Investigated/Reviewed Incidents and submit to OHCQ and the DDA Regional Office, the type of restraint used for each individual and the number of times the restraint was used during that quarter. If an individual's behavior plan utilized more than one type of restraint each type of restraint would be listed and the number of times that each restraint was used would be listed for that individual. 6. Additionally, for planned use of restraints only, the Community Agency/SRC shall submit a copy of the standing committee's review of planned restraint use, with the Appendix 5, Quarterly Incident Report for Internally Investigated/Reviewed Incidents, for each individual that required the use of planned restraint during that quarter.

Appendix 2J (Cont)

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
Restraints: **-Unauthorized/ inappropriate use of restraints** **-Chemical intervention- that is not considered a chemical support** **-Use of restraints that result in any type of injury**	OHCQ, DDA regional office, family/legal guardian/advocate(s), case manager/resource coordinator, State protection and advocacy agency (MDLC) . SRCs must also report incident to Resident Grievance System (RGS).	Appendix 4 – must be received by OHCQ, State protection and advocacy agency (MDLC), and the DDA regional office within 1 working day of discovery. Appendix 7 must be received by OHCQ, State protection and advocacy agency (MDLC), and DDA regional office within 21 working days of discovery.	1. Evaluate the Agency/SRC's initial and/or written report and determine whether OHCQ will investigate. (OHCQ may refer the matter to other agencies, e.g., protective services, law enforcement, initially or at any time during their review and/or investigation, as indicated.) 2. Notify the DDA regional office as to which agency will investigate. 3. If OHCQ investigates, investigation must be completed, whenever possible, within 45 calendar days and the written report with findings and conclusions submitted to the DDA regional office within 3 working days of completion.	1. Assure that Agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	**CHEMICAL SUPPORTS:** Chemical supports are the use of medication as an intervention to support an individual for a medical appointment that would not typically require sedation. The use of chemical supports must be approved by the team as part of an individual's plan and reviewed and approved by the standing committee. 1. The rationale for utilizing chemical supports must be documented. 2. The team must ensure that the chemical support is the lowest effective dose and is only being implemented after other methods have been systematically tried and objectively determined to be ineffective. This must be done before the team can approve the use of a chemical support. 3. The team must specify the type of medical appointment(s) for which the chemical support(s) have been approved and the name of the LHCP who has approved the chemical support. 4. The licensed health care practitioner must review any chemical support that has been prescribed at a minimum of every ninety days. 5. The licensed health care practitioner must document that the possible outcomes of continually missed medical appointments or lack of treatment outweighs any potential side effect from the chemical support Each occasion of the use of a chemical support for a medical appointment, must be documented in the individual's record. All documentation must contain, at a minimum, the individual's name, the date chemical support was used, the type of chemical support used, the individual's response to the chemical support and what are the potential side effects of the chemical support. The appointment for which it was used. Whether the chemical support is successfully accomplishing the purpose for which it is approved.

Appendix 2K

REPORTABLE INCIDENT	REPORT TO	TIME FRAMES	RESPONSIBILITIES OF OHCQ	RESPONSIBILITIES OF DDA REGIONAL OFFICE	OTHER AGENCY/SRC REQUIREMENTS
Other – examples: Suicide threat/attempt An outbreak of a communicable disease Family/domestic issues that overflow into community agency/SRC	OHCQ, DDA regional office, family/legal guardian/advocate(s), case manager/resource coordinator. If incident is the result of abuse or neglect, MDLC must be notified. SRCs must also report incident to Resident Grievance System (RGS).	Appendix 4 – must be received by OHCQ and the DDA regional office within 1 working day of discovery. Appendix 7 – must be received by OHCQ and DDA regional office within 21 working days of discovery.	1. Evaluate the Agency/SRC's initial and/or written report and determine whether OHCQ will investigate. (OHCQ may refer the matter to other agencies, e.g., protective services, law enforcement, initially or at any time during their review and/or investigation, as indicated.) 2. Notify the DDA regional office as to which agency will investigate. 3. If OHCQ investigates, investigation must be completed, whenever possible, within 45 calendar days and the written report with findings and conclusions submitted to the DDA regional office within 3 working days of completion.	1. Assure that Agency/SRC complies with reporting and investigating requirements. 2. At the discretion of the Regional Director and in coordination with OHCQ, assist in investigating incident and/or conduct inquiries in addition to those of OHCQ and/or other agencies, and/or refer the matter to additional agencies, as indicated.	Communicable diseases have additional reporting requirements beyond the scope of this policy. Additional reporting requirements can be found at the Office of Epidemiology & Disease Control Program's website: http://www.edcp.org

Appendix 3

Memo

To: All Providers

From: Gwen Winston
Statewide Quality Assurance Chief

Date: February 6, 2003

Re: Reporting All Deaths in State Funded/Operated Facilities

This memo summarizes the January 4, 1999 memo circulated by John E. Smialek, MD, Chief Medical Examiner outlining the requirement of reporting deaths in State-funded or State-operated facilities. In his memo, Dr. Smialek states that "ALL deaths of residents in these facilities are to be reported to the Office of the Chief Medical Examiner immediately". It is imperative that notification to the Medical Examiner be made immediately after death to provide the Examiner's Office with time to determine the need for autopsy. For additional information on this requirement, please refer to COMAR 10.35.01.18 which is attached.

If you should have any questions about the above information, please do not hesitate to contact me at 410-767-5630 or the Medical Examiner's Office at 410-333-3225. The Medical Examiner's Office can be reached 24 hours per day. Thank you for your continued cooperation in this reporting requirement.

cc: Diane Coughlin, Director/DDA
William Dorrill, Deputy Director/OHCQ
David Fowler, MD/Chief Medical Examiner
Regional Directors

Appendix 3A

COMAR 10.35.01.18 Deaths in a State-Funded or State Operated Facility.

A. Death in a State-funded or State-operated facility which constitutes a medical examiner's case, as defined in Health-General Article, §5-309, Annotated Code of Maryland, shall be investigated by the Office of the Chief Medical Examiner.

B. Notification and Investigation. The sheriff, police, or chief law enforcement officer, in the jurisdiction where a death occurs, shall notify the medical examiner whenever a death that constitutes a medical examiner's case occurs in a State-funded or State-operated facility. If the death may have occurred by violence, by suicide, by casualty, suddenly when the person was in apparently good health, not attended by a physician, or in any suspicious or unusual manner, the medical examiner or investigator shall:
   (1) Respond directly to the administrative head of the facility;
   (2) Conduct an investigation;
   (3) Complete the investigation report; and
   (4) Arrange to have the body sent to the Office of the Chief Medical Examiner for an autopsy, if necessary.

C. Completion of Investigation Report.
   (1)A medical examiner or investigator shall document in an investigation report all of the information regarding the death that was:
      (a) Gathered in the course of the investigation; and
      (b) Provided by the administrative head of the facility to the sheriff, police, chief law enforcement official, or health officer in the jurisdiction where the death occurred.
   (2) A medical examiner or investigator shall append to an investigation report the written report of the death that the administrative head of the facility provided to the sheriff, police, chief law enforcement official, or health officer in the jurisdiction where the death occurred.
   (3) Required Contents of Report. The report of the administrative head of a facility where the death occurred shall contain all the information set out in Health-General Article, § 10-714, Annotated Code of Maryland. The report:
      (a) May be oral, if followed by a written report within 5 working days from the date of the death, or written; and
      (b) Shall contain the following relevant information:
         (i) The name, age, and sex of the deceased,
         (ii) The time of discovery of the death,
         (iii) The deceased's place of residence at the time of death,
         (iv) If the death occurred in a place other than the residence of the deceased, the location of the body at the time of discovery,
         (v) The place where the body was found,
         (vi) The name of the person who took custody of the body,
         (vii) The name of the person evaluating the death, if known,
         (viii) Whether an autopsy is being performed, if known,
         (ix) The name, address, and telephone number of the next of kin or legal guardian, if known, and
         (x) Other information the administrative head of the facility determines should be provided to the medical examiner.
   (4) The report of the investigation by the Office of the Chief Medical Examiner constitutes an individual file of the Chief Medical Examiner not subject to disclosure under State Government Article, § 10-611 et seq., Annotated Code of Maryland

State of Maryland, Department of Health and Mental Hygiene
Developmental Disabilities Administration
Incident Reporting Form

Appendix 4

A) Was more than one individual involved in this incident? ☐Y ☐N. If Yes, submit a separate Appendix 4 for each individual. In o to link all individuals in one incident, please provide the name and Social Security number for each additional individual involved i space provided below. (If more than 3 please attach additional page)

1)	2)	3)

I) Individual #1

Name:		Sex: ☐M ☐F
Address:		DOB: / /
City:	State:	Zip:
Individual's social security number: / /		
Date and time incident occurred: / /	at : ☐AM ☐PM (Check One)	
If different, when was incident discovered: / /	at : ☐AM ☐PM (Check One)	
# of individuals present at the time of incident:	# of staff present at time of incident:	
Address where incident occurred, if different from individual's address:		
Is the address where incident occurred a DDA licensed site/service? ☐Y ☐N		

II) Agency Information ***Name:***

OHCQ Provider #:	Date Of Report: / /
OHCQ Site #:	Time of Report: : ☐AM ☐PM (Check One)
What type of program/service is provided for this individual? ☐Community Residential ☐Day – Rehab ☐OCYF	
☐Other ☐Transportation ☐SRC ☐FISS ☐Medical day ☐Vocational ☐CSLA ☐IFC	
Is this a DDA licensed site? ☐Y ☐N	

III) Agency Contact Person

Name:	Title/Relationship:	
Address:		Phone #: ( ) -
City: St: Zip: Fax #: ( ) -		
Email Address: @		

IV) Type of Incident: Check only the primary incident category that indicates the suspected or known cause of the incident: (See section V below if selecting abuse)

☐ ER visit due to a severe injury	☐ Medication error requiring treatment
☐ Unplanned hospital admission	☐ Medication error requiring hospital admission
Name of Hospital**:**	☐ Severe injury
☐ Neglect	☐ Leave w/o notification (individual in immediate danger)
☐ Theft of individual's property (> $50)	☐ Leave w/o notification (absent ≥ 4 hours)
☐ Police Dept. visit w/ report taken	☐ Fire Dept. visit
☐ Unauthorized/inappropriate use of restraints	☐ Chemical intervention
☐ Use of restraints that result in any type of injury	
☐ Other-**explain:**	

V) For abuse: This incident involves:

☐ ***Staff and individuals OR***
☐ ***Two or more individuals***

Indicate Primary Category:

☐ Physical abuse	☐ Use of aversive technique	☐ Inhumane treatment	☐ Seclusion
☐ Sexual abuse	☐ Psychological abuse	☐ Violation of an individual's rights	

VI) In cases of Death: Location of death:

DOD: / /	Was the death a result of unusual, suspicious or unnatural causes? ☐Y ☐N
Was death reported to a local law enforcement agency? ☐Y ☐N	Was hospice involved? ☐Y ☐N
Has an autopsy been requested? ☐Y ☐N	Was death anticipated? ☐Y ☐N
Was medical examiner's office notified? ☐Y ☐N	
Was EMT unit involved? ☐Y ☐N If yes, identify unit:	

OHCQ USE ONLY

Received date: / / Time :	OHCQ investigation #:
Date incident # given to agency: / /	Triage staff Initials:

Rev: 4/2005

DDA Incident Reporting Form #

VII) Briefly describe the circumstances of the incident: (Be certain to include effects on person involved and any other pertinent information that will assist in assessment)

VIII) Briefly describe status of individual at the time of report: (Including any medical treatment needs if known)

IX) Witnesses to the incident:		
Name (Last, First)	**Address**	**Phone #**
		( ) -
		( ) -
		( ) -

X) Please list all staff on duty at time of incident: **(Use additional pages if necessary)**	
Name	**Job Title**

XI) Notifications: Please list persons notified: (Use additional pages if necessary)		
Family		
Does individual have family? ☐Y ☐N	Is family involved with individual? ☐Y ☐N	
If individual has family, when were they notified? / / at ☐AM ☐PM (check One)		
Has advocate, other than family been notified? ☐Y ☐N		
Law Enforcement		
Was this incident reported to a law enforcement agency? ☐Y ☐N		
If yes: Officer's name:	Jurisdiction:	Report #:

Name	Relationship/Agency	Date
	Resource Coordinator	/ /
	DDA Regional Office	/ /
	OHCQ	/ /
	*MDLC	/ /
	**CPS/APS	/ /
	Other	/ /

* The following must be reported to MDLC: All Deaths, Hospital Visits, Medication Errors, Reportable Restraint Use, Reportable injury and any incident that may be the result of abuse or neglect.
**Incidents must be reported to CPS/APS per: Irregular situations - section 1A and Appendix 2A – Sections 6 & 7 of Other Agency/SRC requirements

XII) Agency/SRC staff person completing this form: (Please print)

Appendix 5
4/2005

For DDA & OHCQ Use Only
Date Received:
Provider #:

Quarterly Incident Report

for Internally Investigated/Reviewed Incidents

This form is to be submitted to OHCQ and DDA within 15 days of the end of each quarter of the fiscal year (Oct 15, Jan 15, April 15, and July 15). Each line on the form represents one internally investigated incident. Incidents should be listed chronologically. A full incident report must be completed for all internally investigated incidents as detailed in the policy and maintained on file for review by DDA and/or OHCQ personnel.

Agency Name:

Fiscal Year :
Quarter Ending : ☐Sept ☐Dec ☐Mar ☐June

Address:

Phone #: - -
Executive Director:

Individual's Name	Individual's SSN	Individual's Address	Date	Time	Type of incident *#	Location where incident occurred (unless same as column 3)

*** Categories of Internally Investigated Incidents are Physical Agression, Injury, Theft, Medication Error, Leave Without Notification-<4hrs, Hospital Treatment for chronic Condition and Emergency Room Visit not resulting in Hospital Admission and/or the result of Level I or II injury.**
#Category of Internally Reviewed Incident is planned use of restraint. Include the number of times each restraint was used during this period. Attach a copy of your Standing Committee's review for each individual. / /

Appendix 6

PRIORITIZATION PROTOCOL FOR INCIDENTS OF ABUSE, NEGLECT, SERIOUS INJURY, MEDICATION ERROR, DEATH AND COMPLAINTS

A. Purpose.

(1) The purpose of the Prioritization Protocol for Reportable Incidents of Abuse, Neglect, Serious Injury, Medication Errors, Death, and Complaints is to outline the reportable incident screening and prioritization process for these types of events; delineate the roles and responsibilities of the Office of Health Care Quality (OHCQ), Developmental Disabilities Administration (DDA), and any other entities involved in investigations; establish timelines for the investigation and issuance of reports related to certain specified reportable incidents; and, identify the procedures for monitoring the implementation of plans of correction.

(2) This protocol augments the DDA's *Policy on Reportable Incidents and Investigations* (PORI) and the OHCQ's *Incident Screening Committee Guidelines*. The protocol provides insight into how reportable incidents are reviewed, evaluated and prioritized for investigation. The protocol does not include procedures to be followed when an incident or complaint is referred to another unit within OHCQ or appropriate external agency.

(3) The OHCQ investigates reportable incidents, events or problems involving an individual in a community agency or state residential center based on their scope and severity. The OHCQ and DDA have the prerogative and authority to investigate any incident, including those which are not reported to OHCQ and/or DDA.

B. Incident Screening Process.

(1) All licensed providers and state residential centers are required to identify, report, investigate, review, correct and monitor any event that threatens the health, safety or well-being of individuals receiving services. Licensee requirements for the submission of reportable incidents to DDA and OHCQ are outlined in DDA's PORI, under "General Requirements" and under "Appendices 1 and 2", which are incorporated by reference.

(2) Provider self reported incidents and complaints are reviewed upon receipt by OHCQ to ensure that those incidents posing immediate jeopardy to the individual are immediately investigated. This decision making process is not dependent upon the Incident Screening Committee (ISC). A triage specialist reviews each report and notifies the DD Investigations Unit manager of the need to evaluate the report for appropriate assignment based upon the severity and scope of the incident. (See Section C.)

(3) The ISC, at OHCQ, meets weekly to review all self reported incidents or complaints that have not been acted upon. The ISC takes into account the many factors as appropriate when reviewing incidents, such as:

(a) Did the individual receive needed intervention and health care in a timely manner?
(b) Did the licensee's staff competently respond to the incident?
(c) Is there any indication that regulations have been violated?
(d) Is there any evidence of a pattern of abuse or neglect?
(e) Is there a pattern of this incident type being reported by the licensee?
(f) What is the provider's incident reporting and investigation track record?

(g) Does the individual's incident history add to the impact of the incident under review?
(h) Is the licensee currently under sanctions?
(i) Does the situation indicate an on-going threat to the individual?
(j) What is the extent or severity of the incident or injury?

In addition, the ISC takes into consideration the number and frequency of serious reportable incidents or complaints reported by the licensee and the quality of the licensee's internal investigations.

(4) When an incident is alleged to have occurred outside of a site or service licensed by DDA, the ISC refers it to the appropriate entities or jurisdictions for their review and investigation. Incidents that could involve possible criminal prosecution are referred to the OHCQ Patient Abuse Unit (PAU). Incidents involving sexual and physical abuse often fall into this category. When indicated, the PAU refers incidents to the Attorney General's Medicaid Fraud Control Unit for consideration of filing criminal charges. When an incident involves legal issues for the individual, the ISC refers it to the Maryland Disability Law Center (MDLC).

C. Incident Prioritization and Guidelines for Investigation.

(1) The ISC assigns a priority level based on the following:

Priority Level	Priority Description	Classification Criteria to Determine Priority Level of Incident	Response Time
1 *ACTs-A*[1]	Immediate Jeopardy	Definition: The incident presents an immediate and serious threat of injury, harm, impairment or death of an individual. Examples of immediate jeopardy may include: fires; second and third degree burns; lack of food, medication or treatment; serious medication errors; status epilepticus; poor diabetic care or, suicide attempts.	OHCQ will initiate, whenever possible, a on-site investigation within 2 working days of receipt.[2]
2 *ACTs-B*	High	Definition: The incident presents a situation where a serious threat exists to the individual's health and/or safety or harm that significantly compromises an individual physical and/or mental health. Examples of a high priority incident may include: being hit with an object; denied assistance with activities of daily living; or obtained suspicious injury.	OHCQ will initiate, whenever possible, an on-site investigation within 4 working days of receipt.

[1]Aspen Complaint Tracking System (ACTs) Program Code.
[2] Most investigations will be initiated on-site by a surveyor. However, there may be emergent occasions where a telephone call is the most efficient way to initiate an investigation and protect consumers.

3 *ACTs-C*	Other Harm	Definition: The incident involves a situation or presents an opportunity for harm that did not affect or would minimally affect an individual's physical and/or mental health. Examples of other harm may include: certain rights violations; lack of appropriate programs; and use of certain aversive techniques.	OHCQ will initiate, whenever possible, an on-site investigation within 30 working days.

Priority Level	Priority Description	Classification Criteria to Determine Priority Level of Incident	Response Time
4 *ACTs-H*	Administrative Review	Definition: The incident presents minimal risk for harm or no harm and an on-site investigation is not necessary. A provider submits an Appendix 4 that indicates situation has been addressed through the implementation of corrective and preventive measures.	OHCQ will include these incidents when preparing for the agency's annual survey. The Appendix 7 Report is reviewed by the DDA Regional Office. The Regional Office will notify the OHCQ within 5 working days of the receipt of any additional information that may require the OHCQ re-evaluate or investigate the incident.
5 *ACTs-F*	Referrals	The incident involves a situation or presents and opportunity where sexual abuse is suspected, physical abuse with severe injuries, theft, other criminal issues, issues that may require legal advocacy or the incident is outside of the OHCQ jurisdiction. Referrals may be made on an immediate jeopardy basis.	OHCQ will make referrals, whenever possible, within 1 working day to appropriate internal unit or appropriate agency for follow-up.
6 *ACTs-G*	Death	The incident involves the death of an individual.	Within 1 working day, whenever possible, the OHCQ will refer the incident to the Mortality Review Unit for review and investigation.

(2) When a provider or SRC reports three or more incidents that involve the same individual within a four week period, OHCQ will determine, based upon the provider's compliance history and nature of the incidents, whether an on-site investigation is warranted. If an on-site investigation is warranted, a priority level will then be assigned.

(3) All deaths are immediately referred to the OHCQ Mortality Investigation Unit for review and investigation. The OHCQ Mortality Investigation Unit conducts investigation using its own policies and procedures and submits its findings to the Mortality Review Committee and to OHCQ. The DHMH Mortality Review Committee is independent of OHCQ and reviews the investigations of all deaths of individuals that occur in DDA licensed settings and services.

D. Roles and Responsibilities:

(1) During the investigation of an incident an OHCQ surveyor reviews the Agency Investigation Report (AIR), if already completed, and related documentation. The surveyor(s) will make his or her best effort to interview all persons with knowledge of the incident, including, but not limited to: the individual receiving services, her/his guardian or family member(s), the agency's direct care and administrative staff who were involved in the incident, etc. The surveyor also makes direct observations of the individual in her/his environment. When possible, evidence is corroborated between interviews, record reviews, and observations. Deficiencies are, to the extent practicable, cited at an exit conference held upon completion of the on-site investigation.

(2) The OHCQ may require a provider, depending on the severity of the incident, to make immediate correction to ensure the health and safety of the individual.

(3) When an investigation results in deficiencies, the agency's Plan of Correction (POC) is due to the OHCQ within 10 working days of the exit conference. The POC due date may be sooner than 10 working days when the nature of the deficiency warrants a more immediate response. The surveyor reviews the POC to: verify that all deficiencies have been addressed, review proposed corrective and preventative measures for appropriateness, and determine if responsible parties have been identified. POC are reviewed, to the extent practicable, by the surveyor within a week of its receipt.

(4) If a POC is deemed unacceptable, the OHCQ will send notice to the agency in writing, whenever possible, within 5 working days of review of the issues which require further review and consideration. The agency must submit a revised POC to OHCQ within five working days of receipt of notification that a POC is not accepted. The surveyor reviews the revised POC with procedures outlined in number three. These timeframes may be extended upon request with good cause shown.

(5) If the POC is accepted, OHCQ will send the Statement of Deficiency (SOD) and the approved POC, whenever possible, within 10 working days to the:

- Licensee;
- Complainant;
- Agency's Executive Director and Board President;
- DDA Regional Office;
- Maryland Disability Law Center;
- Medicaid Fraud Control Unit of the Attorney General's Office, if appropriate;
- Office of the Inspector General, if appropriate; and
- Any other parties deemed appropriate by the OHCQ.

(6) The licensee shall provide a copy of the SOD and the POC to the individual receiving services who is specifically the subject to the deficient practice, or to their resources coordinator, guardian or family as appropriate.

(7) The SOD and POC are also sent to any requesting party under the Public Information Act. In addition, the DDA Regional Office Representative and the MDLC Representative may receive a copy of the Investigation Summary completed by the OHCQ investigator when deficiencies are not cited. This summary is not a public document pursuant to the Md. Code Ann., Health Occ. Art., 1-401(a)(3) and may not be redisclosed.

E. Follow-Up Procedures.

(1) The DDA Regional Quality Assurance Teams conduct site visits, review quality assurance plans and provide technical assistance to agencies. These activities are designed to improve the agency's quality assurance plan and procedures to ensure that systems are in place for preventing the reoccurrence of incidents or patterns of deficiencies within an agency.

(2) The Regional Quality Assurance Teams review Appendix 4 and Appendix 7 and determine what follow-up from the Regional Office is appropriate, for example: no further action required, contact the agency, conduct an on-site visit, or discuss the need for further investigation with OHCQ. The Regional Office will notify the OHCQ within 5 working days of the receipt of any additional information that may require the OHCQ re-evaluate or investigate the incident or complaint.

(3) The OHCQ will conduct follow-up monitoring for all level one incidents and identify a 10-percent targeted sample taken from the level two incidents to be completed within six months of approval of the POC to determine whether or not the agency has implemented the POC. The OHCQ will identify the targeted sample based on criteria which include, but are not limited to: provider history, severity of the incident, and investigator recommendation.

F. Information Sharing.

(1) OHCQ will forward information to MDLC as required by law or on request.

(2) The DDA and OHCQ will have quarterly meetings with the region staff to facilitate the exchange of pertinent information.

(3) The DDA, OHCQ and MDLC will have quarterly meetings to facilitate the exchange of pertinent information.

(4) The OHCQ, DDA, providers and advocates will meet annually to share information and trends found during the survey process.

Appendix 6: The "*Prioritization Protocol for Incidents of Abuse, Neglect, Serious Injury, and Medication Error"* was implemented and made effective by OHCQ on August 1, 2006.

Appendix 7

State of Maryland, Department of Health and Mental Hygiene
Developmental Disabilities Administration
Agency Investigation Report

I) Individual's Name:	**Sex:** ☐M ☐F	**OHCQ Incident#**
Address:		**DOB:** / /
City:	**State:**	**Zip:**
Individual's social security number: / /		
Date and time incident occurred: / /	**at** : ☐**AM** ☐**PM** (Check One)	
If different, when was incident discovered: / /	**at** : ☐**AM** ☐**PM** (Check One)	
# of individuals present at the time of incident:	**# of staff present at time of incident:**	
Address where incident occurred, if different from individual's address:		
Individual's level of supervision as indicated in the IP:		
Individual's level of supervision at the time the incident occurred:		
II) Agency Name:		
Date of Appendix 7 Report: / /	**Time of Report**: : ☐**AM** ☐**PM** (Check One)	
Agency's contact person for this report:	**Title/Relationship:**	
Phone #: ( ) - ext.	**Fax #:** ( ) - ext.	**Email Address:** @

III) Type of Incident:		☐ ***Reportable***	
☐ ER visit due to a severe injury		☐ Severe injury	
☐ Neglect		☐ Theft of individual's property (> $50)	
☐ Unplanned hospital admission: Name of Hospital		☐ Unauthorized/inappropriate use of restraints	
☐ Police Dept. visit w/ report taken and/or individual is safety risk: Police report #		☐ Use of restraints that result in any type of injury ☐ Fire Dept. visit	
☐ Chemical intervention		☐ Medication error requiring treatment and/or hospital admission	
☐ Leave w/o notification (absent ≥ 4 hours)		☐ Death	
☐ Leave w/o notification (individual in immediate danger)		☐ Other-explain:	
Abuse: (Select One) ☐ ***Staff and individuals***		☐ ***Two or more individuals***	
☐ Physical abuse	☐Use of aversive technique	☐ Violation of an individual's rights	
☐ Sexual abuse	☐ Psychological abuse	☐ Seclusion	☐ Inhumane treatment
☐ ***Internally Investigated***			
☐ Injury (mild/moderate)	☐ Physical Aggression	☐Leave w/o notification (<4 hours)	
☐ Police Dept visit – report not taken	☐ Theft (<$50	☐ ER visit due to mild or mild/moderate injury Name of Hospital:	
☐ Hospital treatment for chronic condition Name of Hospital:		☐ Medication error requiring R.N. Consult ☐ Other-explain:	

INVESTIGATION

IV) Briefly describe your understanding of the circumstances of the incident at the time of the initial report:

V) Describe how your understanding of the circumstances of this incident has changed since your initial report (if applicable):

VI) Describe the agency's immediate response to the incident. Was a team meeting held?

VII) Who was interviewed after the incident (list all including the individual, witnesses, staff and the employee who originally reported the incident) If the individual (s) involved are non-verbal how was the interview conducted? Include a discussion of your internal procedure for this type of incident, and whether staff followed the procedure. If not, please explain.

VIII) Describe how the investigation was conducted. Include a list of other parties involved in conducting the investigation and how was evidence obtained and handled.

IX) **Does this individual have a BP? If yes, are the behaviors monitored in the BP related to this incident? If No, is behavior intervention required?**

X) Describe any significant history, diagnosis, contributing events that may be relevant to this incident:

XI) Explain your findings and conclusion from this investigation. Were the allegations substantiated?

Appendix 7 – Cont.

RESULTS OF THE INVESTIGATION
XII) Describe the preventive measures implemented for this individual and each of the other individuals who were involved in this incident and briefly describe any recommendations to reduce the risk of re-occurrence of this type incident.
XIII) **Explain the corrective and/or disciplinary action that was/will be implemented for staff as a result of this incident**.
XIV) Describe the long term impact of this incident for this individual.
XV) List additional services or supports that will be needed for this individual as a result of this incident? Include the names of the person responsible for providing the service/support, current status of the service/support and projected completion date.
XVI) Other relevant information

THIS FORM IS TO BE ATTACHED TO THE APPENDIX 7 UPON COMPLETION BY THE STANDING COMMITTEE

Standing Committee Review: ***Date Scheduled*** / / ***Date Completed*** / /

1) Did the response to and investigation of this incident comply with agency policies and procedures? ☐ Yes ☐ No If No, Explain:

2) Did the agency's response to this incident comply with Comar Regulations? ☐ Yes ☐ No If No, Explain:

3) Does the incident data rule out the possibility of a pattern of this kind of incident at your agency? ☐ Yes ☐ No If No, Explain:

4) Are there quality assurance measures already in place to address this kind of incident? ☐ Yes ☐ No If No, Explain:

5) After a review of this incident the Standing Committee requests that the following action(s) be taken:

REQUESTED ACTIONS	RESPONSIBLE PARTY	DUE DATE FOR COMPLETION	DUE DATE FOR RETURN TO STANDING COMMITTEE

Name of Standing Committee Chairperson/Representative:

Signature of Standing Committee Chairperson/Representative: