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| **MONTCALM CARE NETWORK PROCEDURE 611 North State Street, Stanton, MI 48888**  |
| SUBJECT: Adverse Incidents Involving Recipients  | Section: 8928A  |
| Effective Date: May 27, 1997  | Revised Date: June 10, 2024 |
| Associated Resource: Quality |  |

This procedure applies to Montcalm Care Network (MCN) staff and contracted providers/ provider staff (identified in this procedure as “staff.”)

1. All staff present at the time of an incident will act immediately and within their level of competency to secure assistance and to provide comfort, care and protection to the injured or ill.
2. In the case of incidents involving damage to property, staff will immediately take steps to ensure the safety of those present and to prevent further damage.
3. Incidents shall be documented in compliance with MCN requirements.
4. The staff completing the Incident Report should give as much detailed information as possible regarding the nature of the incident, its precursors if known, and the interventions provided.
5. Incident Report forms must be completed and filed the day the incident occurred.
6. If an MCN employee intentionally omits pertinent information from the report or during the explanation, the employee will be subject to disciplinary action in accordance with personnel policies.
7. The staff involved in or observing the unusual incident will:
	1. Immediately verbally notify the supervisor of apparent serious injury/illness;
	2. Immediately verbally notify the Recipient Rights Officer of serious injury/illness, if there is a death, or if there are other rights concerns. This contact should be documented including the time and date of the contact;
	3. Complete the top half of an Incident Report (MDHHS-0044 or BCAL-4607) including: i Identifying information (Name, Case Number, Age, Sex);

ii Report date, time, agency name;

iii Dates, times, and locations of incidents, if known;

iv Recipients and staff or others involved and/or present;

v. A description of what happened, and actions taken by staff.

vi. Indication of whether there is an apparent physical injury.

* 1. If emergency medical or nursing care is needed, request that the emergency or other physician or nurse complete documentation of any emergency medical care provided to the recipient. This documentation should include a description and extent of the injury, care given, the date and time care was given, the signature and date of signature of the care provider. If a recipient is injured on MCN property or in the

course of receiving MCN direct-provided services, the medical provider is to bill MCN for the cost of services related to the recipient’s injury.

* 1. Give the completed Incident Report to the immediate supervisor as soon as possible, but in no case later than the end of the shift in which the incident occurred.
	2. When two (2) or more staff witness an incident requiring an Incident Report, one (1) report will be completed with all witnesses indicated on the form. Initials or case numbers will be used for other recipients witnessing the incident.
1. The supervisor will:
	1. Ensure all pertinent information, signatures, and staff actions are included on the Incident Report.
	2. Document all program or administrative action taken to remedy and/or prevent recurrence of the incident, if needed.
	3. Verbally notify the responsible clinical personnel if the incident requires immediate clinical intervention.
	4. Ensure initiation of a debriefing with appropriate individuals as soon as possible, as needed.
	5. For contracted providers, keep a copy of the Incident Report and file in an administrative file. The file should be made available to responsible clinical personnel during site visits for further review.
	6. Submit the Incident Report to the Recipient Rights Officer before the end of the next business day. Incident Reports may be hand-delivered, mailed, or faxed to the Office of Recipient Rights.
2. The Recipient Rights Officer will:
	1. Identify any potential recipient rights concerns and investigate further, if necessary.
	2. In the case of recipient death, complete a Recipient Death Review form (8928D).
	3. Forward a copy of the incident report to the Quality and Information Services Director, or designee, if a critical, risk, or sentinel event is suspected.
	4. Forward a copy of the incident report to the Environment of Care Committee Chairperson if a safety or security concern is suspected.
	5. Provide aggregated incident report data to the Recipient Rights Advisory Committee for review.
	6. Log each incident.
	7. File the report in a secure filing cabinet.
3. The Quality and Information Services Director, or designee, will:
	1. Identify if the event qualifies as a critical, risk or sentinel event.
	2. Provide the information regarding critical and sentinel events to the Medical Director, Clinical Director, or designee, for potential review by the Consumer Care Committee.
	3. Submit the event to the PIHP utilizing PIHP-designated processes. In the event where the consumer involved is receiving MCN services as paid by another CMH, the Quality Director/designee does not submit the event to the PIHP but will coordinate with the proper MCN staff to ensure the County of Financial Responsibility (COFR) is notified for their own reporting.
	4. Submit the critical and/or sentinel event to the PIHP or MDHHS utilizing defined PIHP/MDHHS reporting processes.
	5. Complete remediation processes consistent with the PIHP and MDHHS requirements and forms for incident reports regarding Emergency Medical Treatment or Hospitalization when incident involves injury or medication error, or when incident was reported outside the required timelines as specified in MDHHS Critical Incident Reporting and Event Notification Policy.

1. Each committee will review individual and/or aggregated incident report data and submit recommendations for improvement to the Quality Assessment and Performance Improvement Steering Committee, if necessary.
2. The Quality Director will submit an annual written analysis of all critical incidents to Steering Committee for review.
3. Incident Reports will not be maintained in the clinical record of a recipient. In accordance with the Michigan Mental Health Code, incident reports are information collected for peer review purposes, are confidential, and not subject to court subpoena.
4. Incident Reports will be kept for seven (7) years and then destroyed.

References/Legal Authority:

1. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Master Contract Attachment, Quality Assessment and Performance Improvement Programs for Specialty Prepaid Health Plans.
2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Master Contract PIHP Reporting Requirements for Medicaid Specialty Supports and Services Beneficiaries.
3. MDHHS Guidance on Sentinel Event Reporting
4. CARF Behavioral Health Standards, Section: Health & Safety Standards, Critical Events
5. Mid-State Health Network, Policy “Critical Events”