Unity House of Cayuga County Inc.
Policy and Procedure

Category: 1600 - General Policies

Policy: 09 - Incident Management Policy and Procedure

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Office Responsible for Development and Review of this Policy: Quality Improvement

I. Purpose:

Unity House of Cayuga County Inc. provides OPWDD, OMH, and OASAS services that empowers and enrich the lives of people diagnosed with an intellectual or developmental disability, mental health and substance use. This is accomplished by offering supports and services in an inclusive, person-centered environment. In addition, Unity House staff seeks to ensure the safety and well-being of all its residents and program participants.

II. Scope:

Applies to all employees of Unity House.

III. Policy:

It is the policy of Unity House of Cayuga Co. Inc. to identify, report, investigate and review all untoward events, situations, significant incidents and allegations of abuse to persons served in accordance with the Justice Center Regulations, OPWDD Part 624 and 625 regulations, OMH 524 regulations and OASAS 836 regulations. All information and investigative materials related to incidents will be handled in a confidential manner. This policy will be made known to all persons served, parents, guardians, correspondents or advocates; and to employees, Board of Directors, interns, volunteers, consultants and contractors upon admission/employment and annually. This will be done through training, and/or by providing a copy of the policy.

The purposes for reporting, investigating, reviewing, correcting and/or monitoring certain events or situations are to enhance the quality of care provided to persons who receive Unity House services and supports, to protect them (to the extent possible) from harm, and to ensure that such persons are free from mental and physical abuse.

IV. Procedure

The Protection of People with Special Needs Act (Justice Center):
The Protection of People with Special Needs Act (The Act) established the Justice Center on June 30, 2013.

The Act requires that their **Code of Conduct** must be read and signed by anyone who will have regular and substantial contact with any person who is receiving services or supports from facilities or providers covered by the Act. This includes OPWDD, OMH, and OASAS services provided at Unity House. The Code of Conduct represents a framework that will help custodians determine how to help people with special needs live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm. The Code of Conduct is reviewed and signed by all staff at their time of hire and annually thereafter.

Notice to Mandated Reporters identifies legal duties under the New York State Protection of People with Special Needs Act to report Abuse, Neglect and Significant Incidents involving vulnerable persons to the Vulnerable Persons' Central Register (VPCR), a 24/7 hotline operated by the Justice Center for the Protection of People with Special Needs, effective June 30, 2013. Custodians (employees, volunteers, interns, consultants, contractors and family care providers and operators of covered facilities and programs) having regular and substantial contact with people being served and Human Service Professionals must report to the VPCR abuse, neglect and significant incidents.

Whenever a Mandated Reporter has reasonable cause to suspect a Reportable Incident involving a vulnerable person, he or she is required to make a report to the VPCR immediately upon discovery. Immediately means "right away"; must be made to the VPCR within 24 hours. VPCR hotline number: 1-855-373-2122. Further questioning of individuals and witnesses should cease to allow the investigation to progress, maintain confidentiality and minimize discussion about the incident amongst persons involved and other program staff.

Safeguards/Protections: The individual's safety must always be the primary concern. The program must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect the individual from harm or abuse.

When appropriate, the employee, intern, volunteer, consultant, or contractor, alleged to have abused or neglected a person shall be removed from direct contact with, or responsibility for, all persons receiving services from the agency.

Agencies are required to report to law enforcement any time a custodian may have committed a crime against an individual receiving services.

Programs covered under The Act: Facilities and programs that are operated, certified, or licensed by OPWDD, OMH, OASAS, the Office of Children and Family Services (OCFS), Adult Homes licensed by DOH, and certain programs approved by the New York State Education Department (NYSED).

What Constitutes Abuse or Neglect?
The Act defines Abuse and Neglect in broad terms including both actual harm and the risk of harm.

Incident Management Training: Incident Management training, including all incident classifications, will be provided to all staff at their time of hire and annually thereafter.

Abuse and Neglect are defined by the Justice Center and apply to all programs covered under The Act.

Physical Abuse	Conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury by means of slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, corporal punishment, etc.
Sexual Abuse	Any sexual contact between an individual receiving services and a custodian of the program; whether or not the contact would constitute a crime.
Psychological Abuse	Any verbal or nonverbal conduct that may cause significant emotional distress to an individual receiving services. Example include: taunts, derogatory comments or ridicule, intimidation, threats or the display of a weapon.
Deliberate Inappropriate Use of Restraints	Use of restraint deliberately inconsistent with an individual's plan. Restraint will include manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person to freely move his or her arms, legs or body.
Use of Aversive Conditioning	Application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person. I.e.. Noxious odors, noxious tastes, blindfolds, withholding of meals, food in an unpalatable form.
Obstruction of Reports of Reportable Incidents	Conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of an individual; suppressing the reporting of the incident to the VPCR; intentionally making a false statement or intentionally withholding information; intentional failure of a supervisor to act on a report per the regulations; for a custodian, failing to report a reportable incident upon discovery.

Unlawful Use or Administration of a Controlled Substance	Administration by a custodian to a service recipient of a controlled substance without a prescription, or other medication not approved for any use by the FFDA. Also includes a custodian unlawfully using or distributing a controlled substance at the workplace or while on duty.
Neglect	The action, inaction, or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious impairment of the physical, mental, or emotional condition of a service recipient. This shall include: Failure to provide proper supervision that results in conduct between persons receiving services that would constitute abuse if committed by a custodian; Failure to provide adequate food, clothing, shelter, or medical, dental, optometric or surgical care; Failure to provide educational entitlements.

The Act defines a Significant Incident as an incident that is not abuse or neglect, but has the potential to result in harm to the health, safety, or welfare of a person receiving services. Significant Incidents are defined differently by each agency governed by the Act and they will be listed later in the policy.

Programs certified by OPWDD, OMH, and OASAS report reportable incidents to the Justice Center along with the all other appropriate parties. Non-certified programs report incidents to their governing agency and but do not report to the JC. All other aspects of notification, investigation and follow up remain the same.

All Reportable Incidents, including allegations of abuse and neglect, will be investigated. If an employee leaves employment prior to the conclusion of a pending investigation, the investigation shall continue until it is completed and for abuse/neglect allegations, a finding is made of substantiated or unsubstantiated.

One-on-One Interaction:
Most abuse occurs when an adult is alone with a service recipient. Our organization aims to minimize the risk involved in these situations – both for the individual and the staff. In one-on-one situations, staff should observe the following additional guidelines to manage the risk of abuse or false allegations of abuse:

- When meeting one-on-one with a service recipient, do so in a public place where you are in full view of others.
- Avoid physical affection that can be misinterpreted. Limit affection to pats on the shoulder, high-fives and handshakes.
- If meeting in a room (i.e. bathroom, bedroom) or office, leave the door open or move to an area that can be easily observed by others passing by.
- Inform other staff that you are alone with a service recipient and ask them to randomly drop in.
- Document and immediately report any unusual incidents, including disclosures of abuse, behavior problems and how they were handled, injuries, or any interactions that might be misinterpreted.

Off-Site Contact:
Some cases of abuse occur off-site. This may put staff at increased risk.
Activities to minimize risk:

- Taking groups of individuals on an outing
- Attending functions at an individual's home with the parents/guardians present
- Never taking an individual to the staff's home
- Doing activities in public places where you are in full view of others

How to report:
Call the VPCR at 1-855-373-2122, submit the report via web form, or use the JC App. The VPCR phone number is provided at all program sites.

What happens when a report is made to the VPCR?
Trained VPCR staff will take a full report over the phone or via a web form, or an app, and, based upon the information provided, will categorize the reportable incident (abuse, neglect, significant incident) and notify the appropriate SOA (State Operated Agency). The Justice Center will be responsible for ensuring that the reportable incident is investigated or reviewed by the appropriate entity.

What protections and liabilities do mandated reporters have?
Immunity from liability – the law grants immunity to Mandated Reporters and other reporters from any legal claims which may arise from a good faith act of providing information to the VPCR.

Protection from Retaliatory Personnel Action – The law prohibits an employer or agency from taking any retaliatory personnel action against a person as a result of a good faith act of providing information to the VPCR.

Confidentiality – The law provides protections against the disclosure of the reporter's identity subject to limited exceptions.

Failure to Report
Failure by a Mandated Reporter to report suspected Abuse or Neglect to the VPCR is a serious matter and possible consequences include administrative discipline, termination, civil liability and criminal prosecution.

How to Report Patient Deaths to the Justice Center:

- Call the JC Death Reporting Line at 1-855-373-2124 to make the initial report immediately upon discovery; and in no case more than 24 hours after discovery. All deaths must also be reported to the SOA.
- Death of a client of a State operated or licensed provider who was enrolled in or receiving services from the facility or program at the time of death or any patient death occurring within 30 days of discharged from the program must be reported to the JC and SOA.
- After the report is made to the JC, the information will be transferred to the State Operated Agency. The program must complete the *Report of Death to the Justice Center* within 5 days of the initial report to the JC. For OPWDD and OMH, this is done

through IRMA and NIMRS, respectfully. For OASAS, the hard copy form must be completed and faxed to the JC.
- If the death is the result of abuse/neglect, the incident must be called into the JC VPCR Hotline and called into the Death Reporting Line.
- Results of an autopsy, if available, must be submitted to the JC and OPWDD within 60 working days of discovery of the death.
- A death that did not occur under the auspices of an agency (died in his/her private home) must be reported in accordance with Part 625.

Incident Review Committee (IRC)

Composition: Per the PPSNA, IRC membership must *exclude* a provider's director (CEO), but must include, but not limited to:

- Member of the governing body (BOD)
- At least two professional staff. At least one profession staff must be a licensed health care practitioner (physician, physician's assistant, nurse practitioner, or RN)
- Other staff, including administrative staff
- Direct Support Professional
- Service Recipient
- Family/consumer/advocacy organization representative
- Psychologist is recommended
- OMH requires a physician on a regular membership or ad hoc basis. The physician shall participate in review of all medically related incidents.

Confidentiality: Members maintain confidentiality of protected health information (PHI) and receive HIPAA training.

Unity House's IRC meets one time each month to review all reportable incidents and 625 events/situations. They review the investigation report and/or follow up information regarding the incident/situation. The IRC ensures that all recommendations of the investigation are addressed and/or all corrective action is completed by ascertaining that necessary and appropriate corrective, preventive, remedial and/or disciplinary action has been taken to protect person receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences and to make written recommendations to their chief executive officer to correct, improve, or eliminate inconsistencies. IRC must ascertain if further investigation or if additional corrective, preventive, remedial, and/or disciplinary action is necessary, and if so, make appropriate written recommendations to the chief executive officer relative to the reportable incident or notable occurrence. Should the IRC recommend additional corrective measures or changes, this information will be communicated by the IRC Chairman to the appropriate Program Director. Their response to the recommendations is provided to the IRC at their next meeting. IRC will identify trends in reportable incidents and notable occurrence (by type, person, site, employee involvement, time, date, circumstances, etc.) and to recommend appropriate corrective, preventive, remedial, and/or disciplinary action to the chief executive officer to safeguard against such recurring situations or reportable incident and notable occurrences. IRC will ascertain and ensure the adequacy of the agency's reporting and

review practices, including the monitoring of the implementation of approved recommendations for corrective, preventive and remedial action.

IRC Chair will ensure that minutes are kept for all meetings. IRC Chair will provide minutes to the CEO within 2 weeks. The portion of the minutes that discuss matters concerning the specific event or situation shall be entered into IRMA/NIMRS within three weeks of the meeting.

When an investigation of an incident or occurrence is conducted by the Central Office of OPWDD/OMH or the Justice Center, the IRC role in reviewing and monitoring the particular incident or occurrence is limited to matters involving compliance with the reporting and notification requirement of this part, protective and remedial actions taken, operational concerns and the quality of services provided.

The IRC Chair will submit an Annual Report to the Board of Directors concerning the Committee's general function, and identified trends in incidents and allegations.

Jonathan's Law

Jonathan's Law established procedures that facilities must follow to notify and inform parents and legal guardians of children and adults receiving certain services (including OPWDD, OMH, and OASAS) of incidents involving their loved ones. It also allows a qualified person to access certain documents pertaining to such incidents.

Under the law, qualified persons include:

- Parents or other legal guardians of minor patients;
- Parents, legal guardians, spouses, or adult children of adult patients who are legally authorized to make health care decision on behalf of the adult patient; or
- Adult patients who have not been determined by a court to be legally incompetent.

A facility will inform the qualified person(s) by telephone of accidents or injuries that affect the health or safety of an individual receiving services within 24 hours of the initial report of the incident. If requested by a qualified person, the facility must promptly provide a copy of the written incident report. The facility must also offer to meet with the qualified person to further discuss the incident. The director of the facility must provide the qualified person(s) with a written report on the immediate actions taken to address the incident (e.g. steps taken to protect the involved individual) within 10 days of the initial report of the incident.

If requested by the qualified person in writing, Jonathan's Law requires facilities to provide records and documents pertaining to allegations and investigations into abuse, neglect, and significant incidents to the qualified person(s). These documents must be provided within 21 days after the investigation is concluded. The names or information that identifies other persons receiving services and employees will be redacted unless these individuals authorize disclosure. Federal laws or regulations may pose additional restrictions on the release of records or information contained in those records.

Records subject to release will be monitored and addressed by the DQA or designee.

Work Flow for Investigations

Report is made to the NYS Justice Center via phone or Web form or App

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VPCR Staff will classify the Report as:
Abuse/Neglect
Significant Incident
Death
Non-NY JC Incident
Not an Incident

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XML detailing the incident is sent to OPWDD/OMH/OASAS Central Office from the NYS Justice Center

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XML detailing the incident is assigned to the investigating entity (JC, SOA, Agency)
(If the JC is assigned the investigation, they will complete the investigation and submit to the JC General Counsel for review)
If the agency is assigned the investigation, see below:

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Process for Allegations of Abuse/Neglect:

1. Agency completes the investigation with 30 days (OPWDD/OMH), 21 days (OASAS), attaches all investigative materials need to be submitted to OPWDD/OMH/OASAS within 45 days.
2. Investigation packet is reviewed by SOA and submitted to the NYS JC by the SOA within 50 days of the report date.
3. JC reviews the incident and sends to their General Counsel's office.
4. The General Counsel's office reviews the incident and sends the agency, the individual, and the parent/legal guardian (if applicable) the Letter of Determination regarding the outcome of the investigation.
5. The Corrective Action Plan is submitted to the SOA and JC within 60 days from the date of the Letter of Determination

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Process for Significant incidents:

1. Incident must be imported from the JC Portal into IRMA/NIMRS and edited appropriately.
2. The incident must be investigated.
3. The incident must be reviewed by IRC and closed within 45 days.
4. The investigation, corrective action, and IRC minutes are entered into the electronic data base (IRMA/NIMRS). For OASAS, the final report is sent to OASAS.

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Process for Deaths:

1. Incident must be imported from the JC portal into IRMA/NIMRS
2. Report of Death must be submitted to the JC (through IRMA/NIMRS or hard copy for OASAS) within 5 days.
3. For OPWDD, all deaths must be investigated. Final report sent to OPWDD for submission to the Mortality Review Committee.

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For Non-NY JC Incidents:
If the incident falls into another category, reportable to SOA, edit and address appropriately.
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Not an Incident:
No further action required.

The Definitions of each of the Significant Incident and other categories below are listed in Appendix A, B, C at the end of this document for OPWDD, OMH, and OASAS.

OPWDD – Reportable to JC and OPWDD

Significant Incidents:
Conduct Between Persons Receiving Services
Seclusion
Unauthorized Use of Time Out
Medication Error with Adverse Effect
Inappropriate Use of Restraints
Mistreatment
Missing Person at Risk for Injury
Unauthorized Absence
Choking with Known Risk
Choking with No Known Risk
Self-Abusive Behavior with Injury
Injury with Hospital Admission
Theft/Financial Exploitation
Other Significant Incident

OPWDD – Reportable to OPWDD Only

Minor Notable Occurrences
Injury (Document in IRMA only)
Theft or Financial Exploitation (Notification to OPWDD and entry into IRMA)

Serious Notable Occurrences
Death
Sensitive Situation

Agency Minor Incidents (Agency Internal Occurrences [Minors] – process for managing minor incidents is found in a separate policy.)
Minor Injury (bruises, burns, sun burns, abrasions, insect bites with allergic reaction, etc.)
Falls

OPWDD 625 Regulations – Events/Situations that are not under the auspices of the agency: (see 625 regulations below)
Physical Abuse
Sexual Abuse
Passive Neglect
Active Neglect
Self-Neglect
Financial Exploitation
Emotional Abuse
Death
Other

OMH – Reportable to JC and OMH

Applies to certified programs under OMH.
Significant Incidents:
Assault
Crime
Falls by Patients
Fights
Financial Exploitation
Fire Setting
Injury of Unknown Origin
Medication Error
Missing Patient
Mistreatment (Unauthorized Restraint or Seclusion. Inappropriate use of Time Out, Intentional Improper Administration of medication)
Self-Abuse
Severe Adverse Drug Reaction
Sexual Assault
Sexual Contact Between Children
Suicide Attempt
Verbal Aggression by Patients
Wrongful Conduct
Other Incident

OMH – Reportable to OMH Only

Serious Crimes in the Community
Missing Subject of AOT Order
Suicide Attempt Off Site

OASAS – Reportable to JC and OASAS

Significant Incidents:
Conduct Between Individuals Receiving Services
Unauthorized Seclusion
Unauthorized Time Out
Medication Error with Adverse Effect
Inappropriate Use of Restraints
Crime
Body Cavity Search
Violation of Confidentiality
Death
Missing Client
Suicide Attempt
Physical Plan Issues Leading to Incidents
Lack of Food/Nutrition
Inadequate Supervision resulting in an Incident
Inappropriate Relationships between staff and client
Overdose
Any ER visit
Medication Errors
Any First Responder called to a certified site
Fire Setting

Agency Process for completion of documentation and notifications for each incident:

Upon discovery of an incident, the primary responsibility of staff is to ensure the safety of individuals receiving services. Immediately thereafter, the reporting process is to begin.

Report of an incident is made to the JC, SOA or Agency of a Reportable, Significant Incident or SOA reportable incident, Serious Notable Occurrence or Minor Notable Occurrence

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Immediate protections must be put in place for the individual.

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All appropriate notifications are made immediately upon occurrence or discovery, no later than 24 hours, as appropriate:

Justice Center
SOA
Executive Director
Family/Legal Guardian/Advocate
Care Manager
Clinician
Program Director
MHLS, if applicable (within 72 hours)
Police (Law Enforcement must be contacted immediately for allegations of physical and sexual abuse or crime against the individual)
EMS
Adult Protective Services
NYS Child Abuse
CAB
All other appropriate entities

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Depending on the category, the incident is edited by the program in IRMA/NIMRS or entered into the data base within 24 hours or by the close of the next working day, whichever is later.

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The Program Director or QI will review the information within 24 hours and will update/report missing or discrepant information.

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NIMRS/IRMA should be updated with new information has appropriate.
NIMRS entries must be emailed to OMH.

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An investigation shall commence immediately by the CEO, COO, CCO, IMM, and QAS and must be completed within 30 days from the date of report. For allegations of abuse/neglect, the CCO or designee will send the Letter to the Target of the Investigation immediately following notification of the incident.

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The Investigation Report with the conclusions and recommendations will be submitted to the Executive Director, COO, Program Director and HR (as needed) for review and to address the recommendations presented in the investigation.

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CCO or designee will present the investigation report, notifications, and initial IRMA/NIMRS/incident report to the IRC for their review within one month.

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CCO or designee will ensure the entire investigatory record is submitted to the JC and SOA within 50 days.

OPWDD 625 Regulation (Categories identified above):

If an agency becomes aware of an event or situation involving an individual receiving services, the agency should take action to protect the involved individual. This may include:

- Notify an appropriate party that may be in a position to address the situation (ie. Adult Protective Services, law enforcement officials, family members, school, hospital, etc.);
- offer to make referrals to appropriate service providers, clinicians, State agencies or other parties;
- interviewing the involved individual and/or witness;
- assessing and monitoring the individual, reviewing records and other related documentation; and/or
- educating the individual about his or her choices and options regarding the matter.

The agency must submit an initial report about the event/situation in IRMA within 24 hours of the occurrence or discovery or by the close of the next working day, whichever is later. Actions taken by the agency to protect the individual must be documented in IRMA.

The agency must report updates on a monthly basis (or more frequently) until the situation is resolved.

The death of any individual who had received services certified, operated, or funded by OPWDD, within thirty days of his or her death, and the death did not occur under the auspices of the agency shall be reported to OPWDD immediately upon discovery by telephone. The agency shall submit an initial report about the death in IRMA within 24 hours of discovery of the death, or by close of the next working day, whichever is later. The agency shall submit subsequent information about the death in IRMA within 5 working days following the discovery of the death.

OPWDD: RIA (Restrictive Intervention Application)

Effective July 30, 2012, the use of a restrictive physical intervention technique is required to be reported electronically to OPWDD within 5 days of occurrence in IRMA.

It is used by OPWDD for the tracking and trending of the requisite restrictive personal/physical intervention data on a statewide basis. RIA will enhance the agency's ability to track, trend, and analyze the relationship between restrictive personal/physical interventions and untoward events with the ultimate goal being to reduce and/or ameliorate resulting injuries and allegations of abuse.

All current users in IRMA will automatically have access to the RIA in IRMA.

Records Retention:
Agencies must retain records pertaining to incidents and allegations of abuse/neglect for a minimum time period of ten years from the date that the incident or allegation of abuse is closed.

For additional information on incident management regulations, refer to OPWDD's 624 and 625 regulations, OMH's 524 regulations and OASAS' 836 regulations.