Office of
Mental Health

Corrective Action Plans (CAPs)
Provider Guidance Document for Justice Center Signifcant Incidents

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Significant Incident: A reportable incident, other than an incident of abuse or neglect, that because of the severity or sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a patient (14 NYCRR Part 524)

For specific incident types and definitions of Significant Incidents, please refer to 14 NYCRR Part 524 or your Incident Management Guide from the Office of Quality Improvement.

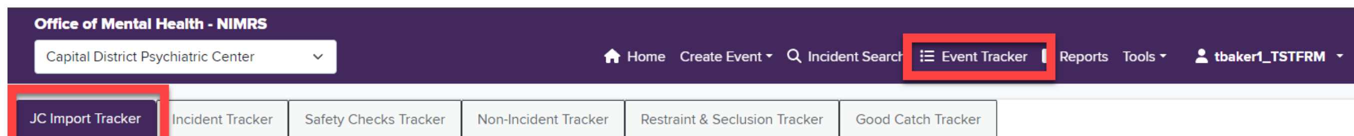
- For additional information see also:

  Incident Management Field Guide (ny.gov)

  omh_nimrs_reportability_card.pdf

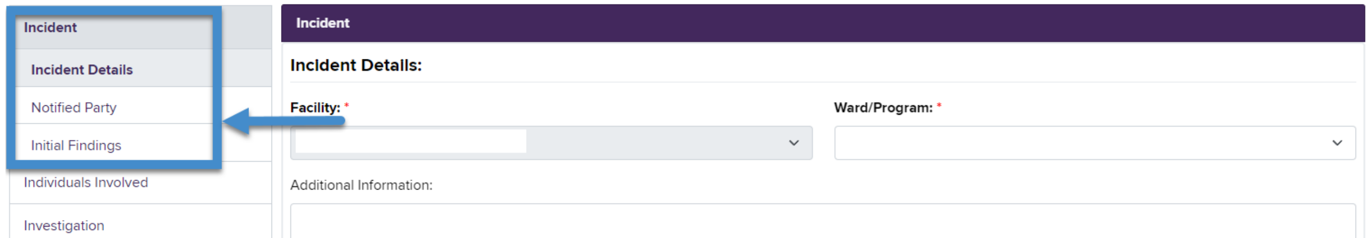
Steps to process a Significant Incident

1) **Import Incident** from the Justice Center Incident Import Queue into NIMRS.

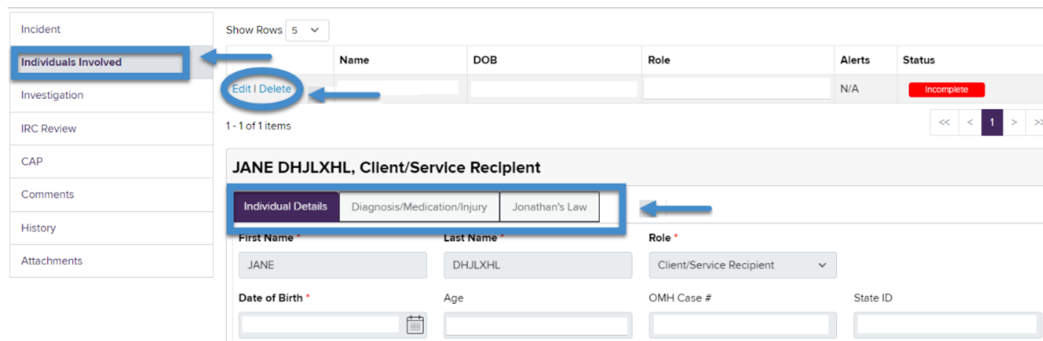


2) **Document Incident Details including Initial Findings and Immediate Response** in NIMRS:
Document any immediate safety measures taken; including, but not limited to:

- Separation of staff/individual or individual/individual
- Environmental assessment (i.e., removal of broken or dangerous objects)
- Notifications to law enforcement
- Medical interventions
- Contacts/Notifications made



3) **Complete Individuals Involved information including Jonathan's Law tab** in NIMRS.



4) **Email OMH** by clicking the "Email OMH" milestone button in NIMRS. This should be done within 24 hours unless the provider has been notified that the JC has designated the incident a 3 Business Day Review (3BDR).

5) **Complete Investigation**: The Investigation should be commensurate with the seriousness of the Incident.

- Several Significant Incident types require a Special Investigation including:
  - Wrongful Conduct
  - Inpatient Assaults, (including Sexual Assaults) resulting in serious injury to any person
  - Missing Patients of inpatient programs

- Refer to the regulations, part 524.14 for the complete list of incidents that require a Special Investigation.

- The classification of the event is based on the information in the allegation, not the investigation findings (i.e., if you learn that a staff person did not act in a manner that constitutes Wrongful Conduct, you would indicate this is an unsubstantiated allegation of Wrongful Conduct.) You would not change the final classification to Not an Incident.
- Any additional allegations or findings that are discovered during the investigation that meet the criteria of a reportable incident, need to be called into the Justice Center and/or OMH as well.
- Reference any linked cases by providing the NIMRS # and/or the Incident Serial Number (ISN) if you have additional, relevant information documented in your investigation.
- For a complete guide on how to conduct a Special Investigation, please visit: [Guidelines for Investigation 2001 (ny.gov)]
- If a Significant Incident meets criteria for a Sentinel Event for which the completion of a Root Cause Analysis (RCA) is required, please be advised that OMH does not require that the RCA be attached or submitted in NIMRS. For questions about how to submit an RCA to OMH, please contact your Clinical Risk Manager.

6) **Investigation Conclusions** in NIMRS:
   a. Document the findings and conclusions. Each issue of potential risk identified throughout the investigation must be addressed. Conclusions should be clear and supported by the evidence. The provider can also upload their investigative report into NIMRS to assist with providing details of the investigation where applicable.

7) **IRC Findings** in NIMRS: Document whether the IRC agreed or disagreed with your findings and conclusions, and if they have any additional suggestions or recommendations. The IRC Findings section should illustrate the discussion of clinical and systemic issues and how they impact quality of care at the facility The provider should document:
   - All dates the Incident was discussed in their IRC Meetings. The date of the initial review should be noted as the “IRC Review Date”.
   - Any immediate actions taken to ensure safety of persons involved and the environment.
   - Any additional issues of concern or recommendations.

- What corrective actions have been or will be completed to address the finding(s), issues of concern and recommendations.
- The review of previously implemented CAPs and any adjustments/changes to them if they were not effective.
- If a full special investigation for the significant incident, such as Wrongful Conduct, is completed please indicate your conclusion (substantiated or unsubstantiated).

Once completed, provider should click “Confirm IRC Milestone” button in NIMRS.

8) **Submit Investigation**: once the investigation has been completed and reviewed by the IRC, click the “Submit Investigation” milestone button in NIMRS.

➢ When Central Office, (i.e., OMH) reviews an investigation, the OMH Reviewer will often have questions about the process, such as was anyone interviewed, and if so, who, or was any camera footage reviewed?

To facilitate the review and avoid revision requests, consider including the following statements when applicable:

- There are no cameras in the facility/no video footage to review.
- The video did not reveal the actions indicated in the initial report.
- There is not supporting testimony from staff.
- There were no witnesses to corroborate the allegation

Statements to Avoid:

- “Based on interviews and documentation” – be specific, especially with regard to indications that the individual made the statement based on their illness.
- “Standard of care met”
- “There is no evidence”
- “No investigation done”

➢ **Policies and Procedures**:

- Emergency Protocols: Please indicate, where applicable, if emergency protocols were followed per policy. For example: Was a code called and if so, did it run as expected? Was the crash cart stocked and in working order? Did emergency response come in a timely manner?
- Assessments: Were all relevant assessments completed and documented as per policy? For example: Falls assessment, swallowing evaluation, or any applicable risk assessments (such as the CSSR-S or Broset)?
- Observation/Monitoring: Was the individual on the appropriate level of observation for their assessment needs? Was the observation followed?

9) **CAP Documentation and Submission**:

- The creation of a Corrective Action Plan is based on a thorough and complete review of any reportable incident for identified systemic concerns ***regardless of substantiation or confirmation.***
- If you indicate in your findings/conclusions that there will be facility improvements, changes to policy, staff/client counseling, etc., you must identify corresponding corrective action(s) for those findings. This section should reflect what you have documented in the Investigation Findings & IRC tab.
- “None” will only be accepted as a Corrective Action if the provider clearly demonstrates in the investigation that there are no steps that can be taken to mitigate the risk of this incident reoccurring at your facility. The expectation is to provide information that shows a thorough investigation of the incident was done.
- Providing documentation that supports your findings is best practice.
- Documentation of a CAP includes:
    - Corrective action type
    - Corrective action description
    - Person(s) responsible for implementation of the corrective action
    - Implementation status (each action item must be marked, at minimum, as Partially Implemented)
    - Dates

Submit CAP: once the CAP section has been completed, click the “Submit CAP” milestone button in NIMRS.

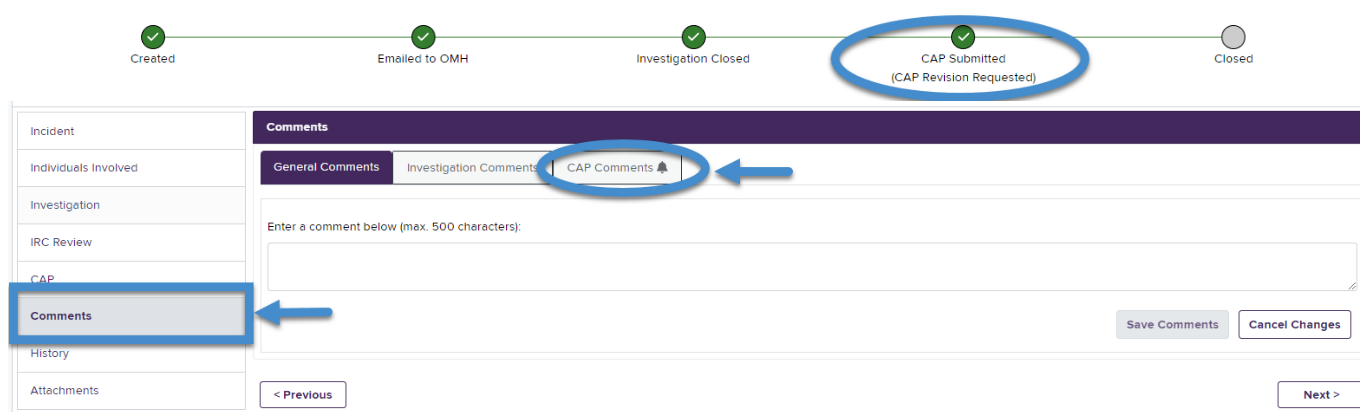
Incident Notes (section): ↑

** This section is for the provider’s **internal use. If there is Information that is relevant to the investigation and should be part of the JC's or OMH's review of the incident, please do not enter the information in the Incident Notes. Include the information in the Investigation Conclusion section or as an attachment.**

Print Concise | Print Incident | Update OMH | Confirm IRC | Submit CAP | Close Incident

OMH Central Office (CO) review of the submitted CAP:
Once submitted, the CAP Status in NIMRS will be "CAP Submitted." The CAP Reviewer will review the Incident. If all required areas of the CAP have been documented and the CAP Reviewer found no additional areas of concern, the CAP will be marked "Approved" and the Reviewer will close the Incident in NIMRS.

If the CAP Reviewer deems that revisions are required before the CAP can be approved, an email will be sent to the provider and the incident will display the status of "CAP Revision Requested". If there is more than one corrective action noted, the action(s) requiring revision will have an "Approval Status" of Revision Requested. Revision notes can be found in the Comments page, under the CAP Comments tab.



Helpful Suggestions: ↑

Significant Incident Regardless of harm: ↑

Wrongful Conduct:

- Document any plan for separation between subject and victim. If subject remains working, indicate why decision was made to not suspend subject and include any additional safeguards that are put in place, while allegation is investigated. (ex: moved to a different unit, given a different assignment, additional supervision, etc.).
- Document witness statements from anyone with direct information about the event, not just the subject and victim. A good investigation will have a statement from anyone working at the time of the alleged incident (even if the statement is that they didn't notice the event as it happened).
- Document that all aspects of the investigation were done. These include: video review; subject interviews, including denial of the accusation; victim interviews or documentation of why victim was not interviewed, witness statements; individual's mental status at the time of the accusation,

review of relevant policies/procedures, a review of relevant staff training, etc.

- Provide a CAP that demonstrates what will be done to prevent or mediate risk in the future for each finding.

Suicide Attempt:

- *For Onsite Attempts*:
  - Document whether the individual and their room were checked for unsafe objects.
  - Document the history of treatment leading up to the event.
  - Document if there were any environmental factors that may have contributed (loose screws on the walls, broken furniture, etc.).
  - Document if supervision level may have played a role or if it has been changed in response to the event.
  - Document if any medical follow up was done, providing some detail about the assessment.
  - Document if and when a psychiatric or other clinical assessment were completed.
  - Indicate any recent suicide risk assessments that were completed for the individual, and any recent stressors or changes in the individual's psychiatric profile that may have been indicative thoughts to self-harm.
  - Provide a CAP that identifies any issues of concern found during the investigation and how they will be addressed going forward.

- *For Offsite Attempts:*

- Date of the last appointment attended and title of the person the individual saw (e.g. psychiatrist, psychiatric NP, psychologist, therapist, RN, etc.
- Were any appointments missed, if so, did outreach follow agency policy.
- Is the individual considered high risk? If yes, were policies and procedures for high-risk individuals followed? If no, is individual considered high-risk following incident?
- Date of last risk assessment[s].
- Did the individual have a safety plan in place, if so, last time reviewed. If not, was one completed following the event?
- Did the individual have any recent crisis visits or inpatient hospitalizations?
- Any follow-up/recommendations for care following the event.

Missing Client:

- If the individual has been located, document the date that the individual returned/was located. If the individual has NOT been located and the SI is due to Central Office, indicate such in your report prior to submission.
- Indicate which steps, if any, were taken to locate the missing individual, such as: notifications to law enforcement, if a missing persons report was filed, dates and times of steps taken, and what places have been contacted regarding the individual's

whereabouts.
- Indicate if the individual was assessed upon return.
- Include references to your policies and protocols here.
- Provide a CAP that demonstrates what will be done to help prevent this in the future.

Fire-Setting:

- Any history of fire-setting?
- Was the individual trained on fire safety?
- Was the fire evacuation plan followed?

Sexual Assault:

- Any history of inappropriate sexual behavior and/or sexual violence?
- What actions were taken to reduce future risk?
- Was the individual assessed after the assault?
- Was rape kit offered and completed and/or police notifications completed?
- Was the individual assessed to be competent of consent?

Sexual Contact Between Children:

- Any history of sexualized behaviors?
- Was the patient assessed for risk prior to the incident? When? Were there any alerts/flags implemented?
- Were supervision levels appropriate? Were they maintained as intended?
- What actions were taken to reduce future risk?

Mistreatment/Medication Over Objection/Restraints/Seclusion:

- State if it is documented what the individual's mental health status was at the time of the incident using the medical record. There should be a clinical justification for why the individual is given med over objection, restrained, or secluded.
- State if it is documented of any video review, if the staff used the correct restraint technique, witnesses confirm or deny, staff deny or confirm, etc.
- Is training and education indicated regarding medication over objection policy and restraint and seclusion?
- State that a CAP is provided that indicates any issues of concern that were raised in the review of this incident and how those will be mitigated in the future.

Injury of Unknown Origin:

- Consider whether injury may have been caused accidentally, by self or others, a fall, or related to a medical condition.

Crime in the Community/Crime:

- Did the individual have a history of violent behavior/arrests, etc.
- Was a violence risk assessment completed? Before/After the incident?
- Is there any history of substance use?
- Provide information about individual's engagement in treatment or programs. (AOT if applicable)
- Is the individual medication compliant? (if applicable)

Not an Incident:

- The incident (as described in the narrative) does not meet reportability criteria outlined in Part 524
- Provider must explain explicitly why it is not reportable

Significant Incidents Only with Serious Injury or Harm: ↑

Falls (for inpatient and residential programs):

- Document the individual's supervision level during the incident and after the incident and if supervision level had or could have had any impact (where applicable).
- Document whether there were any environmental factors that contributed to the fall.
- Document any medical interventions provided after the fall.
- Document if medications were evaluated/if they were a contributing factor, or if they were recently changed.
- Document any Fall history.
- Document when/if any Fall Risk assessments have been completed.
- Provide a Corrective Action Plan (CAP) that demonstrates what will be done to help prevent this in the future.

Assault: (of any patient or staff member, visitor, vendor, or licensed independent practitioners while on-site):

- Document any separation between the individuals.
- Document any indicators that may have predicted or led to the individuals fighting, the supervision levels, video review (where applicable), and witness statements.
- Document if there is any history of conflict between the individuals involved.
- Document if there were any injuries/need for medical attention?
- Provide a CAP that explains the plan to prevent assaults going forward.

Fight:

- Any history of conflict between the individuals involved?
- Any violence/aggression observed by staff?

Self-Abuse:

- Document whether the individual and their room were checked for unsafe objects.
- Document the history of treatment leading up to the event.
- Document if there were any environmental factors that may have contributed (loose screws on the walls, broken furniture, etc.).
- Document if supervision level may have played a role or if it has been changed in response to the event.
- Document if any medical follow up was done, providing some detail about the assessment.
- Document if and when a psychiatric or other clinical assessment were completed.
- Indicate any recent any recent stressors or changes in the individual's psychiatric profile that may have been indicative thoughts to self-harm.
- Document why/how you determined there was no intent to die.
- Provide a CAP that identifies any issues of concern found during the investigation and how they will be addressed going forward.

Medication Error:

- Any issues with medication management identified?
- Any issues with accessing medical follow-up?
- Were persons involved separated/assessed?

Other Incident:

- Choking that result in serious injury or harm
- Seizure that causes injury requiring stitches etc.
- Accidental injury that results in serious injury or harm
- Use of Narcan

Death Reporting: ↑

(OMH licensed or operated Inpatient Units, Residential Programs, or CPEP-**Report to JC and OMH**. OMH licensed or operated OUTPATIENT programs-**Report to OMH**)

- A natural death of an individual, with known health issues, or obvious accidental cause (i.e., car accident) does not require the same level of documentation as an unexplained death, suicide, or accidental death due to overdose.
- Include relevant treatment history and a brief summary of the individual to help frame the death report.
- If you know an autopsy will be conducted, please indicate this in the incident record including other relevant details such as date the exam was requested and reference #, if available.
- In cases where the cause of death is indeterminate or unknown, please submit any information that is known within 45 days. Should additional information become available through a Medical Examiners report or autopsy, you must reopen the incident in NIMRS, add the additional information, and close the incident again.
- If it is known that no autopsy will be conducted at the time of the original report submission, please document that in the report so it is clear that no additional information will be made available.
- The final classification in NIMRS should match the information in the report and/or cause of death.

- ***Homicide***: If the perpetrator of the homicide is also a service recipient, please see that it is indicated what the perpetrator's level of risk prior to the incident, including any recent assessment for violence (such as the Broset Violence Checklist) that may have been done on the individual. In addition, this will need to be reported as a Crime.

- ***Expected (Natural Causes):*** If known, please see that they provided information about any medical treatment related to the cause of death, including the individual's compliance with medical treatment and support.

- ***Unexpected***: Describe the immediate circumstances and nature of the event, such as if the cause of death is related to (this is not an exhaustive list):
    - *Choking or Fall*: Does the individual have a history of either, and if so, how was it being addressed and monitored? Were those processes in place at the time of death?
    - Was the individual assessed and on the appropriate level of observation or monitoring at the time of death? (precaution level?)
    - Medication (including Clozaril): Medication policy and procedure related to the specific medication, such as bowel protocols with Clozaril. Were they followed?
    - Substance-Related: Did the individual have a known history of substance use/abuse? Was the individual getting treatment or support for this substance use?

- **Accidental:**
    - Car accident, House Fire etc.

- If it was an accidental overdose, please include how it was deemed accidental and not a suicide.

- ***Substance-Related:***
- Any known history of substance use? If yes:
- Was the individual receiving substance abuse treatment?
- Were toxicology screens being performed?
- When was the last risk assessment completed?

- ***Death by Suicide:*** When suicide is noted as the confirmed or suspected cause of death, the following information should be present:
  - Information related to the last appointment the individual attended. This may include:
    - Was a risk assessment completed and if so, what was the result?
    - Did the Individual express any thoughts of suicide?
    - Was there a change in presentation?
    - Did they miss this appointment? Was that typical? What outreach was done to re-engage the Individual?
  - History, specific to suicide attempts or ideation or any mental health or psychosocial conditions that may lead to a higher risk of suicide.
  - Was a safety plan created, reviewed, or updated? If so, when?
  - For inpatient suicide, please be sure it is indicated what the level of supervision was and when this decision had been made. Please also see it is indicated if the level of supervision had changed recently and why.
  - If the suicide is within 72 hours of discharge from an inpatient, CPEP or residential program, please see that it is indicated what the discharge plan was, and any safety or crisis plans made prior to discharge.

  - See that it is indicated if any recent suicide assessments were completed for the individual, any recent stressors or changes in the individual's psychiatric profile that may have been indicative of self-abuse.

Non- NYJC Incident Guide ↑

Incidents classified as "Non-NYJC" means that the JC has determined that the incident does not meet the criteria for reporting to them. Despite not meeting the reporting criteria for the JC, these incident reports will be sent to the provider's JC import queue for further review and processing. As such, Non-NYJC Incidents must be cleared from the Provider's JC Import Queue. The options include:

- Reviewing the incident to ensure it is not an OMH Only (i.e., death of an outpatient client, Missing Subject of an AOT Court Order, Suicide Attempt, off site, Crime in the Community) or Justice Center reportable incident. If the reviewer confirms it is not a reportable incident, there are two options:

- Option 1: move the incident to the Non-Incident Queue in NIMRS. Nothing further is needed, once moved.
- Option 2: Import for internal tracking purposes, change the incident type to one of the incident types in the dropdown menu that begins with an asterisk (*). Complete your investigation and close the incident.

- If upon review of the incident narrative, it is determined to be an OMH Only reportable incident, you may import the incident and then complete as indicated above.
- If upon your review of the incident narrative, the incident was **incorrectly** classified as a NON-NYJC and meets the criteria of abuse & neglect or Significant incident, you will need to reach out to the Justice Center at jc.sm.incidentreview@justicecenter.ny.gov and request the incident be upgraded. Please include the ISN# and rationale for this request and cc: your OMH Clinical Risk Manager.

If you require additional support, please reach out to the Office of Quality Improvement at 518-474-3619.