NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Office of Quality Improvement

Incident Management Field Guide

44 Holland Avenue
Albany, New York 12229

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I. General Background

a. Purpose

The Protection of People with Special Needs Act, or PPSNA (Chapter 501 of the Laws of 2012) created the Justice Center for the Protection of People with Special Needs ("Justice Center"). The Justice Center is a State agency charged with the responsibility to track and prevent, as well as investigate and prosecute, reports of abuse and neglect of persons with disabilities or special needs (i.e., "vulnerable persons"). The PPSNA created a set of consistent safeguards for vulnerable persons served by systems under the jurisdiction of six state agencies, including the Office of Mental Health (OMH), to protect individuals against abuse, neglect, and other dangerous conduct, to aggressively investigate and address instances of neglect and abuse, and to provide fair treatment to employees upon whom vulnerable persons depend for their care.

In accordance with PPSNA requirements, OMH proposed regulations outlining incident management requirements for state operated and licensed providers under its jurisdiction. The PPSNA required that the Justice Center approve these regulations as consistent with its standards. After obtaining this approval, OMH adopted the proposed rules as final regulations on December 9, 2015.

This implementation guidance is intended to assist providers in understanding and complying with the final regulations. It explains definitions for reportable incidents and describes the steps for reporting to the Justice Center and OMH through the Vulnerable Persons Central Register (VPCR) hotline and the New York State Incident Management & Reporting System (NIMRS).

b. What mental health providers must comply with 14 NYCRR Part 524 incident reporting requirements? **(14 NYCRR §524.3)**

Providers of mental health services that are *directly operated* by OMH and providers of mental health services that have been *licensed* by OMH pursuant to Article 31 of the Mental Hygiene Law (including Article 31 licensed wards, wings or ambulatory services that are part of an Article 28 general hospital) are required to comply with the incident reporting requirements of the PPSNA and 14 NYCRR Part 524 *with two exceptions*: (1) State operated Sex Offender Treatment Programs; and (2) OMH operated programs located within correctional institutions. These latter programs are not required to report to the Justice Center; however, they must continue to report incidents to OMH in accordance with OMH Official Policy directive QA-510. Although unlicensed, funded providers (such as supported housing, health homes, peer support, and case management) are **not** subject to the Justice Center's jurisdiction and thus are not subject to most of the provisions of 14 NYCRR Part 524, there are two important caveats:

1. Staff of unlicensed, funded providers that are licensed human service professionals are likely "mandated reporters" who are required to report reportable incidents involving vulnerable persons if they discover or learn of such events. For example, if a Health Home Care Manager is told by a patient

on his caseload that she was physically abused by a staff member of an Article 31 outpatient clinic, that incident must be reported to the Justice Center.

2. HCBS Waiver services must report adverse events to OMH under Mental Hygiene Law Section 29.29 and federal requirements.

The process for reporting depends on incident type. The steps for reporting are described in Section III of this guidance document. Providers remain responsible for notifying other agencies (such as any accrediting or regulatory agencies) as required by all governing rules or statutes, including federal requirements.

c. What is an "incident?" (14 NYCRR §§524.4, 524.5)

Section 29.29 of the New York State Mental Hygiene Law directs OMH to establish uniform policies and procedures for the submission of incident reports by providers under its jurisdiction. "***Incident reports***," as referenced in this section of law, means reports of accidents, injuries, and other events affecting patient health and welfare.

However, in Section 488 of the New York State Social Service Law, the PPSNA established a category of incidents called "***Reportable Incidents***" which must be reported by those required to report under the law ("***mandated reporters***") to the Justice Center and investigated. Under the Social Services Law, "***Reportable Incidents***" include allegations of abuse and neglect, and significant incidents. A "***Significant Incident***" is an event that, because of its severity or the sensitivity of the situation, may result in harm to the health, safety or welfare of a vulnerable person.

Given these two statutory approaches, for purposes of this implementation guidance, the term "incidents" includes:

- Reportable Incidents (i.e., allegations of abuse and neglect and significant incidents), which must be reported both to the Justice Center and OMH, pursuant to the PPSNA; and
- Other adverse events that, while not required to be reported to the Justice Center, must be reported **only** to OMH, pursuant to Mental Hygiene Law Section 29.29.

d. Who is responsible for reporting incidents? (14 NYCRR § 524.4(j))

The PPSNA and 14 NYCRR identify a group of persons as "**Mandated Reporters**," who have a duty to report incidents. "**Mandated reporters**" include:

1) Custodians

A "custodian" is a director, operator, employee or volunteer of a State operated or licensed provider or a consultant or contractor with such a provider that has regular and substantial contact with persons served by the provider.

While it is usually easy for community-based Article 31 providers to determine who are "**custodians,**" for large organizations with multiple licenses, it occasionally is more difficult. The following questions may be helpful in making these decisions:

- To determine if a person is an "employee" of a provider, does the person work in a facility, ward, or wing licensed or operated by OMH? If so, that person would be a custodian – even if patient contact is not required to perform their job.

- If the person is an employee of a large organization (such as a hospital), is the person assigned to work in the Article 31 licensed ward or wing? If the person is not specifically assigned to the Article 31 ward or wing, does the provider have a policy indicating that person's responsibilities include the Article 31 licensed ward or wing? If so, these people would be custodians.

- If the person works for a contractor of the Article 31 provider, what are the services he or she will provide? To perform those services, is routine, significant contact with patients required? For example, a person that drives a patient van for a transportation company that contracts with a provider would likely be a custodian. A person that fills vending machines for a company that contracts with a provider would not be a custodian.

2) Human Services Professionals

The list of human services professionals that are considered to be "Mandated Reporters" is broad and is included in 14 NYCRR Part 524 in Section 524.4(i)(2).

Practice Tip

All Mandated Reporters who discover an incident are responsible for reporting it, even if several Mandated Reporters report the same incident. However, providers are permitted under 14 NYCRR Section 524.8(e) to develop written protocols that excuse a Mandated Reporter from submitting a separate report if he or she knows that the report has already been made by another Mandated Reporter and that he or she has been named in that report as a person with knowledge of such incident. Regardless, these written protocols must ensure that reports involving multiple mandated reporters are properly made and documented.

e. When must an incident be reported? (14 NYCRR §524.8)

Employees of mental health providers (i.e., "custodians") are Mandated Reporters and must immediately make a report of a Reportable Incident to the VPCR upon discovery of what appears to be a Reportable Incident. "**Discovery"** occurs when a Mandated Reporter has "reasonable cause to suspect" that a reportable incident has occurred because:

(1) the Mandated Reporter has personally witnessed the incident OR
(2) another person has come before the Mandated Reporter in his/her official or professional capacity and provides the Reporter with information that gives him/her "reasonable cause to suspect" a reportable incident has occurred

The term "**reasonable cause to suspect**" is not defined in the PPSNA. Thus, if a Mandated Reporter does not personally witness an incident, but receives information from someone else, he or she then has a judgment call to make. "Reasonable cause to suspect" does not mean that there must be conclusive evidence that the incident occurred. A rational or sensible suspicion should be enough. 14 NYCRR Part 524.8 includes a provision that allows for a brief window of time to make a decision, in circumstances where a patient reports an allegation of abuse or neglect to a provider which appears to be impossible or incredible. In such cases, the provider must promptly review the allegation and make a determination, within 24 hours of the report, whether there is reasonable cause to believe a reportable incident has occurred. "Discovery" thus occurs when the provider decides, within that 24 hour "window" period, that reasonable cause to believe does, in fact, exist. If it is determined that reasonable cause does not exist and a report is not made to the Justice Center, the decision must be well documented. In fact, any time something is brought to a Mandated Reporter's attention in his/her official capacity and a decision is made that there is no reasonable cause to suspect a reportable incident occurred, documenting that decision is recommended.

f. Confidentiality

All incident reports and incident investigation documents are confidential quality assurance documents, protected by New York State Education Law Section 6527. Incident reports are not considered part of an individual's clinical record and should not be filed in such record. A number of statutes govern disclosure of confidential quality assurance documents, depending on the circumstances of the requested disclosure, including New York State Mental Hygiene Law §§33.23 and 33.25 ("Jonathan's Law"), New York State Public Health Law §2805-m, New York State Social Services Law §496, and 45 CFR Parts 160 and 164 (HIPAA).

g. Key Incident-Related Terms and Acronyms

- "**CAP**" means "Corrective Action Plan," a plan developed by a provider to remediate problems identified in an investigation.

- "**Custodian**." As used in the PPSNA, this term refers to those who have a legal obligation to protect vulnerable persons from harm while they are under their

care (or the care of the provider they work for). In the OMH regulated system, the following would be considered a "custodian" – a director, employee, or volunteer of a provider operated or licensed by OMH, or a consultant or contractor with an OMH operated or licensed provider who has regular and substantial contact with persons served by the provider.

- "**Discovery**" is a term that is used to identify when a mandated reporter must report an incident. An incident is "discovered" at the time a mandated reporter witnesses a reportable incident, or when another person provides a mandated reporter with information that gives him/her reasonable cause to suspect a reportable incident has occurred.

- "**Likely to result in injury or harm**" means that the injury or harm is a probable or the expected result of the particular conduct.

- **"Mandated reporter"** means someone who is required by the PPSNA to report suspected abuse and neglect of vulnerable persons, as well as "significant incidents," to the VPCR immediately upon discovery. All custodians are mandated reporters, as well as a specific list of human service professionals, included in 14 NYCRR §524.4(i).

- **"Minor injury or harm"** means injury or harm that does not meet the definition of **"Serious Injury or Harm."**

- **"NIMRS"** refers to the New York State Incident Management and Reporting System, developed and maintained by OMH.

- **"Physical injury" and "impairment of physical condition"** means any *confirmed* harm, hurt, or damage resulting in *significant* worsening or diminution of a vulnerable person's (VP) physical condition.

- **"PPSNA"** refers to the NYS Protection of People with Special Needs Act, the legislation that created the Justice Center for the Protection of People with Special Needs (Chapter 501 of the Laws of 2012).

- "**Reasonable cause to suspect**" means that, based on a mandated reporter's observations of the evidence, professional training, and experience, he or she has a rational or sensible suspicion that a vulnerable person has been harmed or placed in danger of being harmed.

- "**Reasonably foreseeable potential to result in injury or harm (RFP)"** means that a reasonable person would be able to predict or anticipate that his or her conduct would result in harm or injury to a vulnerable person. It does not mean that such harm or injury is absolutely certain to occur, but instead means that given the circumstances involved, it is reasonable or realistic to expect that, more likely than not, it would.

- "**Serious Injury or Harm**" means: (1) physical injury or harm that requires more than first aid; (2) psychological harm evidenced by negative changes in behavior

or a change in psychotropic medication or intervention; (3) a risk for life threatening physical injury or psychiatric emergency or trauma.

- **"Serious or protracted impairment of the physical, mental, or emotional condition"** means a state of substantially diminished physical, psychological, or intellectual functioning in relation to, but not limited to, such factors as failure to thrive, control of aggressive or self-destructive impulses, or ability to think and reason.

- "**Vulnerable person (VP)**" is an individual who is receiving care in a facility, provider agency or program that is operated or licensed by OMH (excluding the Sex Offender Treatment Program or programs located within correctional institutions).

- **"VPCR"** refers to the "Vulnerable Persons' Central Register," a statewide database maintained by the Justice Center to perform necessary functions related to the receipt and acceptance of reportable incidents involving vulnerable persons and the investigation of these incidents.

- **"WSIR"** refers to the "Web Submission of Investigation Reports," a Justice Center web portal which providers have been instructed to utilize to submit investigation materials to the Justice Center.

II. Incident Categories (14 NYCRR §524.5)

a. Reportable Incidents

Pursuant to the PPSNA, "**Reportable Incidents"** (i.e. Allegations of Abuse and Neglect, and Significant Incidents) must be reported to the Justice Center and the Office of Mental Health.

1. **Allegations of Abuse and Neglect**: An allegation of abuse or neglect *must* involve an act (or failure to act) by a "custodian" that causes or was likely to result in, injury or harm to a person receiving services. All allegations of abuse or neglect must be reported to the Justice Center and OMH. This category includes:

Allegations of Abuse & Neglect – Reportable to Justice Center & OMH

Incident Type	Definition
Physical Abuse	Non-accidental physical contact with a VP which causes or has the RFP to cause physical pain or harm
Psychological Abuse	Any verbal or nonverbal conduct that is intended to cause a VP emotional distress
Sexual Abuse	Any sexual contact involving a custodian and a VP, or any sexual contact involving a VP that is encouraged or allowed by a custodian

Neglect	Any action, failure to act, or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a VP
Deliberate Inappropriate Use of Restraint	Restraint that is done for the purpose of punishment or convenience, or which is done with deliberate cruelty
Obstruction of Reports of Reportable Incidents	Conduct by a custodian intended to impede the reporting or investigation of a reportable incident
Unlawful Use or Administration of a Controlled Substance	Any illegal administration, use, or distribution by a custodian of a controlled substance (e.g. codeine, Oxycontin, Ambien, cocaine)
Aversive Conditioning	The use of unpleasant physical stimulus to modify behavior. ANY use of aversive conditioning is prohibited in facilities under the jurisdiction of OMH.

2. **Significant Incidents*:*** The PPSNA and 14 NYCRR Part 524 define a "Significant Incident" as a Reportable Incident, (other than an incident of abuse or neglect) that because of its severity or the sensitivity of the situation results in, or has the RFP to result in, harm to the health, safety, or welfare of a vulnerable person.

Practice Tip:

"Location, location, location!"

In order for an event to be considered a Significant Incident, it must occur on program premises or when the VP is under the actual or intended supervision of an OMH licensed or operated program.

Exception: Falls by VPs are only significant incidents if the VP is a patient in an inpatient or residential setting, the fall occurs on program premises, and serious injury occurs.

For an incident to be a "Significant Incident," must a VP actually suffer some sort of resultant harm? It depends. Some incident types (e.g. suicide attempts, fire setting, and missing patients) are considered Significant Incidents regardless of whether or not they result in injury or harm. Other incident types are considered Significant Incidents only when they **result in**, or **create a reasonably foreseeable risk of**, harm to a VP**. It is important to review the incident category definitions in 14 NYCRR Section 524.5 to gain a clear understanding of when harm is a necessary element for an incident to be considered "significant" and therefore reportable.**

Where harm is a necessary element for an incident to be considered a "significant incident," the level of the harm is referred to as "**serious injury or harm**." The regulatory definition of **Serious Injury or Harm** can be found below. In general, it means injury or harm that requires medical intervention or treatment beyond **First Aid**:

14 NYCRR Section 524.4(q) **Serious injury or harm means:**

- physical harm requiring medical treatment or intervention beyond first aid, (excluding routine diagnostic tests such as laboratory work, X-rays, or scans if no medical treatment is provided);
- psychological harm evidenced by negative changes in affect, behavior, cognition, or which necessitate a significant change in psychotropic or psychotherapeutic intervention; or
- a risk for life threatening physical injury or for psychiatric emergency or trauma

14 NYCRR Section 524.4(d) **First Aid means:**

"One-time treatment, and any follow up, of minor scratches, cuts, burns, splinters, or other minor injuries which do not ordinarily require medical care." Some examples include:

- Using a non-prescription medication (e.g. Tylenol) at recommended dosage
- Cleaning, flushing, or soaking wounds on the surface of the skin
- Applying wound coverings, such as Band-Aids, gauze pads, butterfly bandages
- Using hot or cold therapy
- Removing foreign bodies from the eye using only irrigation or a cotton swab;
- Using non-rigid means of support, such as elastic bandages
- Removing splinters or foreign materials from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means
- Drinking fluids for relief of heat stress

Practice Tip:

Is a visit to an emergency room always a reportable incident?

A visit to an emergency room is not, in and of itself, considered a reportable incident. Incident reports are not necessary for visits to a hospital or emergency room if the person received no treatment. An X-Ray, CAT scan, drawing of blood, or any other diagnostic assessment is not considered treatment. Example: A VP thinks his arm is broken and is taken to the E.R. An X-ray is performed, and his arm is not broken. He is advised to take ibuprofen at non-prescription strength and use hot or cold therapy. This is not an incident. If the X-ray showed his arm was broken and a doctor applied a cast (a rigid means of support), the application of the cast is treatment beyond first aid. Other examples of treatment beyond first aid include stitching a wound, or administering a tetanus shot.

Furthermore, if a patient must go to an emergency room or CPEP in response to exacerbation of symptoms or decompensation, that, in and of itself, is **not** a reportable incident. Similarly, if emergency medication is given to a patient or medications are changed to address symptom acuity, that alone is **not** a reportable incident. However, if an event listed in the table of significant incident occurs and hospitalization or significant change in medication is necessary **as a result** of that event, it is a reportable incident.

Significant Incidents – Reportable to Justice Center & OMH

Incident Type	Definition
Adverse Drug Reaction	An unintended, unexpected or excessive response to a medication given at normal doses, which results in serious injury or harm
Assault	A violent or forceful physical attack by a person *other than a custodian*, in which a VP is either the victim or aggressor, which results in serious injury or harm
Crime	An event which is or appears to be a crime under NYS or Federal law, which (1) Involves a VP as the victim or aggressor; or (2) Does or could affect the health or safety of one or more VPs; or (3) Could have a significant adverse impact on the property or operation of the program
Falls by VPs	Events where Inpatient or Residential VPs trip, slip, or otherwise fall on program premises, resulting in serious injury or harm
Fights	A physical altercation between two or more VPs in which there is no clear victim and no clear aggressor, resulting in serious injury or harm
Financial Exploitation	Events where a custodian uses or misuses a VP's resources, (such as funds, assets, or property) by deception, intimidation, or similar means, with the intent to deprive the VP of those resources. Examples include the deliberate misplacement, theft, or wrongful, temporary, or permanent use of a VP's belongings or money

Significant Incidents – Reportable to Justice Center & OMH

Incident Type	Definition
Fire Setting	Action by a VP, either deliberate or accidental, that results in fire
Injury of Unknown Origin	An injury to a patient for which a cause cannot be immediately determined because 1) the source of the injury could not be explained by the patient or other person; ***And*** (2) the injury is suspicious because of the extent or location of the injury, or the number of injuries observed at one point in time, or the frequency of the incidence of injuries over time.
Medication Error	An error in prescribing, dispensing, or administering a drug that results in serious injury or harm
Missing Patient	A patient **of an Inpatient or Residential facility** who has not been accounted for when expected to be present (in accordance with facility or program practice or policies) and who has not been found on the facility grounds or other expected location, or who is known to have left the facility grounds without the permission of an employee when such permission is otherwise required, and who is considered dangerous to others or unable to care for him/herself. This category also includes minors (under age 18) missing from outpatient programs when expected to be present or under the supervision of staff.

Mistreatment: • Inappropriate (unauthorized) Restraint or Seclusion	Use of restraint or seclusion that is unauthorized (inappropriate) because it was implemented without a valid physician's order or in a manner that was otherwise not compliant with applicable state or federal regulations, but which does not rise to the level of abuse (i.e., physical abuse or deliberate inappropriate use of restraint)
Mistreatment: • Intentional Improper Administration of Medication	Intentional administration to a VP of a prescription drug or over-the counter medication which is not in substantial compliance with a prescription
Mistreatment: • Inappropriate use of time out	Use of time out to remove a patient from regular programming and isolate him/her in an area for the convenience of a custodian or as a substitute for programming
Self-Abuse	Self-inflicted injury not intended to result in death that results in serious injury or harm
Sexual Assault	A sexual attack including but not limited to those that result in vaginal, anal, or oral penetration (i.e., rape or attempted rape and sodomy or attempted sodomy, and/or any sexual contact between a person who is 18 years old or more and a person who is less than 15 years old, or between a person who is 21 years old or older and a person who is less than 17 years old, or which involves a VP who is deemed incapable of consent.)
Sexual Contact Between Children	Vaginal, anal, or oral penetration by patients under age 18 that occurs in a setting where the patient receives around-the-clock care or on the premises of an outpatient program.
Suicide Attempt	An act committed by a VP in an effort to cause his or her own death
Verbal Aggression by Patients	A sustained, repetitive pattern by a VP or VPs of ridiculing, bullying, demeaning, making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on another VP or VPs, which causes serious injury or harm
Wrongful Conduct	Actions or inactions related to service provision by a custodian that are contrary to sound judgment or training, the safeguarding of patient health, safety, or welfare, or patient rights, but which do not meet the definition of

Significant Incidents – Reportable to Justice Center & OMH

Incident Type	Definition
	abuse or neglect**.** This category includes: (1) intentional physical contact with a patient which causes or could cause minor injury (excluding restraint, when done in compliance with 14 NYCRR Section 526.4, or reasonable emergency safety interventions necessary to protect the safety of any person; 2) intentional verbal or nonverbal conduct that is meant to cause a patient emotional distress, but does not result in harm, or results in only minor harm, such as taunting, name calling, issuing threats, using insulting, disrespectful, or coarse language or gestures directed toward a patient; violating patient rights or misusing authority; (3) sexual activity involving a patient and a custodian; or activity of a sexual nature involving a patient that is encouraged by a custodian, such as inappropriate touching or physical contact, sending sexually explicit materials through electronic means (including mobile phones, electronic mail, etc.), voyeurism, or sexual exploitation; or (4) conduct that falls below the standards of behavior established in regulations or facility policies and procedures for the protection of patients against unreasonable risk of harm (e.g., sleeping while on duty)
Other	This category is **not** a discrete category of reportable incident, but is used as a "default category" when the Justice Center classifies an event as a Significant Incident and it does not reasonably fit in any other listed category.

b. Incidents reportable *only* to OMH:

Pursuant to Mental Hygiene Law Section 29.29, the following incidents must be reported to OMH directly in NIMRS. They are NOT called in to the VPCR.

Reportable only to OMH

Incident Type	Definition
Crimes in the Community	An event which is or appears to be a crime under NYS or Federal law, which is perceived to be a *significant danger* to the community or involves a VP whose behavior poses an *imminent concern to the community*
Missing Subject of AOT Order	A person subject to an AOT order who fails to keep a scheduled appointment, who has had no credible contact within the past 24 hours, and/or who cannot be located within a 24 hour period (outpatient programs only). A diligent search should occur when a person is suspected to be missing or is a "no show" to treatment.
Suicide Attempt, Off Site	An act committed by a VP in an attempt to cause his or her own death.

"Crimes in the Community:" What gets reported?

Practice Tip:

This reporting category is used by OMH in large part to obtain important data about the link between mental illness and violent crime, i.e., to dispel the myth that persons with mental illness are more likely to be the perpetrators of violent crime rather than victims. When trying to determine if a crime involving a VP should be reported to OMH, it is important to use judgment and focus on three terms: "the community," "significant danger" and "imminent concern." Many crimes involving patients that occur in the community would **not** meet these criteria, such as turnstyle jumping, drug possession, DWI or petty theft. Crimes that may meet these criteria include homicide, arson, or terroristic threats. A good general rule to follow is if the crime generated significant media attention, it should be reported to OMH.

c. *Patient Death:* (14 NYCRR §524.11)

The death of a patient receiving services from an OMH-licensed residential or inpatient program at the time of the death, including any patient death occurring within 30 days after the discharge from said program, must be reported both to the Justice Center and OMH. The death of an individual receiving services from all other OMH-licensed programs (including those occurring within 30 days of discharge from said program) are reportable **only** to OMH

Practice Tip:

Specific procedures for reporting death to the Justice Center and OMH are detailed in part (b) of Section III ("How to Report") of this guidance.

III. How to Report

a. How to Report Allegations of Abuse & Neglect and Significant Incidents (14 NYCRR §524.7)

To report Allegations of Abuse and Neglect or Significant Incidents, call the Vulnerable Persons Central Register (VPCR) at 1-855-373-2122 or submit the report via web form accessed at: https://vpcr.justicecenter.ny.gov/WIRW/#/
When reporting incidents to the VPCR, the 4-digit OMH Facility Code should be included to facilitate timeliness and accuracy of assignment. For most programs, the OMH Facility Code is the first 4 digits of the Operating Certificate Number; it is also the facility identifier used when completing the OMH Patient Characteristic Survey.
Mandated reporters who become aware of incidents that allegedly occurred at an OMH licensed or operated facility need to notify the Justice Center immediately upon discovery. If the incident is accepted by the Justice Center, the provider will receive electronic notification, which will allow them to create a NIMRS report and investigate the incident.

b. How to Report Incidents reportable only to OMH
(14 NYCRR §524.10)

For incidents that are not required to be reported to the Justice Center, but which must be reported to OMH, the following steps should be taken:

1. An authorized NIMRS user logs into NIMRS and selects "New Incident" from the home screen menu.

2. The NIMRS incident screen opens and a pop-up message describing the process for reporting incidents to the Justice Center will appear. User should click "X" to bypass the pop-up.

3. Enter required information on each NIMRS screen (Incident, Client, Initial Findings etc.) and click "Email OMH."

   If the report is mistakenly called into the VPCR, it will be classified as a "Non-NYJC Incident." These reports are no longer being transferred to the provider in NIMRS, unless they fall into one of the categories of an OMH-reportable incident (suicide attempt in the community, crime in the community, missing AOT client, or death from an outpatient program). If a provider does not receive a report in NIMRS for an event called into the VPCR that is believed to be reportable, the provider should contact their OMH Clinical Risk Manager.

   "Non-NYJC Incidents" that are reportable to OMH should be imported as NIMRS incidents and completed like any other reportable incident. If a provider erroneously receives a "Non-NYJC Incident" that does not meet the definition of an OMH reportable incident, it can be imported into NIMRS for internal tracking or designated as a "Non-Incident" which requires no further action.

4. Document the investigation and "Close" the report in NIMRS.

   A web-based video demonstrating how to "Close" incidents in NIMRS can be viewed in "Processing Significant Incidents in NIMRS" at the NIMRS ***Learning Center*** web page at

   http://www.omh.ny.gov/omhweb/dqm/bqi/nimrs/videos.html

c. How to Report Patient Deaths (14 NYCRR §524.11)

If there is reason to suspect abuse or neglect was related to the death of any patient of an OMH licensed program, this must be reported to the:

Vulnerable Person's Central Registry (VPCR) Hotline at (855) 373-2122.

1. **Inpatient, Residential, or CPEP Services**:

   All deaths of patients receiving services from an inpatient, residential, or CPEP program must be reported to the Justice Center Death Reporting Line upon discovery. In addition, known deaths of individuals who had received services from such a facility or program in the 30 day period preceding death must also be reported.

   To report a death, call the Justice Center Death Reporting Line at **(855) 373-2124.** After the initial report is made to the Justice Center, the provider's authorized NIMRS users should review the report in the ***Justice Center Import Queue*** and create a NIMRS incident report for submission to OMH.

   Within 5 days of the initial report to the Justice Center, the ***Report of Death to the Justice Center*** must be completed and submitted to the Justice Center using NIMRS.

2. **Outpatient Services**:

   Deaths of patients receiving services **only** from an outpatient program, must be reported to OMH via NIMRS upon discovery. Follow the same steps noted in "***How to Report Incidents reportable only to OMH"*** in section III(b), above.

IV. Investigation and CAP Development (14 NYCRR §524.9)

a. Allegations of Abuse or Neglect

1. OMH Led – In cases where the Justice Center has delegated an investigation to OMH and OMH delegates the investigation to the provider, upon completion of the investigation, the provider must submit all investigative materials to the WSIR within 45 days from the date of the report to the VPCR. Any identified corrective actions should be documented in the **Corrective Action Plan** tab page in NIMRS. The provider proceeds with implementation of established corrective actions, pending receipt of the NYS Justice Center Determination Letter. Upon receipt of

the Determination Letter, providers should review Justice Center recommendations to determine if the CAP should be modified. CAPs must be closed in NIMRS within 90 days of receipt of the Justice Center Determination Letter.

2. Justice Center Led – For allegations of abuse and neglect, wherein the Justice Center has assumed investigatory responsibility for, the provider is responsible for taking reasonably necessary steps to secure relevant documentation and ensure safety. If at any point the provider identifies corrective actions related to the allegation, these actions should be documented in the **Corrective Action Plan** tab in NIMRS. The provider will then proceed with implementation of established corrective actions, pending receipt of the NYS Justice Center's investigative report and Determination Letter. Upon receipt of the letter and Justice Center investigative report, the provider should review all findings and recommendations and develop corrective action if appropriate.

b. Significant Incidents

Investigative findings for Significant Incidents must be documented in NIMRS and closed within 45 days from the report to the VPCR. Once the report is closed, OMH will review the information provided to determine if the investigative report is complete and ready for submission to the VPCR. If additional information is required, OMH will directly contact the provider. Once OMH has determined that the report is complete, the information will be sent by OMH to the VPCR where the final disposition will be recorded.

V. Incident Review Committees (IRC) (14 NYCRR §524.13)

OMH operated and licensed mental health providers must have an Incident Review Committee to ensure that incidents are effectively reviewed and monitored. Incident Review Committees also play an important role in identifying preventive and corrective measures. The PPSNA established specific incident composition requirements that providers are expected to meet. It is important that the composition of an Incident Review Committee is such that a free and open exchange of information is encouraged, in order to facilitate full and complete investigations.

While at times scheduling difficulties may occur, it is critical that the scheduling of meetings does not hamper or preclude a prompt and thorough review of each incident. Each Incident Review Committee shall meet within 45 days of acceptance of the report by the Justice Center, or sooner, should the circumstances so warrant, but no less frequently than on a quarterly basis, to allow for the timely review and closure of incidents. All members of the Incident Review Committee must be trained in relevant confidentiality laws and regulations

VI. OMH Customer Relations Line

Providers under OMH jurisdiction should make sure that persons receiving services are advised of the provider's internal grievance process. If a member of the public, consumer or representative has or continues to have concerns regarding services or questions about care, OMH maintains a toll-free Customer Relations Line. This line handles questions and complaints from the public, including persons receiving care from mental health providers that are under OMH's jurisdiction. Providers are encouraged to post information about OMH's Customer Relations Line prominently, so that persons who are experiencing clinical symptoms or who have complaints about their care know that they can call OMH for assistance. Members of the public or persons receiving services may also use the email address on our webpage.

The OMH Customer Relations Line toll-free number is: **1-800-597-8481.**

VII. Jonathan's Law (Mental Hygiene Law §33.23 and 33.25)

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 mental health services provided by providers under the jurisdiction of OMH) of incidents involving their loved ones. It also allows qualified persons 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 decisions 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 (reportable incidents) to the qualified person(s). Written requests for documents under Jonathan's Law should be made directly by the qualified person to the facility that is providing care to the patient. 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.

The law now requires that records and reports released pursuant to these written requests must have a cover letter that states:

> **"Pursuant to Section 33.25 of the Mental Hygiene Law, the attached records and reports shall not be further disseminated, except that you may share the report with: (i) a health care provider; (ii) a behavioral health care provider; (iii) law enforcement, if you believe a crime has been committed; or (iv) your attorney."**

Please note, however, that federal laws or regulations may pose more stringent or additional restrictions on the release of records or information contained in those records.