

# OMH Incident Management Training

## **Review of NYCRR Part 524 Revisions**

Fall 2014



# Agenda

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- Introductions
- Review of Handouts
- Part 524 Revisions
- Incident Reporting in NIMRS
- 15 Minute Break
- Overview of Corrective Action Plans (CAPs)
- Questions



# Clinical Risk Managers (CRM)

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- Western NY – Julie Duncan
- Central NY – Gary Hook
- Hudson River Region – Ellie Hunt
- Long Island Region – Jessica Wright
- NYC – Caroline Guzman
- Asst. Director of Clinical Risk Management –  
Shawn DesRoches



# Protection of People with Special Needs Act

(Chapter 501 of the Laws of 2012)

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- The Act created the **Justice Center for the Protection of People with Special Needs**, responsible for effective incident reporting and investigation systems, fair disciplinary processes, informed and appropriate staff hiring procedures, and strengthened monitoring and oversight systems for six different state agencies covered under the Act.
- The Justice Center operates a 24/7 hotline for reporting allegations of abuse, neglect and “significant incidents” in accordance with the Act’s provisions.



# Revised 14 NYCRR Part 524

## Purpose

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- To ensure that providers develop, implement and monitor an incident management system designed to protect the health and safety of patients and enhance quality of care.
- Effective Incident Management programs encompass:
  - Timely incident reporting
  - Investigations commensurate with the seriousness of the event
  - Investigations of **all** incidents
  - Tracking and trending of incidents
  - Effective corrective action to protect individuals from future harm.
  - Being Proactive
- Current Part 524 of Title 14 NYCRR has been revised and will be replaced with new Part 524 emergency regulations which will be in effect for 90 days from release.



# Applicability

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- Applies to all mental health providers operated or licensed by OMH, with two exceptions:
  - 1) Secure treatment facilities, established pursuant to Article 10 of the Mental Hygiene Law (Sex Offender Treatment Programs) and,
  - 2) Programs operated by OMH that are located in correctional institutions.

These facilities and programs will continue to report incidents to OMH in accordance with OMH Policy QA-510.



# What is a Reportable Incident?

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- Reportable incident categories:
  - All allegations of abuse or neglect
  - Significant Incidents
  
- All reportable incidents must be reported to the Justice Center and the Office of Mental Health immediately and no later than 24 hours after discovery.



# Incident Category Definitions

## *Allegations of Abuse or Neglect*

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*Abuse* occurs when a vulnerable person is harmed, or is placed at risk of harm because of an act of a custodian and includes:

- Physical abuse
- Psychological abuse - In order for a case of psychological abuse to be **substantiated** after it has been reported to the Justice Center, the conduct must intentionally or recklessly cause, or be likely to cause, a **substantial diminution** of a patient's emotional, social or behavioral development or condition, supported by a **clinical assessment** performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor.



# Incident Category Definitions

## *Allegations of Abuse or Neglect (cont.)*

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- Sexual abuse
- Deliberate inappropriate use of restraint
- Unlawful use/administration of a controlled substance by a custodian at the workplace while on duty
- Obstruction of reports of reportable incidents



# Incident Category Definitions

## *Neglect*

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*Neglect* means that a vulnerable person has been harmed, or is placed at risk of harm, because of failure by a custodian to exercise his/her duty to care for the vulnerable person by:

- Failing to provide supervision
- Failing to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care; or
- Failing to provide access to educational instruction where there is a duty to ensure that the vulnerable person obtain such instruction.



# Incident Category Definitions

## *Significant Incidents*

- ***Significant Incident*** means a *reportable incident*, other than an *allegation of abuse or neglect*, that because of its severity or the 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 vulnerable person.
- In order for an event to be considered a Significant Incident it must occur **on program premises** or when the vulnerable person is under **the actual or intended supervision of an OMH licensed or operated program.**
- Please be aware that some Significant Incident definitions are dependent on **serious** harm/injury while others are not.



# Incident Category Definitions

## *Key Significant Incident Terms*

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- ***Serious***, in the context of injury or harm, means:
  - (1) 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)
  - (2) psychological harm evidenced by negative changes in affect, behavior, cognition, or a change in psychotropic or psychotherapeutic intervention; or
  - (3) a risk for life threatening physical injury or psychiatric condition.
  
- ***First aid*** is defined as *“one-time treatment, and any follow up, of minor scratches, cuts, burns, splinters, or other minor injuries which do not ordinarily require medical care.”*



# Incident Category Definitions

## *Reporting Death*

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- The death of a consumer of an OMH operated or licensed mental health provider who has enrolled in or was receiving services at the time of the death, including any consumer's death occurring within 30 days after their admission to or discharge from an OMH operated or licensed mental health program, must be reported both to the Justice Center and OMH.
- Individual NIMRS Death Reporting form
- Justice Center Telephone Notification



# Incident Reporting Requirements

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## ***Reportable Incidents –***

**MUST be reported to the Justice Center and NYS OMH**

- Allegations of Abuse or Neglect
- Significant Incidents:
  - On the premises or under actual or intended supervision:**
    - ✓ Adverse Drug Reaction (*resulting in serious injury/harm*)
    - ✓ Assault (*resulting in serious injury/harm*)
    - ✓ Child Missing from Staff Supervision
    - ✓ Choking
    - ✓ Crime
    - ✓ Falls by patients (*resulting in serious injury/harm*)
    - ✓ Fights (*resulting in serious injury/harm*)
    - ✓ Fire Setting
    - ✓ Injury/Injury of unknown origin
    - ✓ Medication errors (*resulting in serious harm*)
    - ✓ Missing patient



# Incident Reporting Requirements

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## ***Reportable Incidents–***

**MUST be reported to the Justice Center and NYS OMH**

**(cont.)**

- **Significant Incidents (cont.):**
  - ✓ Mistreatment
  - ✓ Self abuse (*resulting in serious injury/harm*)
  - ✓ Severe adverse drug reaction
  - ✓ Sexual contact between children
  - ✓ Sexual assault
  - ✓ Suicide attempt
  - ✓ Unlawful use or administration of controlled substance
  - ✓ Verbal aggression by patients (*resulting in serious injury/harm*)
  - ✓ Other Incident (*has/creates risk of a serious adverse effect on life, health or safety of patient*)



# Incident Reporting Requirements

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Reportable to  
OMH only

When they  
occur off the  
premises of  
the facility or  
when the VP  
was *not*  
under actual  
or intended  
supervision.

- ❑ Crimes in the Community
- ❑ Missing Subject of AOT Order
- ❑ Suicide Attempt, Off Site



# Impact on NIMRS

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- NIMRS will continue to be used for reporting to OMH, however Reportable Incidents must be first reported to the Justice Center.
- Several new NIMRS screens have been added to enable transfer & tracking of information between the VPCR and NIMRS.
- Web-based video tutorials demonstrating new functions are on the OMH Division of Quality Management website. Links are included in Resources.



# Incident Investigations

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- The Justice Center and OMH have the statutory authority to investigate allegations of abuse or neglect and significant incidents.
- **All incidents** shall be thoroughly investigated in a timely manner by staff competent in investigative techniques.
- Investigation Delegation
  - Justice Center Led
  - Provider Delegated
  - OMH Led
- Submit all A/N investigative materials and close out Significant Incidents within 45 days of acceptance in the VPCR.



# Jonathan's Law

## MHL 33.23 and 33.25

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Established procedures that facilities must follow to notify and inform qualified persons of:

- ❑ Incidents involving their loved ones
- ❑ Allow the qualified persons to access certain documents pertaining to such incidents.

Who is a “qualified person”?

- ❑ Parent/legal guardian of minor children
- ❑ Parent, legal guardian, spouse, adult children of adult parents who are legally authorized to make health care decisions on behalf of adult patient
- ❑ Adult patients who have determined by court to be legally competent.



# Incident Review Committee (IRC)

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- Committee membership must at least include:
  - Members of the governing body of the mental health provider;
  - Persons identified by the provider's director, including some of the following:
    1. direct support staff;
    2. licensed health care practitioners;
    3. service recipients; and
    4. representatives of family, consumer, and other advocacy organizations.
- The provider's director shall not be a member of the Committee.
- The Committee must include a physician on a regular membership or *ad hoc* basis, to participate in review of all medically-related incidents.
- The Committee must meet at least quarterly **and always within 10 business days** of completion of any pending investigation of allegations of abuse or neglect, or sooner should the circumstances so warrant.



# OMH Customer Relations

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- ❑ Toll-free (800) 597-8481
- ❑ Approx. 600 calls per month
- ❑ Questions about MH services in NYS
- ❑ Complaints about the quality of care
- ❑ Referral source for MH services
- ❑ Posters and Brochures
- ❑ Translation services available
- ❑ Not for reporting incidents