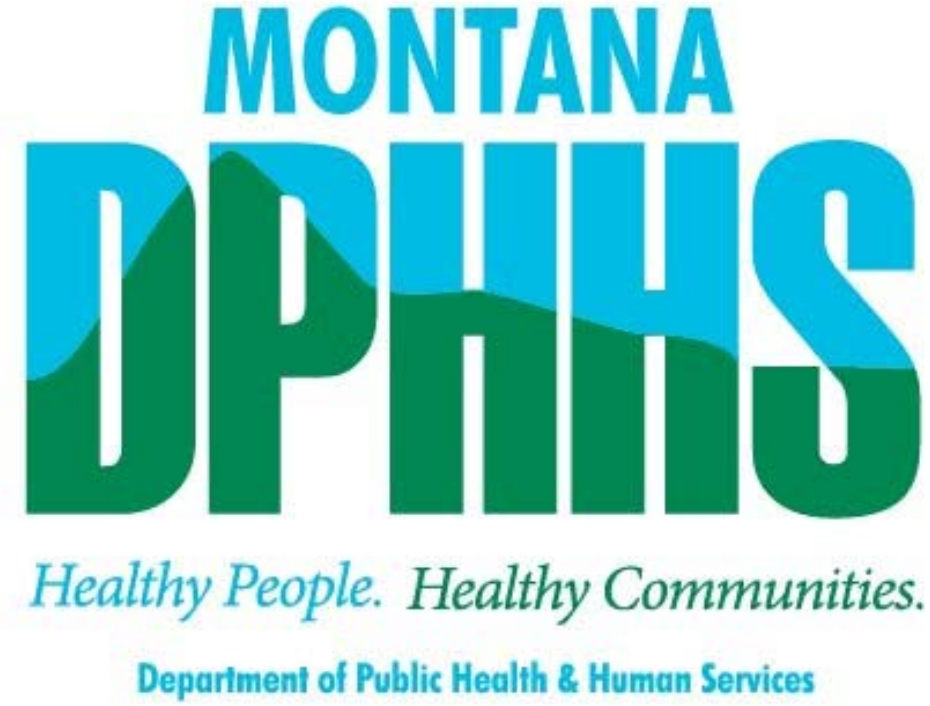
DEVELOPMENTAL DISABILITIES PROGRAM
INCIDENT MANAGEMENT PROCEDURES MANUAL



February 1, 2013

Table of Contents

Introduction

Incident Management Principles

People should have a quality of life that is free of abuse, neglect, and exploitation. A provider agency's incident management system must emphasize prevention and staff involvement in order to provide safe environments for the people they serve.

Quality starts with those who work most closely with people receiving services.

The incident management procedures for the State of Montana Developmental Disabilities Program (DDP) are in effect when a defined incident occurs during the course of delivery of DDP funded services including Children's, Adult, and Self Direct services.

This procedure manual is intended to provide guidance for both DDP staff and provider agencies to support and ensure persons health and safety while receiving services. It identifies and addresses requirements for staff and functions of the incident management system (IMS) put forth by the Developmental Disabilities Program.

It is the policy of the Developmental Disabilities Program that the implementation of a plan of action will be required to prevent the recurrence of similar incidents, along with other activities that allow provider agencies to be proactive in their responsibilities to reduce the risk of harm to persons receiving services.

Incident Management System: Purpose

The purpose of the Developmental Disabilities Program incident management system is:

- To identify adverse events, potential jeopardy, and factors related to risk;
- To notify key people involved in the planning and support of the person;
- To trigger a response to protect the person and minimize further risk to the persons and others;
- To have the ability to collect and analyze information about persons, services, providers, and the service delivery system; and
- To have the capacity to identify patterns and trends in order to guide service improvement efforts.

Confidentiality

Incident reports and investigations are confidential. An incident of abuse and neglect involving a child is subject to the confidentiality provisions of 41-3-205 , MCA. An incident of abuse, neglect and exploitation involving a person with a developmental disability is subject to the confidentiality provisions of 52-3-813 , MCA.

Section 1: INCIDENT DEFINITIONS/CATEGORIES/NOTIFICATION LEVELS

An important component of the Developmental Disabilities Program (DDP) incident management system is the classification of incidents persons may experience while receiving services. For the purpose of the incident management system policy, incidents are classified into three (3) categories: **CRITICAL INCIDENTS**, **REPORTABLE INCIDENTS** and **INTERNAL INCIDENTS**.

All incident reports (IR's) are entered into an electronic web-based data management system (DMS) approved by the Department of Public Health and Human Services of the State of Montana. All critical, reportable, and internal incidents will be reviewed by the incident management committee as described below.

CRITICAL INCIDENTS (data management system notification level "high"):
A critical incident is one that has compromised the safety and well-being of a person as identified in the incident categories. A critical incident is an event that requires an immediate and appropriate response to protect the person and minimize risk, as well as immediate notification to key people. All critical incidents require an investigation.

REPORTABLE INCIDENTS (data management system notification level "medium"):
A reportable incident is one that can compromise the safety and well-being of a person as identified in the incident categories. A reportable incident is an event that requires timely and appropriate response to protect the person and minimize risk, as well as timely notification to key people.

INTERNAL INCIDENTS (data management system notification level "low"):
All other unusual incidents that are not listed under critical or reportable notification level are internal incidents. The discovery of incidents (incidents that occur in the absence of paid staff) can be reported in this category.

NOTE

Any incident report can be investigated if warranted.

NOTIFICATIONS

- Critical incidents will be reported as soon as possible and within 8 hours. Critical incidents must be entered into the data management system within 48 hours or 2 working days.
- Reportable and internal incidents will be entered into data management system within 48 hours or 2 working days.
- Notifications are made to legal representatives, other team members, DDP, advocates and other service provider agencies per Appendix C (Notification Reporting Requirements) as needed or per the plan of care.

NOTE

All suspected abuse, neglect and exploitation must be reported to Adult Protective Services, Child Protective Services or law enforcement, whichever is applicable. The names of those who report critical incidents of suspected abuse, neglect or exploitation are not to be released, unless required by law or regulation.

MANDATORY REPORTERS UNDER MONTANA LAW INCLUDE:

41-3-201(1) MCA, CHILD ABUSE OR NEGLECT REPORTS
(2) Professionals and officials required to report are:
(f) a foster care, residential, or institutional worker; or
(j) an employee of an entity that contracts with the department to provide direct services to children.
52-3-811 MCA, ADULT PROTECTIVE SERVICES
(3) Professionals and other persons required to report are:
(h) a person providing services to an older person or a person with a developmental disability pursuant to a contract with a state or federal agency; and
(i) an employee of the department while in the conduct of the employee's duties.

The data management system (DMS) does not list ABUSE/ NEGLECT/ EXPLOITATION/ CIVIL RIGHTS VIOLATION as an actual event but is treated as a cause of other events whether witnessed or discovered. The event in the DMS is "Injury" and then in the General Information section, you are asked if the injury was a result of suspected abuse or neglect, select abuse/neglect and the notification becomes high or critical. Below are the definitions of ABUSE/NEGLECT/EXPLOITATION/CIVIL RIGHTS VIOLATION.

Abuse
52-3-803 (1), MCA "Abuse" means:
(a) the infliction of physical or mental injury, or
(b) the deprivation of food, shelter, clothing, or services necessary to maintain the physical or mental health of an older person or a person with a developmental disability without lawful authority. A declaration made pursuant to 50-9-103 constitutes lawful authority.

Sexual Abuse
52-3-803 (11), MCA "Sexual abuse" means the commission of sexual assault, sexual inter-course without consent, indecent exposure, deviate sexual conduct, or incest, as described in Title 45, chapter 5, part 5.

Neglect
52-3-803 (7), MCA "Neglect" means the failure of a person who has assumed legal responsibility or a contractual obligation for caring for an older person or a person with a developmental disability or who has voluntarily assumed responsibility for the person's care, including an employee of a public or private residential institution, facility, home, or agency, to provide food, shelter, clothing, or services necessary to maintain the physical or mental health of the older person or the person with a

developmental disability.

Self-Neglect For the purpose of this manual, "self-neglect" means failure of a person to meet their own needs and/or accept offered services.

Exploitation
52-3-803 (3), MCA "Exploitation" means:
(a) The unreasonable use of an older person or a person with a developmental disability or of a power of attorney, conservatorship, or guardianship with regard to an older person or a person with a developmental disability to obtain control of or to divert to the advantage of another the ownership, use, benefit, or possession of or interest in the person's money, assets, property by means of deception, duress, menace, fraud, undue influence, or intimidation with the intent or result of permanently depriving the older person or person with a developmental disability of the ownership, use, benefit, or possession of the person's money, assets, or property;
(b) an act taken by a person who has the trust and confidence of an older person or a person with a developmental disability to obtain control of or to divert to the advantage of another the ownership, use, benefit or possession of or interest in the person's money, assets, or property by means of deception, duress, menace, fraud, undue influence or intimidation with the intent or result of permanently depriving the older person or person with a developmental disability of the ownership, use, or benefit of the person's money, assets or property.

Mental Injury
52-3-803 (6), MCA "Mental injury" means an identifiable and substantial impairment of a person's intellectual or psychological functioning or wellbeing.

Physical Injury
52-3-803 (10), MCA **"**Physical injury" means death, permanent or temporary disfigurement, or impairment of any bodily organ or function.

A civil rights violation is defined as any incident that occurs when a person or another person alleges that a civil right of the person has been violated. The incident must be referred to the agency that has jurisdiction to investigate allegations of rights violations. The rights of all persons include the fundamental human, civil, constitutional and statutory rights.

This is coded in the ABUSE section in the data management system as a civil rights violation and therefore is a critical incident.

PERSON TO PERSON ABUSE REPORTS

Where the reporting staff or supervisor has reasonable cause to suspect that a person receiving DDP funded services has been subjected to abuse, sexual abuse, neglect, or exploitation as defined by the Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act (52-3-801, et. Seq., MCA), and the alleged perpetrator is suspected to be another person receiving services, the incident is required to be reported to the department. These incidents are classified as "Person to Person Altercations" with the cause of abuse. THESE ARE INCIDENTS OF ABUSE and require critical investigations.

INCIDENT DEFINITIONS

NOTE

THE CATEGORIES OF INCIDENTS LISTED ARE THE ONLY ONES TO BE USED FOR THIS POLICY.

INJURY –

Injury is generally defined as damage inflicted to the body. For the purposes of this policy, injuries include:

- Abrasion
- Airway obstruction
- Allergic reaction
- Bite/sting
- Bleeding
- Blister
- Bruise
- Burn
- Choking
- Concussion
- Cut
- Dislocation
- Fracture
- Frostbite
- Hematoma
- Hyperthermia
- Infection
- Laceration
- Lesion
- Loss of consciousness
- Pain
- Poisoning
- Pressure Ulcer
- Puncture
- Rash/hives
- Redness
- Scrape
- Scratch
- Sprain/Strain
- Sunburn
- Swelling/Edema
- Other – see examples below:
  - Loss of fingernail/toenail due to trauma;
  - Loss of tooth/teeth due to trauma;
  - Hypothermia

Self-Injurious Behavior, Pica and Seizure behaviors are causes of injuries and not events and should be clearly marked in data management system under "cause" of an injury or suspected injury. Illness of a person, in and of itself, generally is not to be reported as an injury, but can be reported under “Other – Serious Illness”.

Besides being classified by type of injury, injuries are also classified by the level of the severity of the injury. The reporting classifications are:

Critical (notification level “high”): any injury of known or unknown origin that requires an emergency room or physician visit that results in a hospital admission and/or any injury from suspected abuse or neglect. In the DMS under “injury severity” drop down box select “severe (hospital, ER/admission)".

Reportable (notification level “medium”): injuries requiring treatment by staff or onsite medical personnel such as first-aid, treatment with a PRN pain medication (not over-the-counter medications). In the DMS under “injury severity” drop down box select “moderate (nurse/physician treatment)” or “minor (first aid)".

Internal (notification level “low”): an incident or injury that is temporary and results in either no injury or very minor injury requiring no treatment. Examples include: shallow scratch which does not break the skin; minor skin irritation which does not open the skin; using over-the-counter pain medications or hot/cold packs. In the DMS under “injury severity” drop down box select “very minor.”

MEDICATION ERROR –

Per the National Coordination Council for Medication Error Reporting and Prevention: "A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or person." Internal medication errors are physician or pharmacy errors that are discovered but not administered to the person. All other medication errors are considered reportable **unless** the error causes the outcome of the incident to elevate the incident to a critical notification level. Critical level incidents in this category include: hospitalization, death, or incidents that are caused by suspected abuse or neglect.

Although the data management system includes a field for coding medication severity levels, the DDP will not be using that field.

- **Charting Error -** Medication charted prior to the person taking the medication; medications given to persons and not charted; failure to chart refusals; charting for a co-worker; and/or the use of ditto marks, erasing entries on the Medication Administration Record (MAR), using "white out" on the MAR.
- **Omission -** Medication not given to person; not obtaining refills on time and/or; sufficient quantities not available. A refusal of medication is also an omission.
- **Order Expired -** Medication given beyond the "stop order" and/or medication given past an expiration date.
- **Transcription errors**
  - Wrong dose or the dose on the MAR does not match the dose on the prescription and/or pharmacy label;
  - Wrong person or the name on the MAR does not match the name on the prescription and/or pharmacy label;
  - Wrong medication or the name of the medication on the MAR does not match the medication listed on the prescription and/or pharmacy label;
  - Omission or new medication that was prescribed was not written on the MAR;
  - MAR entry shows the wrong route or the route for giving the medication does not match the doctor's order written on the prescription and/or pharmacy label;
  - Wrong time or the time(s) for medication administration is not the same as indicated on the prescription and/or pharmacy label.
- **Wrong dose**
  - Person given the wrong dose of medication.
- **Wrong person**
  - A medication was given to the wrong person.
- **Wrong medication**
  - The wrong medication was given to the person or a medication was prescribed or given to a person with an allergy to that medication.
- **Wrong route**
  - A medication was given by the incorrect route.
- **Wrong time**
  - The medication was actually given at a time that is different than that written on the MAR or outside of the predefined time interval from its scheduled administration time. (outside the window for administration).
- **Other**
  - Physician or pharmacy errors.

- Medium/texture/consistency or medication not given in proper form.
- Position: Medication specifically prescribed to be given to person when sitting upright in wheelchair not when sitting in recliner
- Storage issues: Administration of a drug that was stored incorrectly or for which the physical or chemical dose (integrity of the drug) has been compromised.
- Finding medication in an area not specifically indicated for medication storage or handling.

NOTE

Regardless of whether a person has experienced adverse side effects and/or their health/welfare is in jeopardy, some types and/or patterns of medication errors emerging from regular trend analysis of all medication errors may raise the incidents to a critical incident classification. As a result, service providers should respond as such and initiate investigations into those circumstances.

RESTRAINTS RELATED TO BEHAVIOR --

- Restraint related to behavior – Physical restraint may only be used as an emergency procedure as described in ARM Title 37, chapter 34, subchapter 14, Positive Behavior Support and all instances of the use of physical restraint must be reported as a critical incident.
- Mechanical restraint as described in ARM Title 37, chapter 34, subchapter 14, Positive Behavior Support may only be used upon written order by a licensed physician for medical reasons. It is not necessary to report the use of mechanical restraint ordered by a licensed physician for medical reasons but all other uses of mechanical restraint must be reported as a critical incident.

RESTRAINT OTHER (UNAUTHORIZED USE OF RESTRICTED OR PROHIBITED PROCEDURES)

Restricted or Prohibited Procedures – The unauthorized use of restricted or prohibited procedures as described in ARM Title 37, chapter 34, subchapter 14, Positive Behavior Support must be reported as a critical incident.

NOTE

The following are not considered restraints when used in accordance with the person's plan of care:

- *Devices used to provide support for the achievement of functional body positions and equilibrium that have been prescribed by an appropriate health care professional;*
- *Stretcher belts or gait belts intended to prevent a person from accidentally falling;*
- *Equipment that does not restrict or prevent movement or the normal use/functioning of the body or body parts to which it is applied;*
- *Helmets as a protective device;*
- *Mechanical supports to provide stability necessary for therapeutic measures, such as immobilization of fractures, administration of intravenous or other medically necessary procedures;*

- *Holding a person's limb(s) or body to provide support for the achievement of functional body positions and equilibrium;*
- *Any specific medical, dental or surgical procedure that has been prescribed by an appropriate health care professional; or*
- *Car seats, high chairs, playpens or items generally used by parents and considered to be used for a child's general health and safety do not fall into this category, unless abuse, neglect or exploitation are suspected.*

DEATH –

The permanent cessation of all vital bodily functions is a critical incident with high notification and requires investigation.

"OTHER" INCIDENTS AS LISTED IN DATA MANAGEMENT SYSTEM –

- **ACCIDENT - NO APPARENT INJURY –** if not due to suspected abuse, neglect or exploitation may be considered as internal or low notification.
- **ALCOHOL/DRUG ABUSE –** if not due to suspected abuse, neglect or exploitation may be considered as internal or low notification.
- **ALTERCATION –**
    - Any altercations resulting in harm to another person requiring treatment at a medical facility, is a critical incident for both the aggressor and the victim reports. *These incidents are classified as "Person to Person Altercations" and therefore, THESE ARE INCIDENTS OF ABUSE and require critical investigations.*
    - Any altercation where there is a temporary disfigurement and does not require treatment at a medical facility is a reportable incident for both the aggressor and victim reports.
    - Any altercation where there is no temporary disfigurement and/ or physical contact is an internal incident.

  This category covers any incident where the altercation is directed at another person and presents a serious risk of physical or mental harm to the other person. For the purposes of this manual, "person to person" refers to both people receiving DDP funded services.
    - Person to Person Altercation– Alleged Victim – To be used when a person is the alleged victim of an altercation by another person.
    - Person to Person Altercation – Alleged Aggressor – To be used when the person is the alleged aggressor of an altercation against another person.
    - Person to Staff – To be used when the person is the alleged aggressor of an altercation against a provider agency staff person.
    - Person to Other – To be used when the person is the alleged aggressor to another individual not in services or a staff, such as a family member, neighbor or stranger.
- **ASSAULT –** An attack BY a staff or community member to a person. This must be reported to APS/CPS and law enforcement immediately. This is a critical incident and requires an investigation.

- **ABSENT WITHOUT LEAVE (AWOL)/MISSING PERSON (UNACCOUNTED FOR ABSENCE) –** If a person's whereabouts are unknown and there is suspected abuse, neglect, or exploitation or whose supervision needs or pattern of behavior is a concern for reasons of safety and well-being, or beyond a time normally expected as outlined in the person's plan of care, it is considered a critical incident or high notification.
- **BEHAVIORAL ISSUE –** (Do Not Use.)
- **CHANGE OF CONDITION –** (Do Not Use.)
- **COMPLAINT AND/OR POSSIBLE LITIGATION –** (Do Not Use.)
- **CONTRABAND –** (Do Not Use.)
- **POSSIBILE CRIMINAL ACTIVITY/MISCONDUCT –** If not due to suspected abuse, neglect or exploitation, is considered reportable or medium notification.
- **EXPLOITATION –** (see Abuse/Neglect/Exploitation definition) – when exploitation is suspected, you must select either Abuse or Neglect in the General Information section of the DMS; for type, select "Other" with "exploitation" typed in.
- **FIRE –** this is a critical incident regardless of cause.
- **HOSPITALIZATION –** any unplanned/unscheduled admission to a hospital or any unplanned/unscheduled psychiatric hospitalization is a critical incident.
- **LAW ENFORCEMENT INVOLVEMENT –** any incident involving a person where law enforcement has been contacted is considered a reportable incident.
- **PROPERTY DAMAGE –** for any damage exceeding $50.00 in value is a reportable incident.
- **SECURITY BREACH –** (Do Not Use.)
- **SENSITIVE SITUATION –** (Do Not Use.)
- **SERIOUS ILLNESS –** this category is selected when a person visits a doctor or visits a same day care type facility and it does not result in admission to a hospital, for either medical or psychological illnesses. Any unplanned medical doctor visits (outside of routine care). Any unplanned medical doctor visit is a reportable incident.
- **SUICIDE-**
    - An incident involving an act (attempt) to harm or injure with the stated intent to end one's own life is considered critical incident.
    - An incident involving a verbal threat to harm or injure oneself with the intent to end one's own life is considered a reportable incident.
- **THEFT/LARCENY ATTEMPT –** can be coded in the DMS as either a perpetrator or victim of theft/larceny. Depending on the information provided, this may be considered an internal incident.
- **POTENTIAL INCIDENT/NEAR MISS –** any event which has the potential for severe injury or any other harm to a person which is narrowly avoided and needs to be addressed to ensure protection from harm is an internal incident.
- **OTHER –**
    - **PRN MEDICATION –** PRN Medication to reduce or eliminate a behavior is strictly prohibited unless prescribed by a physician for a medical reason and an approved protocol signed by the physician is in place. PRN Medication is coded in data management system under "Other" and "PRN use" in the sub-category. This is a reportable incident.

Documentation of Life Events*

There may be situations where an event may be a one-time occurrence that does not meet the threshold of a defined incident but should nevertheless be documented. Life events can be documented in many places including behavior plans, progress notes, case management notes and the person's social history as well as communication logs, and not just incident reports.

If that event begins to reoccur, it could indicate a pattern or trend that needs to be reviewed. All team members involved in a person's care will be prompted to begin looking at this data and determining if a change in services or supports is indicated.

Section 2: PROVIDER REQUIREMENTS

Provider agencies must have policies and procedures to accomplish the following:

1. **Protection from harm**
   - Take immediate action to either remove persons from a harmful situation or to otherwise protect persons from harm.
   - Provide prompt staff intervention when knowledge of harm, or the potential for harm, occurs.
   - Provide immediate medical assessment and/or treatment of a person if needed following an incident.
   - Any injury(s) suspected to be caused by abuse or neglect must be classified as an allegation of abuse or neglect for reporting purposes and must be immediately examined by a medical professional, where appropriate.
   - Assure all direct care staff (hired by family or agency) and volunteers are trained in Montana's Incident Management Policy and Procedures, the reporting of abuse, neglect or exploitation, and the mandatory reporter requirements. Staff must be trained to respond to, report, and document incidents as required in this manual. On-line training is available in the data management system for submitting Incident Reports (IR's).
   - Identify any potential conflict of interest and have alternative personnel available to conduct investigations if a conflict exists.
   - Provide an orientation packet describing their incident management process to persons and/or family members and legal representatives in a user friendly and easily understood format.

2. **Procedures for reporting incidents when they occur**
   - Promptly identify and report incidents, as described herein.
   - Provide the immediate review of the incident for purposes of initially classifying the event and determining the need for a critical incident investigation.
   - Provide timely and accurate notification of the incident to appropriate state, provider and any contracted staff, legal representatives, public officials and representatives from other agencies. (See Appendix C for additional information)
   - Enter Incident Reports (IR) into data management system within 48 hours or 2 business days from the time the incident occurred.
   - Assure any person who, without false intent, reports an incident or makes an allegation of suspected abuse, neglect or exploitation will be free of any form of retaliation.
   - Cooperate with investigators requesting information including making staff available for interviews within the timeframes for investigation. Failure to comply with access requirements will result in corrective actions that may lead up to sanctions.
   - Notify the Developmental Disabilities Program, DPHHS Licensure Bureau, Adult Protective Services, Child Protective Services, and/or law enforcement of the occurrence of a critical incident when incidents fall within their jurisdiction for an investigation.

3. Establish an Incident Management Committee

- Establish an incident management committee. Provider agencies are required to designate a staff person (preferably an employee with some level of supervisory or management capacity) as the Incident Management Coordinator for the organization.
- Identify the role, function, and membership of the committee, including routine review and assessment of all internal, reportable and critical incidents, monitoring trends of incident report information, and developing policies and procedures designed to protect and prevent harm to persons.
- Require weekly meetings of the agency's incident management committee if any incidents have occurred. If meetings do not occur the coordinator will send notification to the committee members.
- Assure that reports of incidents and any required documentation including incident reports, trend analysis reports and any investigation reports are kept confidential. The names of those who report critical incidents of suspected abuse, neglect or exploitation are not released, unless required by law or regulation.

4. Review incidents and take action

- Initiate and conduct a critical incident investigation when a critical incident has been reported.
- Promptly assign agency staff to conduct critical incident investigations. All critical incidents must be investigated by agency staff who have been trained in investigations through training approved by the Department.
- Complete the critical incident investigation no later than ten (10) working days from the time the incident occurs. An extension may be granted to the initial 10-working-day period. The extension must be requested of, and approved in writing by, the Developmental Disabilities Regional Manager. Any written request and subsequent regional manager approval must be attached to the completed FIRF (see Appendix F).
- Review any IR entered in the data management system regardless of the reporting entity.
- There will be circumstances arising where the critical incident investigation will also be conducted by an entity external to the organization or in tandem with another provider where a person is being served jointly by two or more providers. Disability Rights Montana also may conduct an independent investigation and has access to certain records, pursuant to 42 USC Sec.15043.
- Cooperate fully with law enforcement, Adult Protective Services, DPHHS Licensure, or any other outside agency which may have statutory jurisdiction over the investigation of an incident. The agency will conduct their own internal review of the incident regardless of the outcome of any outside investigation. The agency is only to review the facts known at the time without impeding outside agency's investigations. The provider agency must make staff available for interviews within reasonable timelines for the investigation.

NOTE

If the victim or a witness recants their testimony the incident must still be investigated.

- Document a full investigation using the Final Investigation Report Form (FIRF). A triage review must be documented using the Triage Review Form (TRF). The Administrative Review of an investigation, including a Triage, must be attached to the IR in the data management system for review.

5. Follow up of review and or action taken

- Conduct reviews of all incidents and implement action plan requirements and recommendations, which may include personnel action when warranted to prevent the recurrence of similar incidents.
- Establish procedures for data collection through the data management system and conduct trend analysis as a means to develop appropriate support and service plans for the person(s) to prevent more serious incidents from occurring.
- Assure Incident Report and Administrative Review (AR) information are kept in the person's confidential records.
- Assure that policies and procedures were followed during the course of investigations and noted in the administrative review section of the investigation, including removing the employee who is an alleged perpetrator from contact with the person during an investigation of suspected abuse, neglect or exploitation.
- Forward, at the conclusion of the investigation, a copy of the investigation report (FIRF or TRF) to the following:
    - Agency's board of directors;
    - Other executive staff, as appropriate; and
    - Quality improvement specialist.
- Make the investigation documentation (FIRF or TRF) available to the parties listed below:
    - DPHHS/DDP executive staff including: director of the Developmental Disabilities Program, the community services bureau chief, regional manager of the region in which the incident occurred; and
- As appropriate, designated legal staff for the department, and other agencies as required by law or regulation.
- Assure that the person and/or legal representative and case manager are notified of the outcome of the investigation by providing a redacted copy of the Administrative Review (AR), for any investigation within 5 days of its completion.

* While a report may contain reference to the information concerning the incident received from other residents or persons receiving services, personal information about health status and other personal matters of those other residents or persons receiving services that may appear in a report must be redacted. In addition, employment related actions taken by a provider in relation to an employee who is alleged to be responsible for the harm to the person must also be redacted from a report.

Section 3: NON-PROVIDER AGENCY RESPONSIBILITIES

Targeted Case Management Responsibilities

The case manager (CM) has a core responsibility to assure that a person receives quality services as identified through the plan of care. When incidents occur, the CM has the responsibility to assure that the issues/needs of the person are addressed promptly and correctly, and ultimately to reduce the risk of harm to the person. This can be accomplished through the team process. The CM is responsible for the following in the incident management system.

- Submit an IR in data management system if an incident is observed or discovered;
- Review and sign off on Incident Reports for their caseloads and comment/follow-up if necessary;
- CM will ensure any significant incident information is documented in the social history for permanency;
- Provide information and if necessary clarification to persons and/or legal representative explaining the purpose of incident management in a manner that is easily understood;
- Receive and review Incident Management weekly minutes & monthly trend data and analyze for possible revision to the plan of care;
- When a high risk review level (as described below under "*High Risk Review*") has been identified, the CM will review the plan of care with the team to address the incidents and determine if a revision to the plan is necessary;
- Assess the person's level of risk and then address person's ability to manage the risk with the team;
- Attend weekly incident management committee meetings as assigned;
- Participate in Triage Review initiated by DDP staff; and
- Receive Administrative Review information from the provider following an investigation and follow-up if necessary with the team.

Waiver Children's Case Management (WCCM) Responsibilities

The case manager (CM) has a core responsibility to assure that a child receives quality services as identified through the plan of care. When incidents occur, the CM has the responsibility to assure that the issues/needs of the child are addressed promptly and correctly, and ultimately to reduce the risk of harm to them. This can be accomplished through the team process. The CM is responsible for the following in the incident management system.

- Submit an IR in data management system if an incident is observed or discovered.
- Review and sign off on Incident Reports for their caseloads and comment/follow-up if necessary.
- Provide information and if necessary clarification to families explaining the purpose of incident management in a manner that is easily understood.
- When a high risk review level (as described below under "*High Risk Review*") has been identified, the CM will review the plan of care with the team to address the incidents and determine if a revision to the plan is necessary.

- Participate in Triage Review initiated by DDP staff.
- Receive Administrative Review information from the provider following an investigation and follow-up if necessary with the team.

Quality Improvement Specialist Responsibilities

The quality improvement specialists (QIS) of DDP have core responsibilities in the receiving, reviewing and evaluating the IR's submitted by provider agencies in the data management system. In addition, the QIS will investigate certain critical incidents. The following are the QIS responsibilities:

- Submit IRs in data management system when incidents are observed or discovered.
- Receive, review, and sign off on all IRs.
- Receive and review all investigations.
- Participate, when assigned by the regional manager, in the provider agency's incident management committee meetings.
- Participate in Triage Review, as assigned.
- Receive and review Incident Management weekly minutes, monthly trend data and high risk reviews.
- Assess the person's level of risk and the person's ability to manage the risk with the team.
- Assess the service provider's efforts to ensure the health and safety of the person, and make recommendations or take action as appropriate.
- Conduct critical incident investigations for incidents involving emergency/unplanned hospitalization and a person's death, or when assigned by the regional manager due to a conflict of interest or a pattern of incidents requiring further review.
- Conduct a procedural review for critical incident investigations involving abuse, neglect or exploitation when the incident is referred to the appropriate agency for their statutory investigation.
- Complete assigned investigations within ten (10) working days. In cases where the ten days cannot be met, an extension to the timeline can be granted by the regional manager. This request must be in writing. Upon completion the QIS will submit the investigation to the regional manager for review.
- Complete an Investigation Review Form (IRF) of all provider agency critical investigations submitted via the FIRF. Any investigatory procedure issues noted in the IRF will be addressed with the provider agency.
- The QIS has the authority to issue Quality Assurance Observation Sheet (QAOS) to providers as corrective action measures as needed.
- Following the completion of a full investigation, the QIS will forward the Investigation Review Form and any Quality Assurance Observation Sheets (QAOS) to Central Office for outcome tracking.
- For self-directed services, the QIS will:
    - Triage/investigate incidents classified as critical.

- **o** QIS will be available through the regional office to provide technical assistance if requested by the person or the family self-directing their services.

Regional Manager Responsibilities

The Regional Manager's (RM) responsibilities for incident management are as follows:

- Assign the QIS to complete critical incident investigations or request other Developmental Disabilities Program (DDP) staff or an additional QIS to complete an investigation due to conflicts of interest or other necessary circumstances.
- Participate in a Triage Review or assign a designee, as warranted.
- Grant extensions on investigations as requested in writing on a case by case basis.
- Request further follow-up or investigation of an incident.
- Complete the Administrative Review when the critical incident investigation is conducted by the QIS. The Administrative Review Form (AR) will be made available to the bureau chief along with the supporting documents.
- Based upon this review, DDP may request further follow-up or investigation of the incident.
- Conduct monthly trend analysis meetings with the QIS's of regional reports generated from data management system or reports from the DDP central office and determine appropriate follow-up on trends.

DDP Central Office Responsibilities

The DDP central office staff persons, in their various capacities, are responsible for the following activities:

- The DDP is responsible for developing, disseminating, and revising the Investigator's Training Manual to all persons who will be trained to conduct critical incident investigations.
- The central office staff will enter IR's for self-directed services in the data management system.
- The central office staff including but not limited to DDP director, community supports bureau chief, program support bureau chief, crisis prevention specialist, and state medical director, will meet monthly to review trending data and report back to the regional office of any concerns.
- Central office staff will present incident management trend summaries to the quality council.
- The medical director will review medication errors, injury trends and other medical related concerns as needed.
- The medical director will review all death investigations, including the TRF or FIRF and QIS Death Investigation Review Checklist (QDIRC), and participate on the mortality review committee. Findings from the committee will be shared with the appropriate field staff.
- Assure that all critical incidents involving deaths remain open until after the morality review committee has met and until recommended closure is received from the central office. (Note: this may require granting extension(s) to staff until all information is

received and until after the Morality review committee has met or if mortality review committee requests additional information based upon their findings.)

Responsibilities for Self-Directed Services with a Fiscal Intermediary

- All staff working for a person receiving self-directed DDP funded services is required to report critical incidents by submitting an incident report (paper copy) to central office following the timelines in this manual.

NOTE

Staff who are hired by the family and being paid by DDP funds are mandatory reporters. They are required to make timely and accurate notification of incidents to DDP, APS/CPS or law enforcement, as needed.

- Take immediate action to move the person from a harmful situation or to otherwise protect persons from harm.
- Provide prompt staff intervention when knowledge of harm, or the potential for harm, occurs;
- Provide immediate medical assessment and/or treatment for a person receiving self-directed services if needed following an incident.
- Any injury(s) suspected to be caused by abuse or neglect must be immediately examined by a medical professional and classified as an allegation of abuse or neglect for reporting purposes.
- The person or family choosing to self-direct services must participate and cooperate with the person conducting the investigation.
- All self- direct staff is to be trained on the DDP incident management system on recognizing incidents, notification procedures and the completion of an incident report.

Section 4: INCIDENT MANAGEMENT COORDINATORS and COMMITTEES

All incidents identified as critical, reportable and internal will be reviewed weekly through the provider agency's incident management committee.

Provider agencies are required to designate a staff person (preferably an employee with some level of supervisory or management capacity) as the incident management coordinator for the organization.

Duties of the Incident Management (IM) Coordinator

- Provide technical assistance to staff members regarding the agency's incident management system including completion of the Incident Report Form and other needed documentation.
- Ensure IR's are filled out completely, accurately, and coded correctly in the DMS.
- Ensure that organizations/authorities external to the organization receive notification (verbal and/or in writing) of critical incidents as defined by this policy.
- Coordinate training regarding the application of the DDP incident management requirements.
- Approve IR's in the data management system within 48 hours or 2 working days after the incident management committee meeting and include the committee's recommendations. Any additional information or corrections will be noted in the comment section of the incident report.
- The IM coordinator will contact the person's case manager, to discuss the need to hold a team meeting to discuss the pattern or trend of incidents in order to assure health and safety. This will be noted in the IM minutes.
- Follow-up to ensure that all recommendations were followed and completed.
- Serve as a member of the agency's incident management committee.
- Send minutes to the committee weekly for review prior to the next meeting.
- Maintain the minutes of the meetings and distribute the minutes to the QIS and CM. The minutes will include:
    - Names, titles and agency represented of those in attendance;
    - List of all incidents since previous meeting;
    - Documentation of the incident management committee's findings, recommendations, implementation of recommendations, and results/effects of actions implemented which are also added to the comments in the IR in the data management system; and
    - Any outstanding follow-up from previous incidents not already discussed.
- The IM Coordinator will attach the Administrative Review to the IR in data management system.
- Compile and disseminate monthly Incident Management Trend Summary of all incidents, and documentation of actions taken, no later than 10 working days after the last day of the month. Trend reports are sent to the QIS, to case management supervisors to be distributed to the appropriate person's case manager, and provider agency's Board of Directors. This report must include the following information:
    - Total number of incidents per category (Critical, Reportable, Internal);
    - Types of incidents;

    - Types of incidents by person name;
    - Incidents by total number of injuries;
    - Severity of injuries;
    - Location where injuries and other incidents occur;
    - Times, if applicable, in which injuries and other incidents occur;
    - Specific employees involved in the incident;
    - Specific persons involved in the incident; and
    - Other trends deemed as being appropriate, based on the needs of persons and the mission of the Service Provider.
- Prepare monthly trend reports and analyses of incident data which includes high risk review data and submit to the provider agency's incident management committee.

High Risk Review

The high risk review for any person who meets one (1) or more of the criteria listed below is required within 10 working days (the incident management committee may also determine that more frequent high risk reviews are indicated):

- Three (3) or more critical incidents during the preceding month or five (5) or more critical incidents during the preceding three (3) months;
- A serious or severe injury due to substantiated allegations of staff abuse, neglect, or exploitation; or
- A pattern or trend of reportable incidents involving a person over a three (3) month period that requires a more thorough review and assessment of the person's needs.

The incident management committee also has the discretion to recommend a high risk review for a person who does not meet the minimum criteria as defined above.

Membership and Functions of the Incident Management Committee

- The incident management committee membership must include:
    - The executive director/CEO or the executive director/CEO's designee;
    - Incident management coordinator;
    - Representatives of each of the service provider's operational program units;
    - A case management representative; and
    - The quality improvement specialist assigned to work with the agency is an optional member and will attend meetings, as warranted.
- The incident management committee must meet at least weekly. If there are no incidents to review, then the committee does not need to meet as scheduled and the IM coordinator will send notifications to other committee members and document the reason why.
- At each meeting, the committee is required to review all IR's that have been reported since the last scheduled meeting.
- The review is focused on the following and IM committee meeting minutes must include:
    - Provider name, date of meeting, members in attendance, date of incidents and level of incidents;
    - Review of what occurred and the staff response and follow-up actions;

- Determination of whether already recommended corrective/preventive actions were implemented;
- Consideration of what (if any) additional corrective and/or preventive actions are warranted that would provide additional positive supports to the service recipient and staff;
- Consideration of whether the person's plan of care should be amended based on information developed as a result of this process or through a high risk review. If so, the planning team is to be convened;
- The minutes must reflect that trends have been reviewed and analyzed and;
- The committee will review past incidents to ensure completion and remediation of unresolved concerns have been addressed and documented in the weekly minutes.

NOTE

For all incidents (critical, reportable, internal) the recommendations from the incident management committee must go into data management system on the IR.

Section 5: TYPES OF REVIEWS AND INVESTIGATIONS

Full Investigation (FIRF)

A full investigation is conducted for ALL critical incidents where abuse, neglect and/or exploitation is suspected. A full investigation can also be conducted for incidents elevated to critical and exceed the review of the Triage Review form. The full investigation process will generally follow those outlined in the Investigator's Manual. Appendix A: Key Stages to Conducting Critical Incident Investigations, is a quick reference guide. Following the investigation which is reviewed at the weekly IMC, the administrative review will be completed and attached to the incident report in the data management system.

Full investigations completed by the provider agency or DDP are to be documented using the FIRF.

Triage Review (TRF)

The Triage Review form, commonly known as the "Triage", can be used as the review/investigation of any critical incidents where abuse, neglect and/or exploitation ARE NOT suspected. This review can be used by provider agency staff or DDP staff. The provider agency will determine whether or not a more complete investigation is warranted, however DDP can require a more complete investigation. If no further investigation is warranted, the Triage review will be the completed investigation for this incident and will be documented using the TRF. The Triage Review form will be reviewed at the IM committee meetings and an Administrative Review will be completed and attached to the IR in the data management system.

Administrative Review (AR)

The Administrative Review form (AR) will be completed by the agency's administration or the regional manager depending on who completed the investigation to assure all policies and procedures were followed, appropriate recommendations were made and actions were taken to assure health and safety. This level of review is done for all critical of investigations (Full or Triage) and must be attached to the incident report in the DMS. The IM committee will monitor and follow up on the AR recommendations at IM committee meetings to ensure they are implemented. The AR will not be closed until the recommended action outcomes are completed and documented.

Death (QDIRC)

If the critical incident is a person's death, in addition to the investigation (either Full or Triage) done by the provider agency or the QIS, the Death Investigation Review Checklist, only done by the QIS, is forwarded to the mortality review committee.

Procedural Review (PR)

The QIS will conduct a Procedural Review (PR) of any suspected abuse, neglect, or exploitation incidents to determine if rules, policies and programmatic procedures are in place and being followed to protect persons from harm as outlined in the PR. This will be done regardless of whether outside entity investigations are being conducted. This includes law enforcement (LE), Adult Protective Services (APS), Child Protective Services (CPS), Bureau of Indian Affairs (BIA), DPHHS Licensing Bureau, etc., which are required by statute or

regulation to conduct an investigation into the incident. *QIS will cooperate with LE and APS when conducting an investigation or a procedural review.*

Investigation Review (IRF)

The quality improvement specialist conducts an Investigation Review for all critical incident investigations conducted by the provider agency. The QIS documents the review of all submitted materials on the Investigation Review form (IRF).

Appendix A: KEY STAGES TO CONDUCTING CRITICAL INCIDENT INVESTIGATIONS
CRITICAL INCIDENT INVESTIGATION SUMMARY GUIDE

STAGE OF INVESTIGATION	RESPONSIBILITY	KEY TASKS/ACTIVITIES
1. Incident Identified **INTAKE & PRESERVE EVIDENCE**	SITE SUPERVISORS AGENCY MANAGEMENT	1. Assure health/safety of all persons. 2. Provide medical treatment. 3. Secure the scene (as necessary). 4. Identify, keep witnesses separate. 5. Secure documentary evidence.
2. Arrive at scene **IDENTIFY/COLLECT EVIDENCE**	INVESTIGATOR(S)	1. Review activities of intake and preservation with management. 2. Review incident with Reporter. 3. Identify/collect physical and demonstrative evidence. 4. Sort/classify/interview witnesses, obtain written statements. 5. Identify and collect other documentary evidence.
3. Review/Reconcile **ANALYSIS & PRESENTATION of EVIDENCE**	INVESTIGATOR(S)	1. Review/assess evidence collected. 2. Conduct background interviews (as necessary). 3. Conduct follow-up interviews (as necessary). 4. Conduct final reconciliation of evidence. 5. Prepare Final Investigation Report using standard report format.
4. Final Decision-Making **RECOMMENDATIONS and/or REQUIREMENTS** **ACTION PLAN & ADMINISTRATIVE REVIEW**	AGENCY MANAGEMENT INCIDENT MANAGEMENT COMMITTEE	1. Review competency/quality of investigation. 2. Determine final conclusions of the investigation. 3. Determine recommendations, requirements and action plans. 4. Implement recommendations, requirements and action plans. 5. Submit completed IR and other required documentation to the DDP.
5. DDP Competency Review **QUALITY REVIEW**	DDP QUALITY IMPROVEMENT SPECIALIST	1. Completes audit of investigation using Investigation Review Form. 2. Review and monitor implementation of recommendations and action plan.

Key Stages to Conducting Critical Incident Investigations

Standard protocols are used to identify, collect, and analyze evidence available during an investigation. There are five (5) key stages to any investigation:

1. Intake and Preservation of Evidence (including the identification and initial reporting of the event);
2. Identification and Collection of Evidence;
3. Analysis (reconciliation) and Presentation of Evidence;
4. Recommendations and Action Plan; and
5. Quality Improvement (conclusions, recommendations/requirements and corrective action).

STAGE 1: INTAKE AND PRESERVATION OF EVIDENCE

Once an incident has been identified as meeting the criteria for a critical incident that will be investigated, and a decision has been made as to any external investigation being conducted, provider agency site supervisors and/or other management staff are responsible to assure the following activities occur:

- Assure that the health and safety of all persons (persons, staff, and visitors) is addressed immediately;
- Seek immediate, medical treatment for allegations involving any physical injury, change in medical status, or sexual abuse regardless of whether or not a victim or a witness recants their testimony, and secure the scene. If possible, management staff will secure the scene by locking the area so no one is admitted until the investigator(s) arrives. If this is not possible, then the management staff should properly photograph and diagram the scene; and
- Identify, keep, and separate any witnesses. While it is not always possible to separate witnesses prior to being interviewed by the investigator(s), at minimum, management staff should explain to witnesses the need to not talk about the incident until interviewed by the investigator(s). This helps to minimize the potential that memories will be altered or changed (even unintentionally).

NOTE

It is recommended that all interviews be electronically recorded, as long as interviewees agree to the recording of the interviews and sign a permission form (see Forms).

It is also recommended that 2 people be present when interviewing witnesses or victims.

- Interviews with persons alleged to be sexually abused must be interviewed by a member of the same sex or have a member of the same sex present at all times during the interview.
- There may also be times when agency management will make a decision to require staff to remain after normal work hours have ended in order to interview witnesses for the purposes of the investigation.

- Secure documentary evidence. Management will assure that documentary evidence is maintained in a secure location until the investigator(s) can take possession of the materials. Documentary evidence can include any business record produced by the organization: the person's primary record (medical or otherwise), log books, incident reports, medication records, medical reports, staff schedules, training records, personnel records, financial records, etc.

STAGE 2: IDENTIFICATION AND COLLECTION OF EVIDENCE

Upon assignment of the investigation, the investigator(s) will arrive at the scene in order to begin the identification and collection of evidence. The investigator(s) has primary responsibilities to assure the following occurs:

- Review activities of intake and preservation with agency site supervisors and/or management responsible for conducting steps in Phase 1. Review the initial steps taken by people discovering or witnessing the incident, and upon receiving report of the incident, what management's response was. There should also be a transition of evidence (the chain of custody) initially preserved by management including any documentary evidence and names of potential witnesses (reporter, victim, alleged target, other witnesses with direct or circumstantial evidence, etc.).
- Review incident with the reporter. The investigator(s) should clarify with the reporter that the reporter did indeed report the incident, and verify what exactly the report initially communicated. The formal investigatory interview regarding the incident will take place at a later time.
- Identify and collect physical and demonstrative evidence. While physical evidence will not always be secured for every incident, collect physical evidence as necessary, take photographs and prepare diagrams, along with any other demonstrative evidence relevant to the incident. Focus on these tasks first when possible prior to interviewing witnesses. This is done primarily to assure that when the investigator(s) begins to conduct the investigatory interviews with witnesses they are in the best position to create a comprehensive interview with each person. Release the physical evidence as soon as possible back to normal use.
- Sort, classify, and interview witnesses; obtain written statements from witnesses. Sort witnesses by name in the following categories: Victim(s), Witness(s) with Direct Evidence, Witness(s) with Circumstantial Evidence, Alleged Persons of Interest. When possible, interview the reporter first, followed by the alleged victim, then witnesses with direct evidence, and witnesses with circumstantial evidence. Try to conduct the interview with the alleged perpetrator(s) last.
  Written statements will be obtained from witnesses at the conclusion of the interview, and should be taken prior to concluding the investigatory interview.
- Identify and collect other documentary evidence. This information can include any business records of the organization related to the persons, employees, financial activities, or other administrative processes including activities of the Board of Directors of the corporation. Based upon the emergence of issues during the investigation, the investigator(s) may need to request additional information beyond

what was initially identified and provided. Photocopies of any documentary evidence determined to be relevant to the investigation should be made and maintained as a part of the investigation file.

STAGE 3: ANALYSIS AND PRESENTATION OF EVIDENCE

Once the investigator(s) has identified and collected all evidence relevant to the investigation, the process of reviewing the evidence and reconciling this information needs to begin. In order to best accomplish responsibilities related to this phase of the investigation, it is important to understand and apply some of the core rules associated with **Reconciliation of Evidence**. These are as follows:

- Is the witness's story consistent over time? Generally, a witness's story that is consistent over time will be seen as more credible than a witness whose story changes key facts/information over time.
- Can independent corroboration of a person's version of the incident be established which generally enhances credibility of that person's testimony?
- Is the physical evidence available in the investigation consistent or inconsistent with testimony given by witnesses? Where physical evidence is consistent with a witness statement, more value is given to that version of the event.
- Based upon the witness's location with respect to the incident itself (physical proximity and the environment), how will his/her capacity to make observations be affected? Are there possible environmental barriers that will affect a witness's capacity to see/hear?
- What are the witness's own capacities to see and hear? Are there impairments to either the sense of seeing or hearing?
- What was the witness's level of focus and attention during the course of the incident?
- What is the witness's relationship to other people involved in the incident: This relates to what may be seen as potential bias on the part of a witness because of the nature of a relationship they have with another party involved in the incident.

Core activities associated with the Analysis phase of the investigation include:

- Review and assess evidence collected. Identify all pieces of evidence where there is consistency and separate from the evidences where inconsistencies emerge.
- Conduct background interviews as necessary. These are conducted with persons who may be able to provide clarifying information regarding evidence in an investigation, not with identified witnesses to the incident itself.
- Conduct follow-up interviews with witnesses as necessary. These interviews are with witnesses to the incident itself and are primarily designed to clarify evidence or other questions that arise during the investigation.
- Conduct final reconciliation of evidence using the bulleted "Rules for Reconciling Evidence" identified above.
- Prepare and submit Critical Incident Final Investigation Report to DDP.
- Attach the Administrative Review (AR) to the IR in data management system.

STAGE 4: RECOMMENDATIONS/REQUIREMENTS AND ACTION PLAN

- Provider agency management, in conjunction with their incident management committee, will review the FIRF to determine final conclusions, recommendations and any requirements based on the findings of the investigations, and an action plan to implement those recommendations/requirements including timeframes for completion. This Administrative Review must be completed within ten (10) working days of the completion of the investigation.
- When the quality improvement specialist (QIS) conducts an investigation, a regional manager, will complete the Administrative Review within ten (10) working days after the completion of the QIS investigation.

The core activities of this phase of the investigation include:

- Review all components of the critical incident investigation for competency and quality. The investigation should have been conducted meeting the standards associated with speed, thoroughness, objectivity and provides all necessary information to draw reasonable conclusions and make appropriate recommendations/requirements.
- Develop recommendations/requirements and an action plan based on the findings of the investigation and conclusions drawn from that process:
    - Confirmed based on evidence – most likely the incident occurred as initially submitted – there is a preponderance of information to support the conclusion;
    - Not confirmed based on evidence – incident most likely did not occur as submitted;
    - Inconclusive – evidence neither supports nor disproves the incident occurred and cannot reach a conclusion.
- Any recommendations/requirement and subsequent action plans developed should reflect not only decisions specific to the incident itself but must also reflect assessment of other identified systemic issues related to the incident occurring, including antecedents (reasons why the incident occurred) and post-incident interventions.
- Implement recommendations, requirements and an action plan. The assignment of specific action plan items and target dates for completion are established and the provider agency is making a commitment to assure these recommendations and action plans are actually implemented.
- Determine whether there was a preponderance of evidence to support one of the following conclusions or findings regarding the investigation:
    - Closed
    - To Be Continued (there is not enough evidence to reach a conclusion).

STAGE 5: QUALITY REVIEW – Investigation Review Form (IRF)

- Using the Investigation Review Form (IRF), the QIS will review each investigation following the receipt of the final investigation report. If any deficiencies are discovered, the provider will be notified. (If the investigation is done by the QIS, the RM will complete the review.)
- The QIS will monitor the implementation of the recommendations/requirements and action plan as part of the quality assurance process.

Appendix B: INSTRUCTIONS FOR COMPLETING AN INCIDENT REPORT USING THE GENERAL EVENT REPORT (GER) IN THE DATA MANAGEMENT SYSTEM

The observer/discoverer of incident completes the General Event Report (GER) for any situation that meets the definition of a critical, reportable or internal incident.

Where there is more than one person involved in the incident, a report will be filled out for each person. The report for each person will focus on the actions of that person and the steps taken by the provider on behalf of that person.

NOTE: You must complete all required fields marked with a red asterisk (*). There are additional fields that the State of Montana deems as required but the field is not followed by an asterisk (*) in data management system. For the purposes of these instructions, note all required fields are marked with an asterisk (*).

Steps to fill out a GER:

1. From the First Page or Dashboard click on the 'New' link in the GER module.
2. Select the appropriate program location from the list.
3. Select the particular person from the list. This will open a new GER on that person.
4. In the profile information section, select the Reporting Date* for the incident.
5. Event information:
   *In the event date field use the calendar button to select the date when the event occurred (it defaults to the current date).
   *If the event occurred outside of the agency's physical location, choose the appropriate locations from the drop-down menu in the 'if not at responsible program' section.
   * Describe what happened before the event: <u>Use observable measureable terms to describe the environmental conditions, cues given, etc.</u>
   *Complete location address (if on site you can check the box for same as program address as it will auto fill).
6. Add Event: Chose the appropriate event type in the Add Event section. This will generate another window with a more specific event information form for each event type.
   * For each Event added, specific details of the event will be required.
   <u>Please use observable and measureable terms in describing the event</u>. Keep in mind others will be reading the report and trying to envision the event occurring. Describe who was involved and other witnesses. When other persons who receive services are involved in the incident, use their initials. You will need to fill out a separate incident form for the other person(s) involved.
   When completed with the event field choice click 'Add' to add to GER.

   - Injury
     *Type: If other is chosen in any of the questions, please specify in the 'if Other' box.
     *Cause
     *This event was observer/ discovered
     *Time of Injury
     *Specific location
     *Treated By
     *Injury severity
     *Body part(s)
     *Injury summary
     *"Witnessed," where the staff person was present or involved in the incident; or

*"Discovered," where a staff identifies an incident but was not present, was not involved, or where the incident is "suspected."
*You may also use the body diagram to select specific body part(s) affected by the injury.
*Provide as much detail in the injury summary section as known.

- Medication Error
  - *Type
  - *Medication as ordered
    - Name
    - Dose
    - Measurement unit
    - Frequency
    - Route
    - Time
  - *Medication as given
    - Name
    - Dose
    - Measurement unit
    - Frequency
    - Route
    - Time
  - *First error date
  - *Last error date
  - *Total errors
  - *Cause of error
  - *Reason/explanation for error
  - *Medical attention required
  - *Error discovered date
  - *Error discovered time
  - *Person(s) responsible
  - Severity level 1-10 (Do Not Use)
- Restraint Related to Behavior (this field is NOT used for PRNs)

  IF marking "No" do the following:
  - *Begin time
  - *End time
  - *End date
  - *Status
  - *Injury caused by restraint
  - *Monitoring, at least every 30 minutes
  - *Exercise at least 10 min every hour
  - *Person applying
  - *In charge during
  - *Restraint summary

  IF marking "Yes" do the following:
  - *Select behavior
  - *You may pick multiple behaviors
    - *If behavior is not listed, select "add new behavior" and enter behavior
  - *Intervention
  - *Choose the intervention(s) preformed
    - *If intervention is not listed, select "add new intervention" and enter intervention preformed

*Behavior details
*Name description
*Antecedent
*Intervention details
*Name description
*Behavior event
*Check the box by the table indicating behaviors
*Event date
*Begin time
*End time
*Intensity
*Notification level
*Comments

- Restraint Other
  - *Restraint type
    - Chemical
    - *Mechanical
    - *Physical
    - *Other
  - *Begin time
  - *End time
  - *Location
  - *Restraint summary
- Death
  - *Time
  - *Cause
- Other
  - *Event type
  - *Event subtype (if applicable)
  - *Person was (if applicable)
  - *Event time
  - *This event was
  - *Location
  - *Event summary

7. *General Information
   *Add Necessary information in the General information section.
   *Abuse suspected: yes or no
   *Notification Level based upon DDP definitions High (critical), Medium (reportable), Low (internal)
8. *Notification
   Click on the 'Add Notification Info' button. This will open a pop up window for adding notification information. Fill out the notification details and click on the 'Add" button at the bottom of the form.
9. *Complete the actions Taken or Planned section:
   *Describe any staff actions to immediately protect from harm;
   *Describe any immediate staff actions to make the environment safe;
   *Describe any actions to provide first aid or seek emergency medical assistance; and
   *Identify supervisors and/or other persons notified of the incident.

Appendix C: NOTIFICATION REPORTING REQUIREMENTS FOR CRITICAL, REPORTABLE, AND INTERNAL INCIDENTS

Type of Critical Incident		**Case Manager** **(per ARM 37.34.1501)**	**Legal Representative or Next of Kin** ***unless directly involved in the alleged incident***	**Adult Protective Service*** **(per MCA 52-3-811)** Person is age 18 or older	**Child Protective Service** **(per MCA 41-3-201)** Person under age 18	**County Attorney** **(per MCA 52-3-811)** Person is age 18 or older	**Long Term Care Ombudsman** **(per MCA 52-3-811)** Person is age 18 or older	**DPHHS Licensure Bureau** Person in Licensed DD Group Home or Licensed Foster Home
Allegation of Abuse, Neglect, Exploitation	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.	If the person is not a resident in a long term care facility, report to APS or local affiliate, as soon as possible, w/in 8 hours of witnessed incident.	Report to the Centralized Intake Bureau Hotline (1-866-820-5437) as soon as possible. w/in 8 hours of witnessed incident.	If the report involves a suspected act or omission of the department, report to the county attorney of the county in which the person resides or in which the acts that are the subject of the report occurred.	If the person is a resident in a long-term care facility, report the matter to the long-term care ombudsman appointed under the provisions of 42 U.S.C. 3027(a)(12) and to AS.	Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Allegation of Person to Person Altercations resulting in Abuse, Neglect, Exploitation	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.	If the person is not a resident in a long term care facility, report to APS or local affiliate, as soon as possible, w/in 8 hours of witnessed incident.	Report to the Centralized Intake Bureau Hotline (1-866-820-5437) as soon as possible. w/in 8 hours of witnessed incident.	If the report involves a suspected act or omission of the Department, report to the county attorney of the county in which the person resides or in which the acts that are the subject of the report occurred.	If the person is a resident in a long-term care facility, report the matter to the long-term care ombudsman appointed under the provisions of 42 U.S.C. 3027(a)(12) and to AS.	Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Civil Rights Violation	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.				If the person is a resident in a long-term care facility, report the matter to the long-term care ombudsman appointed under the provisions of 42 U.S.C. 3027(a)(12) and to AS.	Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.

Type of Critical Incident		**Case Manager** **(per ARM 37.34.1501)**	**Legal Representative or Next of Kin** ***unless directly involved in the alleged incident***	**Adult Protective Service*** **(per MCA 52-3-811)** Person is age 18 or older	**Child Protective Service** **(per MCA 41-3-201)** Person under age 18	**County Attorney** **(per MCA 52-3-811)** Person is age 18 or older	**Long Term Care Ombudsman** **(per MCA 52-3-811)** Person is age 18 or older	**DPHHS Licensure Bureau** Person in Licensed DD Group Home or Licensed Foster Home
Restraint Related to Behavior _____ **Restraint Other**	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.	If abuse is suspected, and if the person is not a resident in a long term care facility, report to APS or local affiliate, as soon as possible, w/in 8 hours of witnessed incident.	If abuse is suspected, Report to the Centralized Intake Bureau Hotline (1-866-820-5437) as soon as possible. w/in 8 hours of witnessed incident.		If the person is a resident in a long-term care facility, report the matter to the long-term care ombudsman appointed under the provisions of 42 U.S.C. 3027(a)(12) and to AS.	Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Death	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.					Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Fire	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.					Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Suicide Attempt	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.	If the person is not a resident in a long term care facility, report to APS or local affiliate, as soon as possible, w/in 8 hours of witnessed incident.	Report to the Centralized Intake Bureau Hotline (1-866-820-5437) as soon as possible. w/in 8 hours of witnessed incident.			Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.

Type of Critical Incident		Case Manager (per ARM 37.34.1501)	Legal Representative or Next of Kin *unless directly involved in the alleged incident*	Adult Protective Service* (per MCA 52-3-811) Person is age 18 or older	Child Protective Service (per MCA 41-3-201) Person under age 18	County Attorney (per MCA 52-3-811) Person is age 18 or older	Long Term Care Ombudsman (per MCA 52-3-811) Person is age 18 or older	DPHHS Licensure Bureau Person in Licensed DD Group Home or Licensed Foster Home
Hospitalization	QIS, w/in 8 hours of witnessed incident, IR written in data management System within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management System within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.					Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Unaccounted for Absence	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.					Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
	IR written in data management system within 48 hours or 2 working days.	w/in 48 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.					Must be reported to the local DPHHS Licensing Office within w/in 8 hours of witnessed incident.
Medication Errors	IR written in data management system within 48 hours or 2 working days.	w/in 48 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP and no later than 8 hours after incident.					Must be reported to the local DPHHS Licensing Office within twenty-four (24) hours of the incident's occurrence.
Other Reportable and Internal Incidents	IR written in data management system within 48 hours or 2 working days.	IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP and no later than 8 hours after incident.					

Appendix D: MONTANA DDP INCIDENT MANAGEMENT POLICY ACROYNMS

A/N/E ..... ABUSE, NEGLECT, or EXPLOTATION

APS/CPS ..... ADULT PROTECTIVE SERVICES/CHILD PROTECTIVE SERVICES

AR ..... ADMINISTRATIVE REVIEW

ARM/MCA ..... ADMINISTRATIVE RULES OF MONTANA/ MONTANA CODE ANNOTATED

BIA ..... BUREAU OF INDIAN AFFAIRS

CM/WCCM ..... CASE MANAGER/WAIVER CHILDREN'S CASE MANAGER

DDP ..... DEVELOPMENTAL DISABILITIES PROGRAM

DPHHS ..... DEPARTMENT OF HEALTH AND HUMAN SERVICES

DMS ..... DATA MANAGEMENT SYSTPEM APPROVED BY THE DEPARTMENT

FIRF ..... FINAL INVESTIGATION REPORT FORM

GER ..... GENERAL EVENT REPORT IN THERAP

IMC ..... INCIDENT MANAGEMENT COMMITTEE

IMS ..... MONTANA'S INCIDENT MANAGEMENT SYSTEM

IR ..... INCIDENT REPORT

IRF ..... INVESTIGATION REVIEW FORM

LE ..... LAW ENFORCEMENT

MAR ..... MEDICATION ADMINISTRATION RECORD

PR ..... PROCEDURAL REVIEW

PRN ..... AS NEEDED (MEDICATION GIVEN ON AN AS NEEDED BASIS)

QDIRC ..... QIS DEATH INVESTIGATION REVIEW CHECKLIST

QIS ..... QUALITY IMPROVEMENT SPECIALIST

RM ..... REGIONAL MANAGER

SCOMM ..... SECURE COMMUNICATION (OR EMAIL) IN DATA MANAGEMENT SYSTEM

SIB ..... SELF-INJURIOUS BEHAVIOR

TRF ..... TRIAGE REVIEW FORM

Appendix E: FORMS

MONTANA DEVELOPMENTAL DISABILITIES PROGRAM
FINAL INVESTIGATION REPORT FORM (FIRF)

Agency(s) Involved:				
Name(s) & Title of Investigator:				
Date Investigator Assigned:		Time:		
Date Incident Occurred:		Time:		
Date Incident Reported:		Time:		
Alleged Victim(s):				
Alleged Perpetrator(s):				
Reporting Person and title(s):				
Witnesses Involved:				

	Agencies Notified	By Whom	Date/Time	Method
☐	Law Enforcement:			
☐	Parent/Legal Representative:			
☐	Case Manager:			
☐	QIS:			
☐	APS/CPS:			
☐	Licensing/QAD:			
☐	Provider:			
☐	Other:			

Method of Notification: 1-Phone 2-Fax 3-Email 4-Mail 5-Personal Contact

Describe Allegation at the Time of the Assignment:

1.)	Were there injuries to the victim?	☐ Yes	☐ No	☐ N/A
2.)	Are the injuries to the victim consistent with the allegation?	☐ Yes	☐ No	☐ N/A
3.)	Did the injuries result in hospitalization?	☐ Yes	☐ No	☐ N/A

Describe Immediate Actions Taken:

Date Investigator Visited the Site: _____ Time: _____ ☐ N/A

Evidence Protection, Preservation & Collection

Scene Secured: ☐ Yes ☐ No ☐ N/A

How Secured:

1.) Evidence Collected: ☐ Yes ☐ No ☐ N/A
2.) Evidence Logged: ☐ Yes ☐ No ☐ N/A
3.) Photographs Taken: ☐ Yes ☐ No ☐ N/A

Evidence collected (photos, physical, demonstrative, testimonial, etc):

ID #	Description	Date	Time

4.) Evidence Stored After Collection: ☐ Locked/Secure File
☐ Location of Evidence: _____
☐ Other: _____

Persons Interviewed (Chronological Order):

Date	Time	Name & Title

5.) Alleged Perpetrator Status: ☐ Removed From Contact
☐ Reassignment
☐ Administrative Leave
☐ NA

6.) Alleged Perpetrator Safeguards: ☐ Agreed to Speak with Investigator
☐ Union Representative, if applicable
☐ Consented to recording
☐ Other: _____

Summary

Evidence Summary/Scope of Investigation Questions answered (Includes: staff training, policies followed, protocols, plans of care, and person's safety):

1.)	Was there adequate staff present to ensure health and safety?	☐ Yes	☐ No	☐ N/A
2.)	Was the staff adequately trained in the components of the person's plan of care to ensure health and safety?	☐ Yes	☐ No	☐ N/A
3.)	Did the staff follow the provisions in the plan of care?	☐ Yes	☐ No	☐ N/A

Investigator Recommendations/Provider Agency Follow-Up Actions:

Administrative Review Attached: ☐

Name of Investigator(s):	Date:

DEVELOPMENTAL DISABILITIES PROGRAM

Triage Review Form (TRF)

FOR INVESTIGATING CRITICAL INCIDENTS:
MAY BE USED FOR ALL CRITICAL INCIDENTS EXCEPT INCIDENTS OF *ABUSE, NEGLECT OR EXPLOITATION*.

Review Team Members Participating:	Case Manager(s):	
	Provider Staff(s):	
	QIS(s):	
	Regional Manager:	
	Other:	

Agency Name: _____

Person's Name: _____

Date Incident Occurred: _____

Description of Incident as Known:

Summary of Review:

Recommendations/Requirements/Actions Taken:

Administrative Review Attached: ☐

☐ No further investigation warranted

☐ Full Investigation (FIRF) needed and assigned to: _____

_____ _____

Triage Review Team Chair Date

Review Status:

☐ To be continued ☐ Closed

DEVELOPMENTAL DISABILITIES PROGRAM
ADMINISTRATIVE REVIEW
(To be completed at the conclusion of a Final Investigation or Triage Review)

Agency Name:	
Person's Name:	

Date Investigative Report Received: _____ ☐ FIRF ☐ Triage

Description of the Incident as reported:

1.)	Were the provider agency and DDP policies followed in this incident?	☐ Yes	☐ No
2.)	Were notifications made within appropriate timeframes?	☐ Yes	☐ No
3.)	Were protections provided to victim(s)?	☐ Yes	☐ No
4.)	Was the investigation thorough and included enough information to answer the investigatory questions adequately?	☐ Yes	☐ No
5.)	Was the investigation completed within required timeframes?	☐ Yes	☐ No
6.)	Was the incident a result of a failure to follow federal regulation, Montana statute, the Administrative Rules of Montana, and /or the provider agencies' policy?	☐ Yes	☐ No
7.)	Was there adequate staff present to ensure health and safety?	☐ Yes	☐ No
8.)	Was the staff adequately trained in the components of the person's plan of care to ensure health and safety?	☐ Yes	☐ No
9.)	Did the staff follow the provisions in the place of care?	☐ Yes	☐ No
10.)	In the conduct of this investigation, were all applicable federal regulations, Montana Statutes, Administrative Rules of Montana, and/or provider agency policies followed?	☐ Yes	☐ No

Administrative Findings:
☐ Confirmed based on evidence
☐ Not confirmed based on evidence
☐ Inconclusive

Provider Agency Recommendations:

Provider Agency Requirements:

Provider Actions Taken Based on Investigation:

_____ _____
Agency Administrator/Chair of IMC (or RM for QIS Investigation) Date

Review Status:
☐ To be continued ☐ Closed

DEVELOPMENTAL DISABILITIES PROGRAM
Investigation Review Form (IRF)

Agency Name:		Date of Incident:	
Person Name:			

1. Did the incident require an investigation? ☐Yes ☐No
   Comments:

2. As required by policy, were the following people notified of incidents within the required time frames?

Law Enforcement	☐Yes ☐No ☐N/A	
	Did LE investigate?	☐Yes ☐No add comment below
Child/APS	☐Yes ☐No ☐N/A	
	Did CPS/APS investigate?	☐Yes ☐No add comment below
DDP Staff	☐Yes ☐No ☐N/A	
Case Manager	☐Yes ☐No ☐N/A	
Legal Representative	☐Yes ☐No ☐N/A	
Advocate	☐Yes ☐No ☐N/A	
Licensure	☐Yes ☐No ☐N/A	

   Comments:

3. If the incident involved any physical injury, change in medical status or alleged sexual abuse, was the alleged victim examined by a non-agency medical professional?
   ☐Yes ☐No ☐N/A
   Comments:

4. Was the Incident Report written with all required fields included and submitted within the required timeframes?
   ☐Yes ☐No
   Comments:

5. Were all apparent conflicts of interest between the assigned investigator and witnesses identified prior to assigning the investigator?
   ☐Yes ☐No
   Comments:

6. Was the alleged perpetrator(s) involving allegations of abuse, neglect, or exploitation separated from contact with persons during the investigation?
   ☐Yes ☐No ☐N/A
   Comments:

7. Was evidence collected and secured?
   ☐Yes ☐No
   Comments:

8. Were all potential witnesses interviewed?
   ☐Yes ☐No
   Comments:

9. Were written statements taken?
   ☐Yes ☐No

Comments:

10. Were interviews recorded?
☐Yes ☐No
Comments:

11. Was the incident reviewed, investigated and documented within required timeframe?
☐Yes ☐No
Comments:

12. Was the investigation completed and submitted within the required timeframes?
☐Yes ☐No
Comments:

13. Was the investigation submitted on the appropriate form?
☐Yes ☐No
Comments:

14. Was the investigation signed and dated by the assigned investigator(s)?
☐Yes ☐No
Comments:

15. If DDP made exception to the findings and/or conclusions of the investigation, was the agency notified? (Note the exception and agency response.)
☐Yes ☐No
Comments:

16. Is there evidence available to show that the agency has taken or is taking actions to complete requirements/recommendations/action plans?
☐Yes ☐No
Comments:

17. Was the Administrative Review attached to the Incident Report in data management system? (Note if investigation is closed or is to be continued.)
☐Yes ☐No
Comments:

18. QAOS issued:
☐Yes ☐No
Comments:

Signature of QIS completing Review

Date

DEVELOPMENTAL DISABILITIES PROGRAM
Procedural Review (QIS)
for any suspected A/N/E

Date Incident Occurred: _____ Person: _____
QIS Assigned to Review: _____ Agency: _____
Date Investigative Report Received: _____

Rules:

1.)	Were protections provided to the victim(s)?	☐ Yes	☐ No	☐ N/A
2.)	DDP policies/procedures and ARM requirements followed?	☐ Yes	☐ No	
3.)	Were there injuries to the victim?	☐ Yes	☐ No	☐ N/A
4.)	Did the injuries result in hospitalization?	☐ Yes	☐ No	☐ N/A
5.)	Were notification(s) made within required timeframes?	☐ Yes	☐ No	

Agency Policies:

6.) Was agency policy followed in this incident? ☐ Yes ☐ No
If No, please explain:

7.) Was staff properly trained, orientated and qualified? ☐ Yes ☐ No ☐ N/A
If No or N/A, please explain:

Programmatic Procedures:

8.) Was the Plan of Care followed as written? ☐ Yes ☐ No
If No, please explain:

Additional Observations and Recommendations:

Summary:

9.)	Was follow-up requested?	☐ Yes	☐ No	Date: _____
10.)	QAOS sent regarding this incident?	☐ Yes	☐ No	
11.)	Has follow-up been completed?	☐ Yes	☐ No	

_____ _____
Signature of QIS completing Review Date

Review Status:
☐ To be continued ☐ Closed

DEVELOPMENTAL DISABILITIES PROGRAM

Witness Statement

DATE: _____ **TIME:** _____

LOCATION: _____

NAME OF WITNESS: _____

TITLE OF WITNESS: _____

EMPLOYER OF WITNESS: X _____

STATEMENT:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Witness signature and date required at the end of statement.
Interviewer signature and date required at the end of statement.

Any blank space should be X'd out.

DEVELOPMENTAL DISABILITIES PROGRAM

WITNESS STATEMENT SUPPLEMENT

PAGE _____ OF _____

STATEMENT (CONTINUED):

Witness signature and date required at the end of statement.
Interviewer signature and date required at the end of statement.
Any blank space should be X'd out.

DEVELOPMENTAL DISABILITIES PROGRAM

Consent for Recorded Interview

DATE: _____ **TIME:** _____

LOCATION: _____

NAME OF WITNESS: _____

TITLE OF WITNESS: _____

EMPLOYER OF WITNESS: X _____

I consent to having my interview with _____ ,
Quality Improvement Specialist, recorded electronically.

_____ _____

Witness Signature Date

MONTANA DEVELOPMENTAL DISABILITIES PROGRAM
QIS Death Investigation Report and Checklist

Name of Deceased: _____
Date of Birth: _____
Date/Time of Death: _____
City: _____ Provider: _____
QIS conducting investigation: _____

DDP notified of Death (within 8 hours, date and time, by whom, method):

QIS DEATH INVESTIGATION REPORT

1) Summary of Decedent's Services and Life Situation:

2) Description of Circumstances and Events Leading up to Death Event:

3) Description of Death Event:

4) Conclusions (Policies Followed, Staff Intervened Appropriately, etc.):

5) Recommendations for Provider:

PERSON RECORDS:

☐ Yes	☐ No		Most current full plan of care and amendments
☐ Yes	☐ No	☐ NA	Most recent Incident Reports (T-Logs as Appropriate)
☐ Yes	☐ No	☐ NA	Provider Case Notes/T-Logs (at least one week prior to death)
☐ Yes	☐ No	☐ NA	Current list of medications (if not in plan of care)
☐ Yes	☐ No	☐ NA	Medication Administration Record (previous two months)
☐ Yes	☐ No	☐ NA	Case Manager's Case Notes
☐ Yes	☐ No	☐ NA	Updated medical condition if changes since plan of care

MEDICAL:

☐ Yes	☐ No	☐ NA	Care plan for medical condition
☐ Yes	☐ No	☐ NA	Procedures regarding specific medical needs (ie. feeding protocol, seizure protocol, etc.)
☐ Yes	☐ No	☐ NA	Guardianship (Court Documents)
			Names and address, if possible of:
☐ Yes	☐ No	☐ NA	Primary Care Physician: _____
☐ Yes	☐ No	☐ NA	Other Medical Professionals: _____
☐ Yes	☐ No	☐ NA	Hospital (Includes ER and/or Urgent Care): _____

END-OF-LIFE DECISIONS/DNR ISSUES:

☐ Yes	☐ No	☐ NA	Terminal Illness/Diagnosis
☐ Yes	☐ No	☐ NA	DNR Order
☐ Yes	☐ No	☐ NA	Comfort One
☐ Yes	☐ No	☐ NA	Living Will
☐ Yes	☐ No	☐ NA	Hospice

PROFESSIONAL CARE RECORDS:

☐ Yes	☐ No	☐ NA	Any medical information available such as office notes, hospital records
☐ Yes	☐ No	☐ NA	Ambulance Trip Report
☐ Yes	☐ No	☐ NA	Police or MHP Report
☐ Yes	☐ No	☐ NA	Death Certificate
☐ Yes	☐ No	☐ NA	Coroner's Report (with autopsy report if done)

_____ _____

Signature of QIS completing Review Date