BBHC
BROWARD BEHAVIORAL HEALTH COALITION

Policy and Procedure

Section:	**Continuous Quality Improvement**
Subject:	**Critical Incident Reporting**
Policy Number:	**QI 001**
Effective Date:	**November 1, 2012**
Revision Date:	**April 15, 16; August 28, 17, December 11, 17; September 28, 19**
Review Date:	**Annually**

Purpose: To establish the process to manage, and track incidents reported by the Managing Entity ("ME") subcontracted providers consistent with the Florida Department of Children and Families (the Department) Critical Incident Reporting Operating Procedure (CFOP) 215-6. This policy establishes the requirements governing the accurate reporting and dissemination of information regarding occurrences.

Policy:

1. The Broward Behavioral Health Coalition ("BBHC") is the Managing Entity for the Department in Judicial Circuit 17, Broward County and via this Policy established a Critical Incident reporting process to protect and ensure the safety and security of the clients, the public and staff served through State funds.
2. The Critical Incident Report process includes standards for all programs and services within the Network and subcontracted by with the Managing Entity.
3. This policy will ensure adherence to uniform procedures for Critical Incident Reporting in accordance with applicable federal and state laws, rules, and regulations; the terms and conditions of the contract; and policies, and procedures established by the Managing Entity.
4. Carisk Behavioral Health, Inc. (CBH) will receive, review, report, and/or forward to BBHC a monthly summary of all subcontracted provider reported Critical Incidents.

Procedures:

I. <u>Provider Tasks</u>

a. All BBHC Subcontracted providers shall maintain at least at least two (2) employees at all times properly permissioned and trained to utilize, access and report Incidents.

b. All BBHC subcontracted providers shall identify staff responsible for the report of Critical Incidents to BBHC/Carisk Behavioral Health (CBH) via the Department's Incident Reporting and Analysis System (IRAS). Each provider shall ensure all staff, including volunteers, successfully completes Critical Incident reporting training prior to contact with clients.

c. Upon notification and/or identification of the occurrence of a Critical Incident that meets CFOP 215-6 criteria, all Provider's employees shall:

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i. Ensure the health, safety and welfare of all individual (s) involved. This includes contacts fire/rescue and/or the police as determined appropriate.
ii. Enter record of the Critical Incident into IRAS.
iii. Providers shall complete the CBH Critical Incident Report Template if access to IRAS is not available. Notice of interruption of access to IRAS will be forwarded by the CBH and/or the Department. All Providers are required to maintain at least two (2) staff with IRAS access to avoid this situation.
iv. Ensure contacts are made for assistance as dictated by the needs of the individuals involved.
v. Ensure the client's guardian, representative or relative is notified, as applicable.
vi. When the incident involves suspected abuse, neglect or exploitation, the employee must call the Florida Abuse Hotline to report the incident (1-800-96 ABUSE).

d. Provider shall make a phone call report to 954-901-5057 for Critical Incidents defined as Category A below.

II. Reporting Timeframes and Reportable Critical Incident Definitions:

a. Category A: The Provider must report within two (2) hours of becoming aware of any of the following Critical Incidents that occur at its facility or to a client it serves. Reports defined in Category A must be reported to the IRAS system and a phone call to the Critical Incident Reporting Line (954) 901-5057. Both types of reporting must meet the two (2) hour timeframe.

The Critical Incidents included in this category are:

- Child on child sexual abuse: Any sexual behavior between children which occurs without consent, without equality, or as a result of coercion. This applies only to children receiving services from the Department or by a licensed contract provider, e.g., children in foster care placements or residential treatment.
- Sexual abuse / Sexual Battery: Any unsolicited or no-consensual sexual activity or battery* by one client to another; a DCF or service provider employee or other individual; to a client; or a client to an employee regardless of the consent of the client. *Sexual battery may be defined by Chapter 794 of the Florida Statutes.
- Adult or Child Death: Any death determined as unnatural, unless the death happens within or under the direct care of the provider and/or its staff.
- Media Event: Any Critical Incident resulting in media coverage due to circumstances that meet the threshold for a report to the DCF/ME. That includes press inquiries, broadcast and written media coverage.

b. Category B: The following Critical Incidents must be reported to IRAS within twenty four

(24) hours. Unlike Category A Critical Incidents, a telephone call is not required

- Youth Interaction with Law Enforcement (Child Arrest): When a person under the age of 18 is taken into custody by law enforcement for allegedly committing an act considered a law violation, while in the custody of the department
- Death Any death determined of natural causes and DOES NOT occurs within or under the direct care of the provider and/or its staff, or while in the physical or legal custody of the department.
- Elopement: (1) The unauthorized absence beyond four hours of an adult during involuntary civil placement within a Department-operated, Department-contracted or licensed service provider; or (2) The unauthorized absence of a forensic client on conditional release in the community; or (3) The unauthorized absence of any individual in a Department contracted or licensed residential substance abuse and/or mental health program.
- Employee Arrest: The arrest of an employee of the Department or its contracted or licensed service provider for a civil or criminal offense.
- Employee Misconduct: Work-related conduct or activity of an employee of the Department or its contracted or licensed service provider that results in potential liability for the Department; death or harm to a client; abuse, neglect or exploitation of a client; or results in a violation of statute, rule, regulation, or policy. This includes, but is not limited to, misuse of position or state property; falsification of records; failure to report suspected abuse or neglect; contract mismanagement; or improper commitment or expenditure of state funds.
- Escape: The unauthorized absence of a client who is committed by the court to a state mental health treatment facility pursuant to Chapter 916 or Chapter 394, Part V, Florida Statutes.
- Missing Child: When the whereabouts of a child in the custody of the Department are unknown and the attempts to locate the child have been unsuccessful.
- Security Critical Incident – Unintentional: Unintentional action or event that results in compromised data confidentiality, danger to the physical safety of personnel, property, or technology resources; this excludes instances of compromised client information.
- Significant Injury to Clients: Severe bodily trauma to a client in a treatment/service program that requires immediate medical care or treatment at a hospital.
- Significant Injury to Staff: Severe bodily trauma to a staff member in a treatment/service program that requires immediate medical care or treatment at a hospital.
- Suicide Attempt: Potentially lethal act which reflects an attempt by a an individual to cause their own death
- Other
  - Human acts that jeopardize health, safety or welfare of clients such as kidnapping, riot, or hostage situation.
  - Bomb or biological/chemical threat
  - Death or significant injury of an employee or visitor on the grounds of the Department or one of its contracted or licensed providers.
  - Human acts that jeopardize health, safety or welfare of clients, including calls to the Florida Abuse Hotline.
  - Theft, vandalism, damage, fire, sabotage, or destruction of state or private property

of significant value or importance.

C. **Special Event:** The following incidents must be reported in IRAS.

- Absence of Forensic Client - Any client under the jurisdiction of the Court who is placed in a residential program who leaves the program without permission of the program shall be reported to CBH upon immediate identification of the client's absence. The residential program shall make documented telephonic contact with the case management provider to advise of the client's absence.
  It shall be the casemanagement provider's responsibility to notify the Court of the violation of program rules and absence from the program. The assigned case manager shall provide written notification to the Court of the client's elopement from the program.

III. Carisk -ME Tasks

A. A report from IRAS is received via the IRAS system

B. This message will be received by:

1. Carisk Critical Incident Report Coordinator, which will notify:
   a. Critical Incident Report Coordinator
   b. Director of Clinical Programs
   c. Provider Relations Specialist
2. BBHC QI Manager

C. If the provider has no IRAS access, Carisk (Critical Incident Report Coordinator) will notify the assigned Managers of Provider Relations, who is responsible for notifying the Provider of:

1. Non-compliance; and
2. Provide technical assistance to the Provider in obtaining necessary training, access, and authorizations associated with IRAS. Providers shall have at least two (2) employees at all times properly permissioned and trained to utilize, access and report Incidents

D. Carisk (Critical Incident Report Coordinator) reviews the Critical Incident Report and
E. Identifies the appropriate level of action for the Critical Incident reported as per the CBH Critical Incident Report Response Grid. This level may be modified based on further information obtained and/or follow up received about the Critical Incident.
F. Carisk a (Critical Incident Report Coordinator) will contact Provider for clarification, when required.
G. Carisk (Critical Incident Report Coordinator) will monitor reported Critical Incidents and determine any required follow up with QI or Provider Relations staff when applicable.
H. Provider Relations will be engaged for Critical Incidents directly related to or impacting the provider's ability to meet its contractual obligations.
I. Carisk (Critical Incident Report Coordinator) will complete preliminary review for Critical Incident reports.

J. If and when further in-depth review is deemed necessary Carisk (Critical Incident Report Coordinator) will lead this process and will engage MEs support as needed.
K. Carisk (Critical Incident Report Coordinator) will update provider regarding status on Critical Incident Review Process.
F. Carisk (Critical Incident Report Coordinator) will track the Critical Incident Report for further analysis.
G. Carisk (Critical Incident Report Coordinator) will inform Provider Relations staff on a weekly basis, of any Provider report that does not adhere to this Policy and procedures.
H. BBHC CQI and Carisk's Quality Contractor will hold weekly CQI calls to discuss all complaints/grievances, findings, follow-up or pending items.
I. Carisk (Critical Incident Report Coordinator) will generate a monthly report of all Critical Incident reports received during the previous month, to be submitted to the BBHC by the 10th of the following month. Carisk staff will generate a quarterly report to be submitted to Quality Department and BBHC to be presented to Quality Improvement Committee. This report must be submitted by the 10th of the month following the quarter.

Definitions

Abuse. Any willful or threatened act or omission that causes or is likely to cause significant impairment to a child or vulnerable adult's physical, mental or emotional health.

Department. The Department of Children and Families.

Adult Death. An individual 18 years or older, whose life terminates while receiving services, during an investigation, when it is known that a client died within thirty (30) days of discharge from a residential program,

Child Death. An individual 18 years or less whose life terminates while receiving services, during and investigation, or when it is known that a child died within thirty (30) days of discharge from a residential program or treatment facility or when a death review is required pursuant to CFOP 175- 17, Child Fatality Review Procedures. The manner of death is the classification of categories used to define whether a death is from intentional causes, unintentional causes, natural causes, or undetermined causes.

(1) The final classification of an individual's death is determined by the medical examiner. However, in the interim, the manner of death will be reported as one of the following:

(a) Accident. A death due to the unintended actions of one's self or another.
(b) Homicide. A death due to the deliberate actions of another.
(c) Natural Expected. A death that occurs as a result of, or from complications of a diagnosed illness for which the prognosis is terminal.
(d) Natural Unexpected. A sudden death that was not anticipated and is attributed to an underlying disease either known or unknown prior to the death.
(e) Suicide. The intentional and voluntary taking of one's own life.
(f) Undetermined. The manner of death has not yet been determined.
(g) Unknown. The manner of death was not identified or made known.

(2) If an individual's death involves a suspected overdose from alcohol and/or drugs, or seclusion and/or restraint, additional information about the death will need to be reported in IRAS.

Critical Incident Coordinator. The designated Department or provider/agency staff whose role is to add and update Critical Incidents, create and send initial and updated notifications and change the status of a Critical Incident. Department Critical Incident Coordinators are designated by their respective Circuit/Region /Headquarters leadership.

Critical Incident Reporting and Analysis System (IRAS). Operating procedure that establishes the guidelines for reporting and analyzing Critical Incidents.

Elopement. The unauthorized absence beyond four (4) hours of an adult during involuntary civil placement within a Department-operated, Department-contracted or licensed service provider; (2) the unauthorized absence of a forensic client on conditional release in the community; (3) the unauthorized absence of any individual in a Department contracted or licensed residential substance abuse and/or mental health program.

Hospital. A facility licensed under Chapter 395, Florida Statutes (F.S.). This includes facilities licensed as specialty hospitals under Chapter 395, F.S.

Managing Entity. Corporations contracted by the Department to manage the daily delivery of behavioral health services (i.e. substance abuse prevention and treatment, and mental health services) through the establishment of local networks.

Neglect. The failure or omission on the part of the caregiver to provide the care, supervision and services necessary to maintain the physical and mental health of a child or vulnerable adult; or the failure of a caregiver to make reasonable efforts to protect a child or vulnerable adult from abuse, neglect, or exploitation by others.

Restraint. Any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the individual's body so that he or she cannot easily remove the restraint, and which restricts freedom of movement or normal access to one's body.

Seclusion. The physical segregation of a person in any fashion, or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area.