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PERSONNEL
(Manual Section)

RECIPIENT RIGHTS:
INCIDENT REPORTS – POLICY 3825

Approval of Policy	Dated:
Original Inception Date:	January 11, 1996
Policy Last Reviewed:	June 17, 2024
Last Revision of Policy Approved:	March 7, 2008

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•1 POLICY:

It is the policy of the Agency that staff document any unusual, out-of-the-ordinary events that occur in a program. Incident reports ensure this and are used for the following purposes:

1. to monitor that treatment is suited to the needs of the recipient;
2. patterns of behavior that require intervention are detected early;
3. agency-wide or program-specific problems, like safety issues, are dealt with;
4. needed staff training is developed.

Incident reports are legal documents and may not be destroyed. They are administrative documents that are confidential. They are not subject to court subpoena and are not public documents as defined by Section 300.1748(9) of the Mental Health Code (Revised). They are prepared and used for the purposes of peer and supervisory review and quality control.

•2 APPLICATION:

All employees, all recipients, all providers – licensed or unlicensed.

•3 DEFINITIONS:

INCIDENT: An occurrence that disrupts or adversely affects the course of treatment or care of an individual. Examples include:

1. Serious injury of recipients and incidents which could have caused serious injury; which includes serious unexplained injuries and serious injuries resulting from the application of physical management.
2. Non-serious injury which appears to involve abuse or neglect of a recipient.
3. Suspected abuse or neglect of a recipient.
4. Repeated behaviors which are not addressed in a plan of service.
5. Sexual abuse, which means contact or sexual penetration between a recipient and an employee; a recipient and another person, when that other person is providing

authorized care and/or supervision to that recipient; and a recipient and another recipient when one does not consent.

6. Incidents involving sexual misconduct.
7. First-time occurrences, such as seizures, fire-setting behavior, etc.
8. Medication errors and medication refusals.
9. Every use of physical intervention not covered in a behavior program.
10. Any significant event in the community involving a recipient.
11. A traffic accident involving recipients.
12. A recipient leaving the home without permission or notice.
13. Recipient-to-employee injury.
14. The death of a recipient.
15. Any accident or illness that requires hospitalization (including emergency room treatment).
16. Incidents of displays of serious hostility.
17. Incidents that involve hospitalization.
18. Attempts at self-inflicted harm or harm to others.
19. Instances of destruction of property.
20. Incidents that involve the arrest or conviction of a resident (as required pursuant to the provisions of section 1403 of Act 322 Public Acts of 1988.

LICENSED: A home that has been issued a license to operate as an adult foster care home.

•4 CROSS-/REFERENCES:

•5 FORMS AND EXHIBITS:

Administrative Approval of Procedure:	Dated:
_____	September 26, 2006

•6 PROCEDURE:

Incident Reports for Licensed Settings

•6•1 APPLICATION:

All Licensed Settings

•6•2 OUTLINE / NARRATIVE:

MANDATORY REPORTING REQUIREMENTS FOR SMALL & LARGE GROUP AFC HOMES AND FAMILY AFC HOMES:

AFC Licensing rules for items 14-20 under "Definitions" examples, a reasonable attempt is to be made to contact the resident's designated representative (guardian) and the responsible agency (Northeast Michigan Community Mental Health) by telephone and shall follow the attempt with a copy of the AFC Incident/Accident Report (OCAL-4607) being sent to the resident's designated representative (guardian), responsible agency (Northeast Michigan Community Mental Health), and the adult foster care licensing division within 48 hours. (Exception: Family homes are not required to send the report to AFC licensing.) An immediate investigation of the cause of an accident or incident that involves a resident, employee or visitor should be initiated by the home supervisor, administrator, or licensee and an appropriate Incident/Accident Report (OCAL-4607) shall be completed and maintained.

If a resident is absent without notice, the care provider/RTW/responsible caregiver shall do the following:

1. Make a reasonable attempt to contact the resident's designated representative and responsible agency.
2. Contact the local police authority.
3. Make a reasonable attempt to locate the resident through means other than those specified above.

An Incident/Accident Report (OCAL-4607) shall be submitted to the resident's designated representative and the responsible agency in all instances when a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.

A copy of the Incident/Accident Report (OCAL-4607)that is required for items 14-20 shall be maintained in the home in the AFC documents (NOT THIS AGENCY'S CLINICAL RECORD) for a period of not less than two years. (See Step 5 under Procedure.)

Procedure for completing the Incident/Accident Report Form, OCAL-4607:

1. The Incident/Accident Report is prepared by the responsible staff person as soon as possible, but in no case later than the end of the shift on which the incident occurred.

2. The nurse or attending medical staff is to complete the section for physical injury in all cases of medication errors and incidents that result in medical treatment.

3. The AFC home supervisor or his/her designee will review the report and determine if it meets the criteria listed in 14-20. If so, he/she will make a reasonable attempt to notify the resident's personal representative and responsible agency by telephone. Within 48 hours, a copy of the written report will be submitted to the personal representative, responsible agency, and AFC licensing division. (Exception: Family homes are not required to send the report to AFC licensing.) The supervisor/licensee or designee will note the submission of this information on the Incident/Accident Report.

4. The home supervisor/licensee or designee must complete the area labeled "Corrective Measures Taken to Remedy and/or Prevent Recurrence," and include relevant disciplinary action taken.

5. The home supervisor/licensee or designee will retain a copy of all Incident/Accident Reports in the home, in a file folder labeled "Incident/Accident Reports" and the originals and any remaining copies are sent to the Supports Coordinator. It is recommended there be files for each resident and each file be separated by "non-reportable" and "reportable" (#1-13 and #14-20 under "Definition" examples).

6. The supports coordinator must receive the original Incident/Accident Report for signature and comments. Upon completion of supports coordinator's comments, the supports coordinator is to do the following:
   A. For settings where NeMCMH is NOT the licensee, the supports coordinator will forward a copy to the Recipient Rights Officer, the psychologist or nurse, if applicable, and return the original report to the home for filing in the Incident/Accident Report file folder.
   B. For settings where NeMCMH is the licensee, the supports coordinator will forward the original and all remaining copies to the licensee/administrator for signature. The licensee/administrator or designee will forward a copy to the Recipient Rights Officer and Supports Coordinator, and send the original to the home for filing in the Incident/Accident Report file folder.

The Officer of Recipient Rights shall review all incident reports and 1) determine if an investigation is required, 2) produce aggregate reports, and 3) enter into the Agency's clinical record via the electronic record a summary of the extraordinary incident. Periodic reports will be provided to the Recipient Rights Advisory

Committee, Risk Management Committee, Quality Improvement Council and the Board.

•6•3 CLARIFICATIONS:

•6•4 CROSS-/REFERENCES:

P.A. 218 – Pertaining to the Regulation of Adult Foster Care Facilities

•6•5 FORMS AND EXHIBITS:

Exhibit A - OCAL-4607 AFC Licensing Division – Incident/Accident Report, Michigan Department of Human Services

Administrative Approval of Procedure:	**Dated:**
_____	September 26, 2006

•7 PROCEDURE:

Incident Reports for Non-Licensed Settings

•7•1 APPLICATION:

All Non-Licensed Settings

•7•2 OUTLINE / NARRATIVE:

Procedure for completing the Incident Report Form, DCH-0044

1. The original Indicent Report is prepared by the responsible staff person as soon as possible, but in no case later than the end of the shift on which the incident occurred.

2. The nurse or attending medical staff is to complete the section for physical injury in all cases of medication errors and incidents which result in medical treatment.

3. To ensure notification to the home of an incident occurring outside the home with a provider, provider staff must make a reasonable attempt to contact the consumer's home provider and provide a verbal report.

4. The site supervisor/staff's supervisor must complete the area labeled "Designated Supervisor" and provide specific disciplinary action, if taken. Site supervisor/staff's supervisor will forward the original Incident Report to the Supports Coordinator*.

5. The Supports Coordinator will follow up with sending a copy of the written Incident Report to the psychologist and/or nurse, if needed for behavior and/or medical monitoring.

6. The Supports Coordinator will return the original Incident Report to the Recipient Rights Officer.

7. The Office of Recipient Rights shall review all Incident Reports and 1) determine if an investigation is required, 2) produce aggregate reports, 3) enter into the clinical record via the electronic record a summary of the extraordinary incident. Periodic reports will be provided to the Recipient Rights Advisory Committee, Risk Management Committee, Quality Improvement Council and the Board.

* For incidents occurring in outpatient settings, absent casemanagement support:

1. The original Incident Report is prepared by the responsible staff person as soon as possible, but in no case later than the end of the shift on which the incident occurred.

2. The Supervisor or Division Director must complete the area labeled "Designated Supervisor" and provide specific disciplinary action, if taken. The Supervisor or Division Director will forward the original Incident Report to the Recipient Rights Officer for review and file.

•7•3 CLARIFICATIONS:

•7•4 CROSS-/REFERENCES:

•7•5 FORMS AND EXHIBITS:

Exhibit B – DCH-0044 Department of Community Health Incident Report