STATEMENTS OF POLICY

Title 4—ADMINISTRATION

PART II. EXECUTIVE BOARD

[4 PA. CODE CH. 9]

Reorganization of the Insurance Department

The Executive Board approved a reorganization of the Insurance Department effective February 11, 2004.

The organization chart at 34 Pa.B. 1235 (February 28, 2004) is published at the request of the Joint Committee on Documents under 1 Pa. Code § 3.1(a)(9) (relating to contents of Code).

(*Editor's Note*: The Joint Committee on Documents has found organization charts to be general and permanent in nature. This document meets the criteria of 45 Pa.C.S. § 702(7) (relating to contents of *Pennsylvania Code*) as a document general and permanent in nature which shall be codified in the *Pennsylvania Code*.)

[Pa.B. Doc. No. 04-328. Filed for public inspection February 27, 2004, 9:00 a.m.]

[4 PA. CODE CH. 9]

Reorganization of the Office of Administration

The Executive Board approved a reorganization of the Office of Administration effective February 12, 2004.

The organization chart at 34 Pa.B. 1236 (February 28, 2004) is published at the request of the Joint Committee on Documents under 1 Pa. Code § 3.1(a)(9) (relating to contents of Code).

(*Editor's Note*: The Joint Committee on Documents has found organization charts to be general and permanent in nature. This document meets the criteria of 45 Pa.C.S. § 702(7) (relating to contents of *Pennsylvania Code*) as a document general and permanent in nature which shall be codified in the *Pennsylvania Code*.)

[Pa.B. Doc. No. 04-329. Filed for public inspection February 27, 2004, 9:00 a.m.]

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 6000]

Incident Management

Scope

Individuals who are registered with a county mental retardation program or who receive supports and services from facilities licensed by the Department of Public Welfare's Office of Mental Retardation (OMR), or both, are afforded the protections detailed in this statement of policy.

Providers who receive funds from the mental retardation system, either directly or indirectly, to provide or secure supports or services for individuals authorized to receive services from a county mental retardation program and providers licensed by the OMR are reporters and are to file incident reports as specified in this statement of policy.

County mental retardation programs and their designated support coordination entities are reporters and are to file incident reports as specified in this statement of policy.

Following the processes outlined in this statement of policy will satisfy the incident reporting requirements of 55 Pa. Code (relating to public welfare) for the following regulation chapters:

- Chapter 20—Relating to Licensure or Approval of Facilities and Agencies
- Chapter 2380—Relating to Adult Training Facilities
- Chapter 2390—Relating to Vocational Facilities
- Chapter 6400—Relating to Community Homes for Individuals with Mental Retardation
- Chapter 6500—Family Living Homes
- Chapter 6600—Intermediate Care Facilities for the Mentally Retarded

Purpose

The purpose of this statement of policy is to specify the guidelines and procedures for the incident management process. The incident management process is a subset of a larger risk management process. Incident policies, procedures, training, response and reporting are all important aspects of the incident management process. Combined with other areas of risk assessment such as, but not limited to, employee injuries, complaints, satisfaction surveys and hiring practices, incident management is an essential component of a comprehensive quality management process.

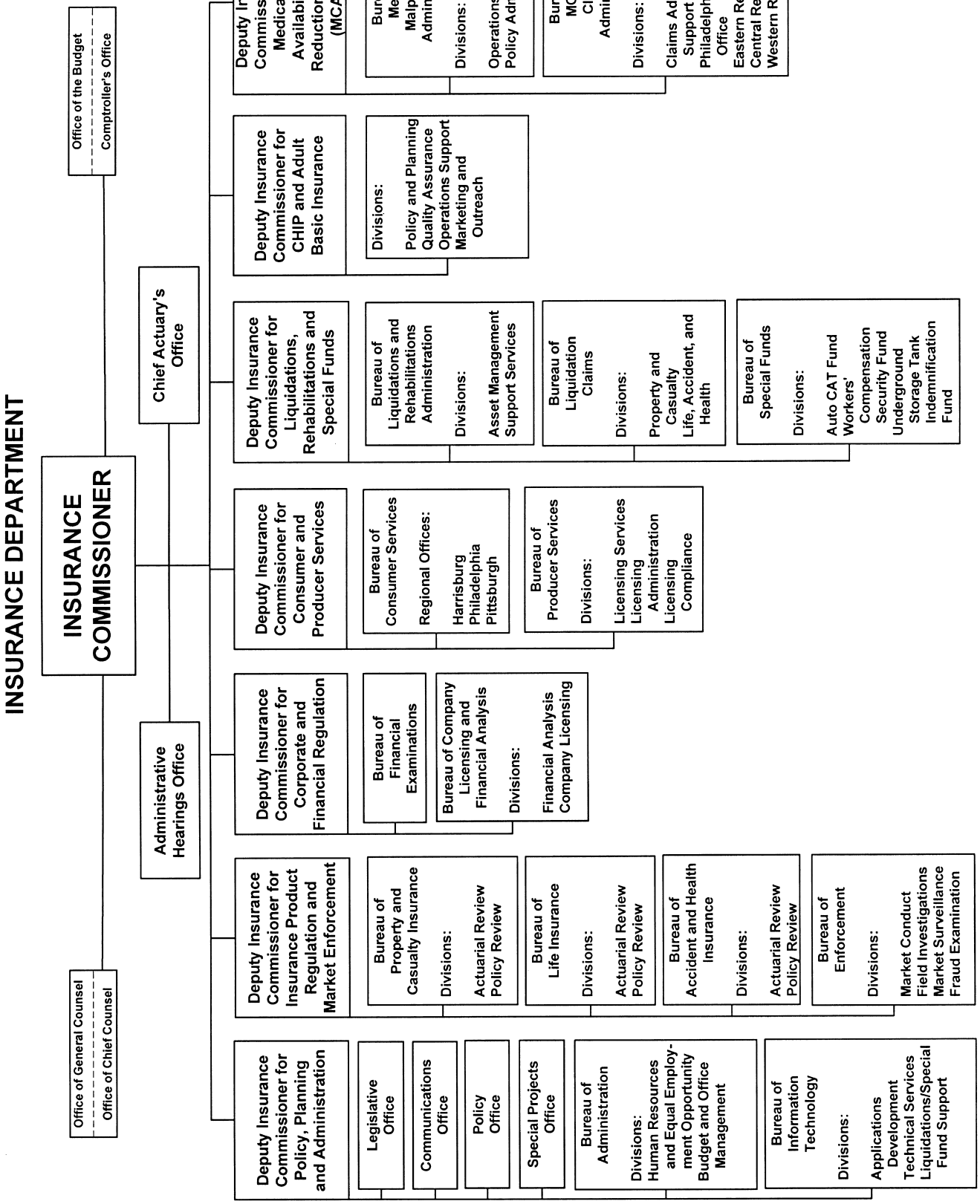
Providers and counties establish incident management and risk management related policies, procedures, orientation and training that address the items identified in Appendix E (relating to incident management components).

This statement of policy establishes processes that will ensure the health and safety, enhance the dignity and protect the rights of individuals receiving supports and services. The processes include uniform practices for:

- Building organizational policies and structures to support incident management.
- Taking timely and appropriate action in response to incidents.
- Reporting of incidents.
- Investigating of incidents.
- Taking corrective action in response to incidents.
- Implementing quality improvement, risk management and incident management processes for the analysis and interpretation of individual and aggregate incident data.

Background

All providers of mental retardation services and supports, including private and State-operated intermediate care facilities for persons with mental retardation (ICFs/MR), county mental health/mental retardation programs and the OMR are partners in the effort to ensure the health, safety and rights of persons receiving supports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Bureau of Consumer Services
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Bureau of Producer Services
Divisions:
Licensing Services
Licensing Administration
Licensing Compliance
Deputy Insurance Commissioner for Liquidations, Rehabilitations and Special Funds
Bureau of Liquidations and Rehabilitations Administration
Divisions:
Asset Management
Support Services
Bureau of Liquidation Claims
Divisions:
Property and Casualty
Life, Accident, and Health
Bureau of Special Funds
Divisions:
Auto CAT Fund
Workers' Compensation Security Fund
Underground Storage Tank Indemnification Fund
Deputy Insurance Commissioner for CHIP and Adult Basic Insurance
Divisions:
Policy and Planning
Quality Assurance
Operations Support
Marketing and Outreach
Deputy Insurance Commissioner for Medical Care Availability and Reduction of Error (MCARE)
Bureau of Medical Malpractice Administration
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Policy Administration
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Eastern Region
Central Region
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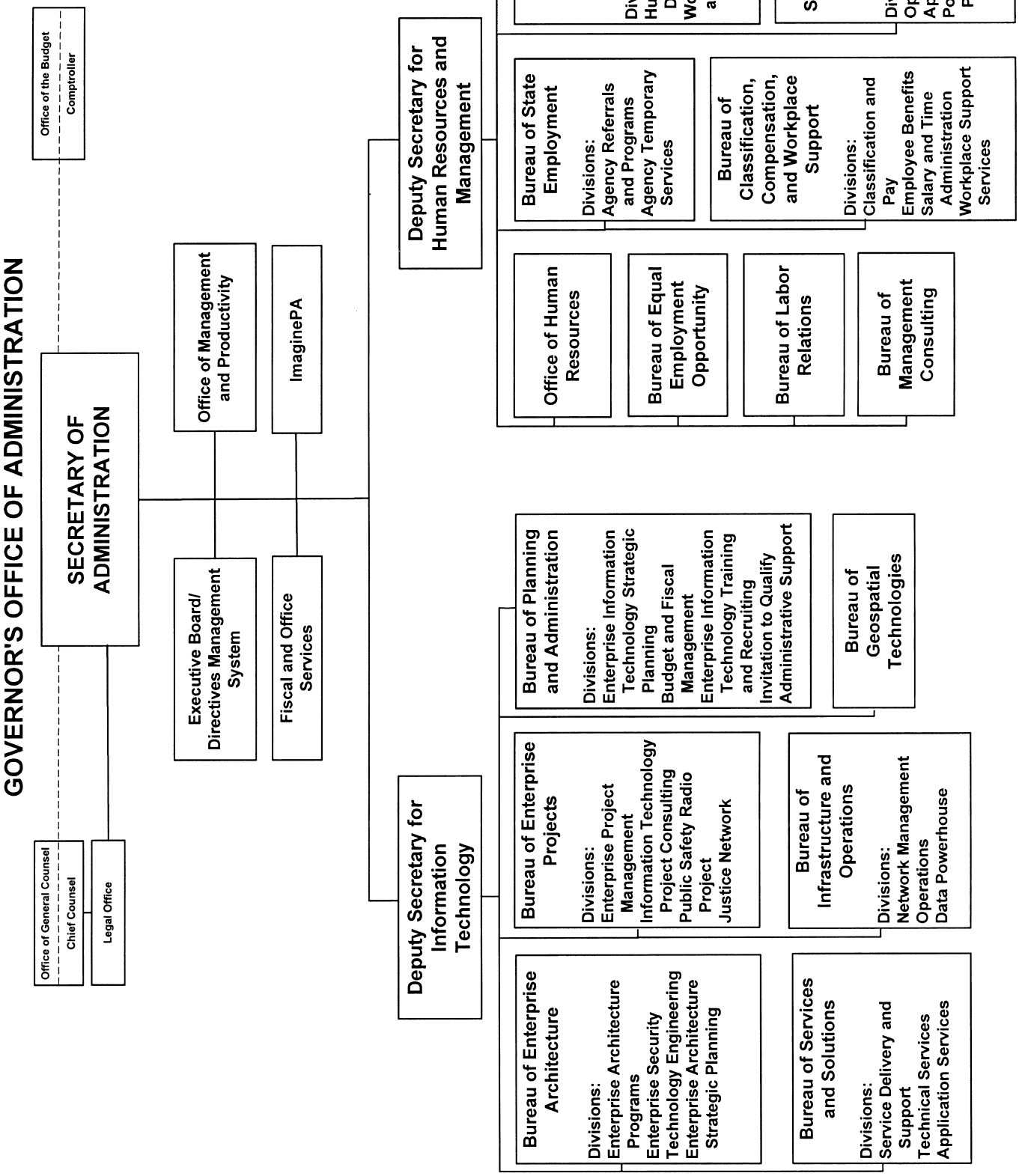
GOVERNOR'S OFFICE OF ADMINISTRATION
SECRETARY OF ADMINISTRATION
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Chief Counsel
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Bureau of Classification, Compensation, and Workplace Support
Divisions:
Classification and Pay
Employee Benefits
Salary and Time Administration
Workplace Support Services
Bureau of Labor Relations
Bureau of Management Consulting
Bureau of Workforce Planning and Development
Divisions:
Human Resource Development
Workforce Planning and Performance
Bureau of Systems, Policy and Program Planning
Divisions:
Operations
Applications
Policy and Program Planning

and services. Each entity reports certain incidents, collects information about those incidents and takes action based on those reports. The development and expansion of community-based supports and services and the increasing flexibility people enjoy to choose a wide variety of both traditional and nontraditional supports have increased the need to establish consistent Statewide processes for safeguarding individuals. To this end, the OMR promulgated Subchapter D (relating to incident management), published at 32 Pa.B. 2117 (April 27, 2002). Following the implementation period, the OMR systematically collected and evaluated feedback from a variety of sources. As part of a continuous quality improvement effort, opportunities for improvement were identified in the feedback, which resulted in the revisions contained in this statement of policy.

Discussion

The primary goal of an incident management system is to ensure that when an incident occurs, the response will be adequate to protect the health, safety and rights of the individual. This statement of policy communicates clear and specific methodologies to ensure appropriate responses at the provider, county and State levels. The standardization of the reporting format, the time frames for reporting and the investigation protocol are key to conducting individual, provider, countywide and Statewide analysis of incidents. The continuous review and analysis of reported incidents at the provider, county and State levels is to enhance risk management processes and to formulate actions to prevent the recurrence of incidents.

All reportable incidents are to be submitted electronically by means of the Home and Community Services Information System (HCSIS), a web-based system developed by the Department of Public Welfare. If HCSIS is unavailable, the submission of incidents is to occur by following the directions in the Incident Management Contingency Plan. See Appendix J (relating to incident management contingency plan).

The incident management processes described in this statement of policy expect that investigations at the provider, county and State levels be conducted by certified investigators. This will ensure that all incidents that require investigation receive a systematic investigation that meets established standards. A training program and certification process has been established by the OMR and communicated by Mental Retardation Bulletin 00-01-06, Announcement of Certified Investigator Training, dated September 6, 2001.

In addition to the OMR reporting processes described in this statement of policy, reporting requirements of other laws, regulations and policies must be followed. See Appendix F (relating to related laws, regulations and policies). Providers, supports coordination entities, counties and OMR must be vigilant to report any incident when there is a suspected crime to law enforcement. When an individual is allegedly abused, neglected or the victim of a crime, the individual is to be offered the support of a Victim's Assistance Program. See Appendix G (relating to victim's assistance programs).

Facilities must comply with Chapters 2380, 2390, 6400, 6500 and 6600. To the extent that this statement of policy exceeds the requirements of Chapters 2380, 2390, 6400, 6500 and 6600, the use of this subchapter is optional for facilities. Because this statement of policy meets or exceeds the regulatory requirements in Chapters 2380, 2390, 6400, 6500 and 6600 compliance with the reporting procedures in this statement of policy will be accepted by the Department as meeting the regulatory requirements of §§ 2380.17, 2390.18, 6400.18 and 6500.20.

The intention of the OMR is to develop an effective incident management system that applies an elevated standard concerning the health, safety and rights of individuals receiving services. Complying with this statement of policy will provide the opportunity to test and revise the policy before regulations related to incident management are revised or initiated. Therefore, it is in everyone's best interest that all providers adhere to the reporting specified in Annex A.

Obsolete Bulletins

Mental Retardation Bulletin 00-01-05, Incident Management, issued August 27, 2001

Mental Retardation Bulletin 00-02-02, Announcement of the Incident Management Implementation Schedule and Contingency Plan, issued March 1, 2002

Mental Retardation Bulletin 00-02-14, Incident Management Interpretive Guideline, issued October 29, 2002

Mental Retardation Bulletin 00-02-15, Incident Management Interpretive Guideline—Hospital Discharge Instructions, issued November 27, 2002

Obsolete Statement of Policy

Sections 6000.461—6000.474 (relating to incident management)

Effective Date

This statement of policy is effective February 21, 2004.

(*Editor's Note*: The regulations of the Department, 55 Pa. Code Chapter 6000, are amended by deleting a statement of policy in §§ 6000.461—6000.474 and by adding a statement of policy in §§ 6000.901—6000.904, 6000.911—6000.913, 6000.921—6000.925, 6000.931, 6000.941, 6000.951—6000.959, 6000.961, 6000.962, 6000.971, 6000.972, 6000.981—6000.985 and Appendices E—K to read as set forth in Annex A.)

ESTELLE B. RICHMAN,
Secretary

Fiscal Note: 14-BUL-065. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART VIII. MENTAL RETARDATION MANUAL

Subpart A. STATEMENTS OF POLICY

CHAPTER 6000. STATEMENTS OF POLICY

Subchapter D. (Reserved)

§§ 6000.461—6000.474. (Reserved).

Subchapter Q. INCIDENT MANAGEMENT

GENERAL PROVISIONS

Sec.
6000.901. Scope.
6000.902. Purpose.
6000.903. Licensing applicability.
6000.904. Definitions.

RESPONSIBILITY FOR REPORTING/INVESTIGATING

6000.911. Providers.
6000.912. Individuals and families.
6000.913. County mental health/mental retardation programs.

REPORTABLE INCIDENTS

6000.921. Categories of incidents.
6000.922. Incidents to be reported within 24 hours.
6000.923. Incidents to be reported within 72 hours.

GENERAL PROVISIONS

§ 6000.901. Scope.

(a) Individuals who are registered with a county mental retardation program or who receive supports and services from facilities licensed by the OMR are afforded the protections detailed in this subchapter.

(b) Providers who receive funds from the mental retardation system, either directly or indirectly, to provide or secure supports or services for individuals authorized to receive services from a county mental retardation program and providers licensed by the OMR are reporters and are to file incident reports as specified in this subchapter.

(c) County mental retardation programs and their designated support coordination entities are reporters and are to file incident reports as specified in this subchapter.

§ 6000.902. Purpose.

The purpose of this subchapter is to specify the guidelines and procedures for the incident management process. The incident management process is a subset of a larger risk management process. Incident policies, procedures, training, response and reporting are all important components of the incident management process. Combined with other areas of risk assessment such as employee injuries, complaints, satisfaction surveys and hiring practices, incident management is an essential component of a comprehensive quality management process. See Appendix E (relating to incident management components).

§ 6000.903. Licensing applicability.

A facility must comply with Chapters 2380, 2390, 6400, 6500 and 6600. To the extent that this subchapter exceeds the requirements of Chapters 2380, 2390, 6400, 6500 and 6600, the use of this subchapter is optional for facilities. Because this subchapter meets or exceeds the regulatory requirements in Chapters 2380, 2390, 6400, 6500 and 6600, compliance with the reporting procedures in this subchapter will be accepted by the Department as meeting the regulatory requirements of §§ 2380.17, 2390.18, 6400.18 and 6500.20.

§ 6000.904. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Department—The Department of Public Welfare of the Commonwealth.

HCSIS—The Home and Community Services Information System.

OMR—The Office of Mental Retardation of the Department.

RESPONSIBILITY FOR REPORTING/INVESTIGATING

§ 6000.911. Providers.

(a) Employees, contracted agents and volunteers of providers covered within the scope of this subchapter are to respond to events that are defined as an incident in this subchapter. When an incident is recognized or discovered by a provider, prompt action is to be taken to protect the individual's health, safety and rights. The responsibility for this protective action is assigned to the provider initial reporter and point person. The protection may include dialing 911, escorting to medical care, separating the perpetrator, calling ChildLine, arranging for counseling and referring to a victim assistance program. Unless otherwise indicated in the individual support plan, the provider point person or designee is to inform the individual's family within 24 hours, or within 72 hours for medication error and restraint, of the occurrence of an incident and to also inform the family of the outcome of any investigation.

(b) After taking all appropriate actions following an incident to protect the individual, the provider is to report all categories of incidents and complete an investigation as necessary whenever services or supports are:

(1) Rendered at the provider's site.

(2) Provided in a community environment, other than an individual's home, while the individual is the responsibility of an employee, contracted agent or volunteer.

(3) Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home.

(c) In situations when multiple providers learn of an incident, the provider responsible for the individual at the time the incident occurred is to report the incident and conduct any required investigation. If it cannot reasonably be determined which provider had responsibility at the time of the incident, all providers who are aware of the incident are to report the incident and investigate.

(d) If, during an investigation, the certified investigator assigned by the provider determines that an alleged perpetrator is not an employee, a volunteer or an individual receiving services from the provider, the certified investigator is to complete the investigation summary in the HCSIS incident management application stating the reason why the investigation could not be concluded. The certified investigator is to review the protective action taken by the agency and ensure communication with county staff occurs, outside HCSIS, to alert the county that appropriate interventions may be needed to protect the individual.

(e) In addition, employees, contracted agents or volunteers of provider agencies are to report deaths, alleged abuse or neglect when they become aware of such incidents regardless of where or when these incidents occur. If the death, alleged abuse or neglect occurred beyond the provider's responsibility as specified in subsection (b)(1)—(3), the provider is not to report the incident in HCSIS, but instead should give notice of the incident, outside of HCSIS, to the individual's supports coordinator.

(f) Any person, including the victim, shall be free from intimidation, discriminatory, retaliatory or disciplinary actions exclusively for the reporting or cooperating with a certified investigation. These individuals have specific rights as defined by the Whistleblower Law (43 P. S. §§ 1421—1428) and the Older Adults Protective Services Act (35 P. S. § 10225.101—10225.5102). See Appendix F (relating to related laws, regulations and policies).

§ 6000.912. Individuals and families.

(a) Individuals and families are to notify the provider, when they feel it is appropriate, or their supports coordinator regarding any health and safety concerns they may have related to a service or support that they are receiving. If an individual or family member observes or suspects abuse, neglect or any inappropriate conduct, whether occurring in the home or out of the home, they should contact the provider or their supports coordinator, or both, and they may also contact the Office of Mental Retardation directly at 1 (888) 565-9435. As specified in this subchapter, the supports coordinator will either inform the involved provider of the incident or file an incident report. Once informed by the supports coordinator, the provider is subsequently responsible to take prompt action to protect the individual, complete an investigation as necessary and file an incident report. In the event of the death of an individual, the family is requested to notify the supports coordinator.

(b) When an individual or the individual's representative arrange his own supports through a payment agent or intermediary service organization and an incident occurs, the individual, the individual's family or his representative is to inform the provider, when it is appropriate, or the supports coordinator that an incident has occurred. The provider or supports coordinator will take prompt action to protect the individual, ensure a certified investigator is assigned as necessary and file an incident report in HCSIS.

§ 6000.913. County mental health/mental retardation programs.

(a) When an individual or family informs his supports coordinator that an event has occurred that can be defined as an incident and there is a relationship as specified in § 6000.911(b)(1)—(3) (relating to providers) the supports coordinator is to immediately notify the provider rendering the support or service. The provider is responsible for taking prompt action to protect the individual, completing an investigation as necessary and filing an incident report in HCSIS.

(b) When an individual or a family member informs the supports coordinator of an event that can be categorized as abuse or neglect as defined in this subchapter and there is no relationship as specified in § 6000.911(b)(1)—(3), the supports coordinator will take prompt action to protect the individual. Once the individual's health and safety are assured, the supports coordinator will ensure a certified investigator is assigned as necessary and file an incident report in HCSIS.

(c) When a family member of an individual informs the individual's supports coordinator of the death of the individual, the supports coordinator will determine if a report has been filed by a provider. If a provider is not required to file the report, the supports coordinator will file an incident report in HCSIS.

(d) In some circumstances, county mental retardation program staff may be required to report incidents. County staff are to report deaths and incidents of alleged abuse or neglect when a provider or supports coordinator relationship does not currently exist, or in circumstances when the process for reporting or investigating incidents, described in this subchapter, for providers or support coordination entities compromises objectivity.

(e) If a county incident manager or designee is informed that a provider's certified investigator suspects that abuse or neglect is occurring beyond the authority of the provider to investigate, the county is to take all available action to protect the health and safety of the individual. The county may need to employ the resources of law enforcement, ChildLine, area agency on aging, counselors or other protective service agencies to protect the individual.

REPORTABLE INCIDENTS

§ 6000.921. Categories of incidents.

(a) The following are the categories of incidents to be responded to by staff who are knowledgeable about incident management processes and protecting individuals. After the immediate health and safety assurances have been met, these incidents are to be reported in HCSIS. The categories are divided into those that must be reported within 24 hours of discovery or recognition and those that are to be reported within 72 hours.

(b) For the incidents that require reporting within 24 hours, the first section of the incident report must be completed in HCSIS within 24 hours. The first section includes a minimum data set (individual and provider demographics, action taken to protect the individual and description of the incident and the category of incident). The final section of the incident report includes additional information about the incident, any required investigation and corrective actions. The final section is to be completed within 30 days of recognition or discovery of the incident.

(c) The second set of incidents requires reporting within 72 hours of recognition or discovery. These incidents are reported using abbreviated data entry screens in HCSIS.

(d) When multiple individuals associated with a provider/entity are involved in certain primary categories or secondary categories, or both, of incidents, the incident can be reported using a site report. Only those events designated in the list of reportable incidents as a site report may be filed in this manner. An individual who is part of a group involved in a site report and is injured must have a separate individual report completed using the proper classification.

(e) Providers, supports coordination entities, counties and OMR must be vigilant to report any incident when there is a suspected crime to law enforcement. When an individual is allegedly abused, neglected or the victim of a crime, the individual is to be offered the support of a

victim's assistance program. See Appendix G (relating to victim's assistance programs).

§ 6000.922. Incidents to be reported within 24 hours.

(a) The following are categories of incidents to be reported within 24 hours after the occurrence of the incident:

(1) *Abuse.* The allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Abuse is reported on from the victim's perspective, not on the person committing the abuse.

(i) *Physical abuse.* An intentional physical act by staff or other person which causes or may cause physical injury to an individual, such as striking or kicking, applying noxious or potentially harmful substances or conditions to an individual.

(ii) *Psychological abuse.* An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

(iii) *Sexual abuse.* An act or attempted acts such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Any sexual contact between a staff person and an individual is abuse.

(iv) *Verbal abuse.* A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

(v) *Improper or unauthorized use of restraint.* A restraint not approved in the individual support plan or one that is not a part of an agency's emergency restraint procedure is considered unauthorized. A restraint that is intentionally applied incorrectly is considered an improper use of restraint.

(2) *Death.* All deaths are reportable.

(3) *Disease reportable to the Department of Health.* An occurrence of a disease on *the Pennsylvania Department of Health List of Reportable Diseases.* The current list can be found at the Department of Health's website, www.health.state.pa.us. An incident report is required only when the reportable disease is initially diagnosed.

(4) *Emergency closure.* An unplanned situation that results in the closure of a home or program facility for 1 or more days. This category does not apply to individuals who reside in their own home or the home of a family member. This may be reported as a site report.

(5) *Emergency room visit.* The use of a hospital emergency room. This includes situations that are clearly "emergencies" as well as those when an individual is directed to an emergency room in lieu of a visit to the Primary Care Physician (PCP) or as the result of a visit to the PCP. The use of an emergency room by an individual's PCP, in place of the physician's office, is not reportable.

(6) *Fire.* A situation that requires the active involvement of fire personnel, that is, extinguishing a fire, clearing smoke from the premises, responding to a false alarm, and the like. Situations which require the evacuation of a facility in response to suspected or actual gas leaks or carbon monoxide alarms, or both, are reportable. Situations in which staff extinguish small fires without the involvement of fire personnel are reportable. This may be reported as a site report.

(7) *Hospitalization.* An inpatient admission to an acute care facility for purposes of treatment. Scheduled treatment of medical conditions on an outpatient basis is not reportable.

(8) *Individual-to-individual abuse.* An interaction between one individual receiving services and another individual receiving services resulting in an allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Individual-to-individual abuse is reported on from the victim's perspective, not on the person committing the abuse.

(i) *Physical abuse.* An intentional physical act that causes or may cause physical injury to an individual, such as striking or kicking, or applying noxious or potentially harmful substances or conditions to an individual.

(ii) *Psychological abuse.* An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

(iii) *Sexual abuse.* An act or attempted act such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Nonconsensual sex between individuals receiving services is abuse.

(iv) *Verbal abuse.* A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

(9) *Injury requiring treatment beyond first aid.* Any injury that requires the provision of medical treatment beyond that traditionally considered first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a Band-Aid, and the like. Treatment beyond first aid includes lifesaving interventions such as CPR or use of the Heimlich maneuver, wound closure by a medical professional, casting or otherwise immobilizing a limb. Evaluation/assessment of an injury by emergency personnel in response to a "911" call is reportable even if the individual is not transported to an emergency room.

(10) *Law enforcement activity.* The involvement of law enforcement personnel is reportable in the following situations:

(i) An individual is charged with a crime or is the subject of a police investigation that may lead to criminal charges.

(ii) An individual is the victim of a crime, including crimes against the person or his property.

(iii) A crime such as vandalism or break-in that occurs at a provider site. This may be reported as a site report.

(iv) An on-duty employee or an employee who is volunteering during off duty time, who is charged with an offense, a crime or is the subject of an investigation while on duty or volunteering. This is reported as a site report.

(v) A volunteer who is charged with an offense, a crime or is the subject of an investigation resulting from actions or behaviors that occurred while volunteering. This is reported as a site report.

(vi) A crisis intervention involving police/law enforcement personnel.

(vii) A citation given to an agency staff person for a moving violation while operating an agency vehicle, or while transporting individuals in a private vehicle, is reported as a site report.

(11) *Missing person*. A person is considered missing when they are out of contact with staff for more than 24 hours without prior arrangement or if they are in immediate jeopardy when missing for any period of time. A person may be considered in "immediate jeopardy" based on the person's personal history and may be considered "missing" before 24 hours elapse. Additionally, it is considered a reportable incident whenever the police are contacted about an individual or the police independently find and return the individual, or both, regardless of the amount of time the person was missing.

(12) *Misuse of funds*. An intentional act or course of conduct, which results in the loss or misuse of an individual's money or personal property. Requiring an individual to pay for an item or service that is normally provided as part of the individual support plan is considered financial exploitation and is reportable as a misuse of funds. Requiring an individual to pay for items that are intended for use by several individuals is also considered financial exploitation. Individuals may voluntarily make joint purchases with other individuals of items that benefit the household.

(13) *Neglect*. The failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law or regulation. This includes the failure to provide needed care such as shelter, food, clothing, personal hygiene, medical care, protection from health and safety hazards, attention and supervision, including leaving individuals unattended and other basic treatment and necessities needed for development of physical, intellectual and emotional capacity and well being. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm.

(14) *Psychiatric hospitalization*. An inpatient admission to a psychiatric facility, including crisis facilities and the psychiatric departments of acute care hospitals, for the purpose of evaluation or treatment, or both, whether voluntary or involuntary. This includes admissions for "23 hour" observation and those for the review or adjustment, or both, of medications prescribed for the treatment of psychiatric symptoms or for the control of challenging behaviors.

(15) *Rights violation*. An act which is intended to improperly restrict or deny the human or civil rights of an individual including those rights which are specifically mandated under applicable regulations. Examples include the unauthorized removal of personal property, refusal of access to the telephone, privacy violations and breach of confidentiality. This does not include restrictions that are imposed by court order or consistent with a waiver of licensing regulations.

(16) *Suicide attempt*. The intentional and voluntary attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include suicidal threats.

§ 6000.923. Incidents to be reported within 72 hours.

(a) The following are categories of incidents to be reported within 72 hours after the occurrence of the incident:

(1) *Medication error*. Any nonconforming practice with the "Rights of Medication Administration" as described in the OMR Medication Administration Training Course. This includes omission, wrong dose, wrong time, wrong person, wrong medication, wrong route, wrong position, wrong technique/method and wrong form. Over the counter medication is excluded. Treatment procedures (for example, skin creams, shampoo, eye drops, and the like) that do not contain a prescription medication are excluded. A medication error occurring during a home visit, when the family is responsible for the administration, is not reportable. An individual's refusal to take medication is not reportable. See Appendix H (relating to abbreviated incident report, medication error).

(2) *Restraints*. Any physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or portion of the individual's body, including those that are approved as part of an individual support plan or those used on an emergency basis. Improper or unauthorized use of restraint is considered abuse and is to be reported under the abuse category. See Appendix I (relating to abbreviated incident report, restraint).

(i) *Physical*. A physical or manual restraint is a physical hands-on technique that lasts 30 seconds or more, used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body such as a basket hold and prone or supine containment.

(ii) *Mechanical*. A mechanical restraint is a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body. Examples of mechanical restraints include anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, restraining sheets and similar devices. A device used to provide support for functional body position or proper balance and a device used for medical treatment, such as a wheelchair belt or helmet for prevention of injury during seizure activity, are not considered mechanical restraints.

(iii) *Chemical*. A chemical restraint is a drug used to control acute, episodic behavior that restricts the movement or function of an individual. A drug ordered by a licensed practitioner as part of an on-going treatment program or pretreatment prior to medical or dental examination or treatment is not a chemical restraint. Medications prescribed on a Pro Re Nata (PRN) basis for the treatment of episodically occurring and well-defined symptoms of an underlying disorder (such as an anxiety disorder, auditory hallucinations, and the like) and not simply for behavior control, are not considered chemical restraints. For further clarification see Mental Retardation Bulletin 00-02-09, issued July 11, 2002, titled *Pro Re Nata Medication Usage for Psychiatric Treatment—Clarification of Interpretation*.

§ 6000.924. Incident management contingency plan.

Reportable incidents are to be submitted electronically by means of the HCSIS, a web-based system developed by the Department. In the event that HCSIS is unavailable, the submission of incidents is to occur by following the directions in the Incident Management Contingency Plan. See Appendix J (relating to incident management contingency plan).

§ 6000.925. Categories of incidents to be investigated.

The following chart indicates those incidents to be investigated by the provider, the county and OMR. The investigation process does not preclude investigations by law enforcement or other agencies responsible to investigate.

Primary Category	*Secondary Category*	*Entity Responsible for Investigation*
Abuse	All	Provider
	Improper or unauthorized use of restraint	Provider and County
Neglect	All	Provider
Rights Violation	All	Provider
Misuse of Funds	All	Provider
Death	When an individual is receiving services from a provider/entity. (See § 6000.911(b)(1)—(3).)	Provider and OMR or Department of Health (county participation as requested by OMR)
Hospitalization	Accidental Injury Unexplained Injury Staff to Individual Injury Injury Resulting from Individual to Individual Abuse	Provider Provider Provider Provider
	Injury Resulting from Restraint	Provider and County
Emergency Room Visit	Unexplained Injury Staff to Individual Injury Injury Resulting from Individual to Individual Abuse	Provider Provider Provider
	Injury Resulting from Restraint	Provider and County
Injury requiring treatment beyond first aid	Staff to Individual Injury Resulting from Individual to Individual Abuse	Provider Provider
	Injury Resulting from Restraint	Provider and County
Individual to Individual Abuse	Sexual Abuse	Provider

SEQUENCE OF REPORTING

§ 6000.931. Multiple categories and sequences.

(a) Many real life occurrences may result in events that may be classified under multiple categories of incidents. In an attempt to assist the point person in identifying an appropriate order for reporting incidents that may be classified under multiple categories, the following sequence is suggested. This sequence may not be appropriate in all situations, but should be used as a guide in selecting the most appropriate category.

(1) *24-Hour Reporting Primary Incident Category.*

(i) Death.

(ii) Suicide attempt.

(iii) Hospitalization.

(iv) Psychiatric hospitalization.

(v) Emergency room visit.

(vi) Abuse.

(vii) Individual to individual abuse.

(viii) Neglect.

(ix) Missing person.

(x) Injury requiring treatment beyond first aid.

(xi) Disease reportable to the Department of Health.

(xii) Fire.

(xiii) Misuse of funds.

(xiv) Rights violation.

(xv) Law enforcement activity.

(xvi) Emergency closure.

(2) *72-Hour Reporting Primary Incident Category.*

(i) Medication error.

(ii) Restraint.

(b) If a death, hospitalization, psychiatric hospitalization, emergency room visit or injury requiring treatment beyond first aid is the result of a medication error or the use of a restraint, a report is to be initiated within 24 hours using the corresponding primary category. Data about the medication error or the restraint is also to be recorded within 72 hours in the abbreviated HCSIS data entry screens for medication error or restraint.

INCIDENT MANAGEMENT PROCESS

§ 6000.941. Administrative structure.

Providers, supports coordination entities and counties are to create an administrative structure that is sufficient to implement the requirements of this subchapter. Specifically, they shall:

(1) Assign an individual with overall responsibility for incident management.

(2) Develop a policy for incident management.

(3) Ensure that staff, individuals and families are trained on incident management policies and procedures.

(4) Assign roles within their organization for reporting and investigation of incidents.

(5) Assure corrective action to individual incidents.

(6) Conduct analysis of data on incidents and the quality of investigations.

(7) Identify and implement individual and systemic changes based on risk management analysis.

ROLES

§ 6000.951. Initial reporter.

The initial reporter is any person who witnesses the incident or is the first to discover or be made aware of the

signs of an incident. The initial reporter first responds to the situation by taking prompt action to protect the individual's health, safety and rights. The protection may include dialing 911, escorting to medical care or calling ChildLine. As soon as the immediate needs of the person have been met, the initial reporter notifies the provider point person of the incident and receives instructions on next steps to take. The initial reporter documents his observations in a narrative report which is kept in the provider/entity's files. In cases of alleged abuse or neglect, the initial reporter will comply with the applicable laws and regulations. See Appendix F (relating to related laws, regulations and policies).

§ 6000.952. Point person.

A point person is assigned and authorized to perform specific duties as described in provider/entity or county policy. In general, a point person is to receive verbal or other reports or allegations of incidents from individuals, families and initial reporters. They are to safeguard the individual, ensure that HCSIS Incident Reports are submitted, communicate with others involved in investigations, follow-up and review of incidents. This role is pivotal in the incident management process. When an incident is reported, the point person, as a representative of the agency, is to:

(1) First confirm that appropriate actions have been taken or order additional actions to secure the safety of the individual involved in the incident.

(2) Separate the individual from the target when the individual's health and safety may be jeopardized.

(3) Ensure notification requirements of the Older Adults Protective Services Act (35 P. S. §§ 10225.101—10225.5102) and 23 Pa.C.S. §§ 6301—6384 (relating to Child Protective Services Law) are met.

(4) Determine whether an investigation or other follow-up is needed.

(5) Secure the scene of an incident when an investigation may be required.

(6) Ensure that, when needed, a certified investigator is promptly assigned.

(7) Notify appropriate supervisory/management personnel within 24 hours of the incident, as specified in provider/entity or county policies.

(8) Initiate a HCSIS Incident Report within 24 or 72 hours as described in the Reportable Incident section of this bulletin.

(9) Notify the family within 24 hours (72 hours for medication error and restraint) unless otherwise indicated in the individual support plan.

§ 6000.953. Incident management representative.

The incident management (IM) representative is the person designated by the provider with overall responsibility for incident management. This includes the assurance that the activities of the initial reporter and point person have been completed. In addition, the IM representative is responsible for the finalization of the incident report within 30 days of the incident. The IM representative is responsible to evaluate the quality of incident investigations as described in the *Pennsylvania Certified Investigators Manual*, Labor Relations Alternatives, Inc.

§ 6000.954. Certified investigator.

A certified investigator is a person who has been trained and received a certificate in investigation from OMR as communicated via Mental Retardation Bulletin 00-01-06, issued September 6, 2001, titled *Announcement of Certified Investigator Training*. Certified investigators are to promptly begin an investigation, when assigned, and are to enter a summary of their investigation findings in the HCSIS Incident Report.

§ 6000.955. Supports coordinator.

(a) A support coordinator is a person who is responsible for the coordination of services for an individual and who receives reports from an individual or family. When an individual or a family member informs the supports coordinator of an event that can be categorized as abuse or neglect as defined in this subchapter and there is no relationship as specified in § 6000.911(b)(1)—(3) (relating to providers), the supports coordinator functioning in the point person role is to take prompt action to protect the individual. Once the individual's health and safety are assured, the supports coordinator will ensure a certified investigator is assigned, as necessary, and file a HCSIS Incident Report.

(b) When a family informs their supports coordinator of the death of a relative, the supports coordinator will determine if a report has been filed by a provider. If no provider is required to file the report, the supports coordinator will file a HCSIS Incident Report.

§ 6000.956. Supports coordinator supervisor/unit manager.

The supports coordinator supervisor and the supports coordinator unit manager are responsible for the finalizing of HCSIS Incident Reports filed by the supports coordinator.

§ 6000.957. County incident manager.

The county incident manager is the person designated by the county with overall responsibility for incident management within his county program. This responsibility includes a review to ensure that incidents are managed and reported in accordance with the process described in this statement of policy and to approve or not approve HCSIS Incident Reports submitted by the provider or supports coordination entity. In addition, the county incident manager is responsible for the final submission of HCSIS Incident Reports filed by the county point person.

§ 6000.958. Regional incident manager.

The regional incident manager is the person designated by OMR with overall responsibility for incident management within his region. This responsibility includes a review to ensure that incidents are managed and reported in accordance with the process described in this subchapter and to approve or not approve HCSIS Incident Reports.

§ 6000.959. Bureau of State Operated Facilities (BSOF) incident manager.

The BSOF incident manager is the person designated by OMR with overall responsibility for incident management for incidents filed by State-operated facilities. This responsibility includes a review to ensure that incidents are managed and reported in accordance with the process described in this subchapter and to approve or not approve HCSIS Incident Reports.

TYPES OF INCIDENT REPORTS

§ 6000.961. Standardized incident report.

The following process applies to the primary incident category to be reported within 24 hours.

(1) The first section of the incident report is to include individual and provider demographics, incident categorization, actions taken to protect the health and safety of the individual, and a description of the incident. See Appendix K (relating to standardized incident report). The first section is to be submitted through HCSIS within 24 hours of the incident being recognized or discovered.

(2) The certified investigator is responsible for conducting certified investigations, completing investigation records and for entering the summary of the investigator's findings into HCSIS. The summary is the compilation of the analysis and findings section of the investigation report. For more information on the analysis and findings section, see the *Pennsylvania Certified Investigation Manual*. The final section of the incident report will retain all of the information

(3) The final section of the incident report will retain all of the information from the first section and will add additional information relevant to the incident. See Appendix K. The final section is to be submitted through HCSIS within 30 days of the incident being recognized or discovered. If the provider agency determines it will not be able to meet the 30-day reporting timeframes for completion of the final section, notification of an extension is to be made to the county and the regional office of OMR by means of HCSIS prior to the expiration of the 30-day period.

(4) When multiple individuals associated with a provider or entity are involved in certain primary categories and secondary categories of incidents, the incident can be reported using a site report. Only those events designated in the list of reportable incidents as a site report may be filed in this manner.

§ 6000.962. Abbreviated incident report.

(a) The following process applies to the primary incident categories requiring reporting within 72 hours. These incidents are not individually approved by the county, OMR regional office or Bureau of State Operated Facilities, but are to have a 30-day analysis completed and maintained by the provider/entity. Analysis of these incidents is to be included in the quarterly report.

(b) Medication errors and the use of restraints are to be reported using the abbreviated HCSIS incident management data entry screens, designed to gather relevant data about these incidents. Data is to be input within 72 hours of the recognition or discovery of the event.

REVIEW PROCESS

§ 6000.971. County review process.

(a) Within 24 hours of the submission of the first section of the incident report, designated county staff are to review the incident to determine that appropriate actions to protect the individual's health, safety and rights occurred. If the appropriate actions have not taken place, the county staff should immediately communicate their concerns to the appropriate provider/entity staff.

(b) After the provider or entity submits the final section of the HCSIS Incident Report, county staff are to perform a management review within 30 days. Counties will conduct the management review process so that at least 90% of the submitted incident reports are approved or not approved within 30 days of finalization by the provider or supports coordination entity. The management review process is to review the full report and approve or not approve the incident report. This process will include a determination that:

(1) The appropriate action to protect the individual's health, safety and rights occurred.

(2) The incident categorization is correct.

(3) A certified investigation occurred when needed.

(4) Proper safeguards are in place.

(5) Corrective action in response to the incident has, or will, take place.

§ 6000.972. OMR regional office review process.

(a) Within 24 hours of the submission of the first section of the incident report, designated OMR regional office staff are to review the incident to determine that appropriate action to protect the individual's health, safety and rights occurred. If the appropriate actions have not taken place the OMR regional office staff should immediately communicate their concerns to the appropriate provider/entity and county staff.

(b) After the county approves the incident report, regional OMR staff are to perform a management review within 30 days. The OMR regional office will conduct the management review process so that at least 90% of the county approved incident reports are approved or not approved within 30 days. The management review process is to review the full report, including the county's response, and approve or not approve the incident report. This process will include a determination that:

(1) The appropriate action to protect the individual's health, safety and rights occurred.

(2) The incident categorization is correct.

(3) A certified investigation occurred when needed.

(4) Proper safeguards are in place.

(5) Corrective action in response to the incident has, or will, take place.

QUALITY MANAGEMENT

§ 6000.981. Support to quality management.

The incident management policy described in this subchapter is designed to support provider/entity, county and OMR quality management and risk management structures and practices. As a part of OMR's quality initiatives, the incident management policy is a key component of the OMR Quality Framework and is integral to maintaining OMR's assurance to the Federal Centers for Medicare and Medicaid Services that the health and safety of individuals receiving services will be protected.

§ 6000.982. Purpose of quality management.

The purpose of quality management within the mental retardation system is to advance the quality of life of people served and supported. OMR assures that through the application of standardized incident management processes, systematic safeguards are in place to protect persons from events that place them at risk. Therefore, each provider and entity covered under the scope of this subchapter is to develop specific policy and procedures to implement a continuous quality improvement process, which includes a risk management and an incident management component. Since there is a wide diversity of agencies/entities responsible for the protection of individuals, the approach to quality management must be tailored to the unique structure of the organization.

Agencies should employ standardized approaches to quality management and incident management.

§ 6000.983. Use of incident data.

(a) HCSIS produces a set of standardized online reports that are available to providers/entities, counties and OMR. In addition to the online reports, providers and counties may request an electronic extract of incident management data through HCSIS.

(b) To assure effective quality and risk management processes, data is collected, aggregated, analyzed and utilized to make improvement decisions. Data and information in HCSIS are to be continuously, as well as systemically, assessed and analyzed by those individuals responsible for risk management, a risk management group or a risk management committee. The responsibility is to review a representative sample of individual incidents for information about the events, the response to the incident including timeliness, thoroughness and the appropriateness of the corrective actions. This responsibility also includes analysis of data and information using standardized methodology and processes. There are a variety of quality management tools for analysis and trending. These tools assist in either defining, analyzing and preventing incidents or in sustaining improvements already implemented. OMR has begun to conduct training introducing some of these quality management tools and to demonstrate how to use them effectively. The outcome of this assessment and analysis process is to identify strategies for prevention.

§ 6000.984. Provider incident management quarterly reports.

(a) Within 60 days following the end of a calendar quarter, a provider/entity is to submit to each county with whom the provider contracts, a qualitative report that describes the analysis of incidents and the systemic interventions implemented to improve the health and safety protections afforded to the individuals served. Supporting data is to be included with the report.

(b) OMR recognizes that providers desire a uniform format for quarterly reporting. A general template will be disseminated by OMR which will give structure to the design of the provider's qualitative quarterly report. This template will be flexible enough to accommodate the wide diversity of agencies/entities involved in the incident management process. Training on this template will occur prior to the first quarterly report due date.

§ 6000.985. County incident management reports.

(a) The county MH/MR program is to submit to his respective regional office a semiannual qualitative report on June 1 and December 1 of each year. A general template will be disseminated by OMR which will give structure to the design of the county's qualitative semiannual report. The report is to describe the analysis of all incidents for individuals registered with the county mental retardation program. The county is to explain the systemic interventions implemented and document instructions to providers that will improve the health and safety protections afforded to the individuals served. Supporting data is to be included with the report. Training on this template will occur prior to the first semiannual report due date.

(b) OMR will review data on all reported incidents at least semiannually to determine what trends may be developing Statewide, or by county, and take appropriate administrative steps to intervene. OMR will issue an annual report reviewing statewide incident trends.

(c) The following is a review schedule for quality incident management reporting:

Report Period	*Provider Report Due to County*	*County Report Due to OMR Region*
July 1—September 30	November 30	June 1
October 1—December 31	February 28	
January 1—March 31	May 31	December 1
April 1—June 30	August 31	

APPENDIX E

INCIDENT MANAGEMENT COMPONENTS

PROVIDERS/ENTITIES ARE TO:

• Promote the health, safety, rights and enhance the dignity of individuals receiving services.

• Develop provider-specific policy/procedures for incident management.

• Ensure that staff and others associated with the individual have proper orientation and training to respond to, report and prevent incidents.

• Provide ongoing training to individuals and families on the recognition of abuse and neglect.

• Ensure when incidents occur that affect a person's health, safety or rights, that the people who are present:

— Take prompt action to protect the person's health, safety and rights. This includes separation of the target when the individual's health and safety are jeopardized. This separation shall continue until an investigation is completed. In addition, the target shall not be permitted to work directly with any other service recipient during the investigation process. When the target is another individual receiving supports or services, and complete separation is not possible, the provider shall institute additional protections.

— Notify the responsible person designated in provider policy.

• Assign trained individual(s) Point Person(s) to whom incidents are reported when they occur and who will make certain that all immediate steps to assure health and safety have been implemented and follow the incident through closure.

• Contact appropriate law enforcement agencies when there is suspicion that a crime has occurred.

• Comply with all applicable laws, regulations and policies.

• Conduct certified investigations.

• Analyze the quality of investigations.

• Respond to concerns from individuals/family about the reporting and investigation processes.

• Inform the family of the incident unless otherwise indicated in the individual's plan.

• Notify the family of the findings of any investigation unless otherwise indicated in the individual's plan.

• Maintain an investigation file within the agency.

• Create an incident management process which:

— Designates an individual with overall responsibility for incident management.

— Considers possible immediate and long-term effects to the individual resulting from an incident or multiple incidents.

— Uses trend analyses to identify systemic issues.

— Analyzes and shares information with relevant staff, including direct care staff.

— Periodically assesses the effectiveness of the incident management process.

— Monitors quality and responsiveness of all ancillary services (such as health, therapies, etc.) and acts to change vendors or subcontractors, or assists the individual to file available grievances or appeals procedures to secure appropriate services.

COUNTIES ARE TO:

• Promote the health, safety, rights and dignity of individuals receiving services.

• Develop county policies and procedures necessary to implement this bulletin.

• Have an administrative structure sufficient to meet mandates of this bulletin:

— Designate an individual with overall responsibility for incident management.

— Train staff in incident management procedures.

— Assure that supports coordinators have proper orientation and training to respond to, document and prevent incidents.

— Support providers with appropriate training and resources to meet the mandates of the bulletin.

• Provide ongoing training to individuals, families, guardians, and advocates regarding their rights, roles and responsibilities that are outlined in this bulletin.

• Provide training to individuals and families on the recognition of abuse and neglect.

• Have the Incident Management Processes in this bulletin referenced in county/provider contracts.

• Maintain an investigation file within the county.

• Create an incident management process which:

— Assures accuracy of incident reports.

— Reviews and closes all provider generated incidents.

— Reviews and analyzes data.

— Identifies and implements individual and systemic changes based on data analysis.

— Analyzes and shares information with relevant staff.

— Regularly reviews trend and occurrence data compiled by providers.

— Assesses provider's incident management and investigative processes.

— Assures provider compliance with plans of correction resulting from incidents and investigations.

• Conduct certified investigations.

• Analyze the quality of investigations.

• Respond to concerns from individuals/family about the reporting and investigation processes.

• In collaboration with the individual's planning team, revise the individual's plan as needed in response to issues identified through the incident management process.

• Comply with all applicable laws, regulations and policies.

• Coordinate with other agencies as necessary.

• In those instances where the county is the initial reporter of the incident, the county will assume the responsibility of the point person.

THE OFFICE OF MENTAL RETARDATION IS TO:

• Promote the health, safety, rights and dignity of individuals receiving services.

• Create an incident management review process which:

— Maintains the statewide data system.

— Analyzes data for statewide trends and issues.

— Identifies issues and initiates systemic changes and provides periodic feedback.

— Evaluates county and provider reports and analysis of trends.

• Monitor implementation of this bulletin.

• Support providers and counties with appropriate training to meet the mandate of the bulletin.

• Certify investigators.

• Provide support and technical assistance to counties to implement the incident reporting system.

• Conduct certified investigations.

• Analyze the quality of investigations.

• Respond to concerns from individuals/families about the reporting and investigation processes.

• Review and revise this bulletin as needed.

• Ensure compliance with all applicable laws, regulations and policies.

• Coordinate with other agencies as necessary.

APPENDIX F

RELATED LAWS, REGULATIONS AND POLICIES

The incident management and reporting detailed in this subchapter are related to a variety of laws, regulations and policies. The applicable licensing regulations (and facilities licensed under those regulations) include:

Related Laws:

• The Mental Health and Mental Retardation Act of 1966 (50 P. S. §§ 4101—4704)

• Title XIX Social Security Act (42 U.S.C.A. §§ 1396—1396v)

• 18 Pa.C.S. § 2713 (relating to the neglect of care-dependent person)

• The Child Protective Services Law (23 Pa.C.S. §§ 6301—6385)

• The Older Adults Protective Services Act (35 P. S. §§ 10225.101—10225.5102)

• Elder Care Payment Restitution Act (35 P. S. §§ 10226.101—10226.107)

• Early Intervention Services System Act (11 P. S. §§ 875.101—875.503)

• The Whistleblower Law (43 P. S. §§ 1422—1428)

Title 55 of the Pennsylvania Code.

• Chapter 20—Relating to Licensure or Approval of Facilities and Agencies

• Chapter 2380—Relating to Adult Training Facilities

• Chapter 2390—Relating to Vocational Facilities

• Chapter 3490—Relating to Child Protective Services

• Chapter 3800—Relating to Child Residential and Day Treatment Facilities

• Chapter 5310—Relating to Community Residential Rehabilitation Services for the Mentally Ill

• Chapter 6400—Relating to Community Homes for Individuals with Mental Retardation

• Chapter 6500—Relating to Family Living Homes

• Chapter 6600—Relating to Intermediate Care Facilities for the Mentally Retarded

Title 6 of the Pennsylvania Code (Aging).

• Chapter 11—Relating to Older Adult Daily Living Centers

Related Policy Guidelines:

• Medical Assistance Bulletin—Revised Medical and Treatment Self-Directive Statement: Your Rights As a Patient In Pennsylvania: Making Decisions About Your Care and Treatment (effective June 19, 1998)

• Mental Retardation Bulletin 00-98-08—Procedures for Substitute Health Care Decision Making (effective November 30, 1998)

• Mental Retardation Bulletin 00-94-32—Assessments: Lifetime Medical History (effective December 6, 1994)

• Mental Retardation Bulletin 00-03-01—Passage of Act 171 relating to the Older Adults Protective Services Act (OAPSA)

ADDITIONAL REPORTING:

In addition to the reporting methodologies described in this statement of policy, the following is provided as a guide to assist in identifying additional reporting. This does not fully define, nor is it intended to substitute for, the applicable statutes and regulations.

Reportable incidents involving individuals who reside in facilities licensed as ICF/MRs (both state and privately-operated), are to be reported to the appropriate Regional Field Office of the Pennsylvania Department of Health, Division of Intermediate Care Facilities.

Reportable incidents that occur in facilities licensed by OMR, involving individuals whose support needs are not funded through the Commonwealth or county mental retardation systems, are to be reported to whomever funds the individual's support and to the Commonwealth/ Regional Office of Mental Retardation. This includes individuals from other states, individuals who are funded by agencies not part of the mental retardation system and individuals whose support needs are privately funded.

Neglect of care-dependent person (18 Pa.C.S. § 2713)

The neglect of care-dependent person 18 Pa.C.S. § 2713 covers any adult who, due to physical or cognitive disability or impairment, requires assistance to meet his needs for food, shelter, clothing, personal care or health care. 18 Pa.C.S. § 2713 extends to certain listed facilities and to home health services provided to care-dependent persons in their residence. The statute criminalizes intentional, knowing or reckless conduct by a caregiver which results in bodily injury or serious bodily injury to a care-dependent person by the failure to provide treatment, care, goods or services necessary to preserve the health, safety or welfare of a care-dependent person for whom the caregiver is responsible to provide care. A caregiver may also be prosecuted if he intentionally or knowingly uses a physical restraint, a chemical restraint or medication on a care-dependent person, or isolates that person, contrary to law or regulation, such that bodily or serious bodily injury results.

Anyone aware of possible violations of this may make a report to the appropriate law enforcement authorities. The reporting requirements of this bulletin are to be followed even if a report of a possible violation of this statute is made to law enforcement authorities. Copies of the statute were distributed via Mental Retardation Bulletin 00-95-25, issued December 26, 1995 and Mental Retardation Bulletin 00-97-06, issued August 29, 1997.

The Child Protective Services Law (23 Pa.C.S. §§ 6301—6385)

The Child Protective Services Law (CPSL) establishes procedures for the reporting and investigation of suspected child abuse. Certain types of suspected child abuse must be reported to law enforcement officials for investigation of criminal offenses. Children under the age of 18 are covered by the act including those who receive supports and services from the mental retardation system. Providers covered within the scope of this bulletin are required to report suspected child abuse in accordance with the procedures established in the CPSL and the Protective services Regulations. The CPSL defines child abuse as any of the following when committed upon a child under 18 years of age by a parent, person responsible for a child's welfare, an individual residing in the same home as a child or a paramour of a child's parent.

• Any recent act or failure to act that causes nonaccidental serious physical injury.

• Any act or failure to act that causes nonaccidental serious mental injury or sexual abuse or sexual exploitation.

• Any recent act or series of such acts or failures to act that creates an imminent risk of serious physical injury or sexual abuse or sexual exploitation.

• Serious physical neglect constituting prolonged or repeated lack of supervision or the failure to provide essentials of life including adequate medical care which endangers a child's life or development or impairs the child's functioning.

Reports of suspected abuse are received by the Department of Public Welfare's (DPW) ChildLine and Abuse Registry (800) 932-0313, which is the central register for all investigated reports of abuse. Individuals who come into contact with children in the course of practicing their

profession are required to report when they have reasonable cause to suspect on the basis of their medical, professional or other training or experience, that a child is an abused child. Every facility or agency is required by the CPSL to funnel reports to the director or a designee to be promptly reported to ChildLine. The reporting, investigation and documentation requirements of this statement of policy must also be followed when a report of suspected child abuse is made. It must be noted that the definition of abuse found in the CPSL differs greatly from the definition promulgated in this statement. Because of this difference it is possible that an allegation may be "unconfirmed" in terms of the CPSL but still substantiated with reference to these guidelines. Likewise, the scope of reports subject to investigation differs so it is important to be familiar with the requirements of the CPSL.

The Older Adults Protective Services Act (35 P. S. §§ 10225.101—10225.5102)

The Older Adults Protective Services Act (OAPSA) of 1987 was enacted to protect all Pennsylvanians age 60 and older. The OAPSA established a detailed system for reporting and investigating suspected abuse, neglect, exploitation, and abandonment for care-dependent individuals. Act 13 was signed into law in 1997 as an amendment to the OAPSA. Unlike the other provisions of OAPSA that applied only to adults age 60 and above, Act 13 applied to adults age 18 and above who were considered "care-dependent" individuals and to "care-dependent" individuals under age 18 if they resided in a facility serving individuals over 18. Employees or administrators of a covered entity reported suspected abuse incidents to the local Area Agency on Aging, where indicated, to the Pennsylvania Department of Aging and to local law enforcement pursuant to Chapter 7 of the OAPSA. These requirements existed in addition to the reporting procedures contained in this Bulletin. In 2002, the OAPSA was further amended by the Elder Care Payment Restitution Act.

The Elder Care Payment Restitution Act (35 P. S. §§ 10226.101—10226.107)

The Elder Care Payment Restitution Act eliminated the requirements of Act 13 for which suspected abuse of individuals with mental retardation under the age of 60 was reported to the Area Agency on Aging and in some cases, to the Department of Aging. This act became effective February 9, 2003.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191)

HIPAA and the applicable regulations at 45 CFR Parts 160 and 164 (Privacy Rule) established a set of National standards for the protection of personal health information. The Privacy Rule addresses the use and disclosure of individuals' health information or "protected health information" by organizations subject to the Privacy Rule or "covered entities." The Privacy Rule establishes standards for individuals' rights to understand and control how their personal health information is used. The U. S. Department of Health and Human Services, Office of Civil Rights is responsible to implement and enforce the Privacy Rule.

REPORTING MATRIX

The following is provided as a guide to assist in identifying additional reporting. This does not fully define, nor is it intended to substitute for, the applicable statutes and regulations.

Reportable Incident	*Report to OMR*	*Report to County*[1]	*Report to AAA*[2] *If 60 or older*	*Report to ChildLine if under 18*	*PA Department of Aging*[3] *If 60 or older*	*DOH*	*Local Law Enforcement*	*Acts 28/26*[4]
Death	X	X	If suspicious	If suspicious	If suspicious	If ICF/MR	If suspicious	If the result of neglect
Disease Reportable to the Department of Health	X	X				X		
Emergency Closure	X	X				If ICF/MR		
Emergency Room Visit	X	X				If ICF/MR		
Fire	X	X				If ICF/MR		
Hospitalization	X	X				If ICF/MR		
Individual to Individual Abuse	X	X				If ICF/MR		
Injury requiring treatment beyond first aid	X	X				If ICF/MR		
Law Enforcement Activity	X	X				If ICF/MR		
Medication Error	X	X				If ICF/MR		
Missing Person	X	X				If ICF/MR	If person is at risk	
Misuse of Funds	X	X	If exploitation			If ICF/MR	If it appears that a crime has occurred	
Neglect	X	X	X	X	If serious bodily injury or serious physical injury	If ICF/MR	If serious bodily injury or serious physical injury	If serious bodily injury
Physical Abuse	X	X	X	X	If serious bodily injury	If ICF/MR	If serious bodily injury or serious physical injury	
Psychiatric Hospitalization	X	X				If ICF/MR		
Psychological Abuse	X	X	X	X		If ICF/MR		
Restraint	X	X				If ICF/MR		If serious bodily injury
Rights Violation	X	X				If ICF/MR		
Sexual Abuse	X	X	X	X	X	If ICF/MR	X	
Suicide Attempt	X	X				If ICF/MR		
Verbal Abuse	X	X	X			If ICF/MR		

[1] If an individual is not funded by OMR or by County MR services a report should be made to the funding agent.
[2] Allegations of abuse or neglect involving children under 18 who reside in a facility that primarily serves adults must be reported to Child Line.
[3] Allegations of abuse or neglect involving children under 18 who reside in a facility that primarily serves adults must be reported to Child Line.
[4] Reporting under Acts 28/26 is only mandated for Commonwealth employees.

APPENDIX G

VICTIM'S ASSISTANCE PROGRAMS

When individuals are abused, neglected, injured or victims of crimes, there are resources to assist them physically, emotionally, financially and legally. Organizations have been developed based on the need to support victims through the criminal justice system, recognizing that victim's needs are oftentimes overlooked. Individuals with disabilities who fall victim to crimes, especially physical violence and sexual assaults, should be encouraged and assisted to access these resources. It is suggested that providers develop relationships with local entities and assist individuals in accessing such services when appropriate.

There are two main types of victim assistance programs: system and community-based organizations. System-based programs that generally operate out of a District Attorney's office provide notification to victims/witnesses of court proceedings. Community based programs are designed to provide support and assistance to victims. Usually, the programs fall under the categories of:

• Rape Crisis/Sexual Assault programs providing services to victims and their family/supporters. Domestic Violence programs provide counseling and temporary housing to victims, as needed.

• Crime Victim Services provide supports and assistance to victims of crimes excluding sexual assaults and domestic violence.

There are domestic violence centers, rape crisis centers and victim assistance offices throughout the Commonwealth. In order to locate the most appropriate resource for individuals, you may contact the following statewide organizations. Additional information regarding local resources is available through these organizations:

PA Commission on Crime and Delinquency (PCCD)
(717) 787-2040

PA Coalition Against Rape (PCAR)
(800) 692-7445
(717) 728-9740

PA Coalition Against Domestic Violence (PCADV)
(800) 932-4632

Office of Victim Advocate (crime victim compensation)
(717) 783-7501

Pennsylvania Protection and Advocacy (PP&A)
(800) 692-7443

APPENDIX H

ABBREVIATED INCIDENT REPORT

Medication Error

The data entry screen is to include the following information:

• DEMOGRAPHICS (pre-populated from HCSIS demographics)

Name of the individual for whom the Medication Error is being reported.

Individual's Base Service Unit (BSU) number.[1]

• CATEGORIZATION

Secondary category of Medication Error.

Date and time when the incident was recognized/discovered.

• MEDICATION ERROR INCIDENT INFORMATION

Staff position of the person giving medication.

Name of medication(s).

Indication if the error occurred over multiple consecutive administrations.

The reason(s) why the Medication Error occurred.

The response(s) to the Medication Error.

The agency system response to prevent this type of error from occurring in the future.

Any additional comments.

Indication if another Incident Report was filed as a result of the Medication Error.

If another Incident Report was filed, the Incident ID number.

In addition to the required information, providers may choose to include optional information to further analyze their medication errors.

• OPTIONAL MEDICATION ERROR INFORMATION

The name or unique identifier of person making the Medication Error.

Indication if the person making the Medication Error was working longer than their regular work hours at the time of the Medication Error.

The length of time the staff person who made the Medication Error has been giving medications.

The number of medications supposed to be given to this person at the same time as the Medication Error was made including the medication when the Medication Error was made.

The number of medications this person receives on a daily basis.

The number of people that the staff person who made the Medication Error has to give medications to around the same time as the Medication Error occurred.

APPENDIX I

ABBREVIATED INCIDENT REPORT

Restraint

The data entry screen is to include the following information:

• DEMOGRAPHICS (prepopulated from HCSIS demographics)

Name of the individual for whom the Restraint was used.

Individual's Base Service Unit (BSU) number.[1]

• CATEGORIZATION

Secondary category of Restraint.

Date of the Restraint.

Time in Restraint.

Time out of Restraint.

• RESTRAINT INCIDENT INFORMATION

Restraint agent.

Antecedent to the Restraint.

[1] If the individual is not registered with a County MH/MR Program, the report is to list the county or state where the person is/was a resident.

[1] If the individual is not registered with a County MH/MR Program, the report is to list the county or state where the person is/was a resident.

Reason for the Restraint.

Indication if the Restraint was used on a planned or emergency basis.

Authorizing Staff.

Indication if Prone (face down) Restraint was used.

Indication if another Incident Report was filed as a result of the Restraint.

If another Incident Report was filed the Incident ID number.

APPENDIX J

INCIDENT MANAGEMENT CONTINGENCY PLAN

In the event that a provider or county or entity is unable to report a 24-hour incident through the Home and Community Services Information System (HCSIS), faxed contingency reporting is to be utilized.

Incidents that are reported via fax are to be recorded on a copy of the attached Incident Management Contingency Form. This reporting method will satisfy regulatory requirements to report an incident. In the event of a serious incident (such as abuse with injury, suspicious death), a provider should also call its OMR Regional Office and County MH/MR Program to alert OMR and the county of the incident.

Once complete, the Incident Management Contingency Form is to be faxed to the appropriate OMR Regional Office and to the County MH/MR Program. The form should have a fax cover sheet that identifies the fax as a reportable incident and states the reason that the report needed to be faxed. Faxing the Incident Management Contingency Form is a short-term solution for meeting regulatory requirements for reporting incidents; however, once access to HCSIS can be established, the incident must be entered into HCSIS.

CONTACT INFORMATION:

OMR Regional Office Fax Numbers:

- Northeast Region (570) 963-3177
- Southeast Region (215) 560-3043
- Central Region (717) 772-6483
- Western Region (412) 565-5479

OMR Regional Office Phone Numbers:

- Northeast Region (570) 963-4391
- Southeast Region (215) 560-2242
- Central Region (717) 772-6507
- Western Region (412) 565-5144

INCIDENT MANAGEMENT CONTINGENCY FORM

FOR USE ONLY WHEN HCSIS IS NOT AVAILABLE

DATE OF REPORT: M M D D Y Y Y Y - -	TIME: AM/PM

The Incident Report must be entered into HCSIS when access to HCSIS can be established.

NAME OF INDIVIDUAL (LAST, FIRST, M.I.)			PROVIDER NAME:
ADDRESS:			ADDRESS:
CITY	STATE	ZIP CODE	CITY STATE ZIP CODE
PHONE:	COUNTY OF REGISTRATION:		PHONE:
BASE SERVICE UNIT NUMBER:			
DATE OF BIRTH: M M D D Y Y Y Y - -	SEX: ☐ MALE ☐ FEMALE		DATE THE INCIDENT OCCURRED OR WAS RECOGNIZED/DISCOVERED: M M D D Y Y Y Y - -
CLASSIFICATION OF INCIDENT:			TIME THE INCIDENT OCCURRED OR WAS RECOGNIZED/DISCOVERED: AM/PM
DATE AND TIME OF DEATH (IF APPLICABLE):			PROVIDER LICENSE NUMBER (IF APPLICABLE):
DESCRIBE THE TYPE OF INCIDENT AND THE ACTION(S) TAKEN TO ADDRESS THE INDIVIDUAL'S HEALTH AND SAFETY AND THE RESPONSE TO THE INCIDENT, WHAT HAPPENED, IF A MEDICAL REFERRAL WAS NECESSARY (PLEASE LIST) AND ANY CIRCUMSTANCES WHICH MAY HAVE PRECIPITATED THE INCIDENT: (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
NAME OF RELATIVE OR GUARDIAN:	RELATIONSHIP:		NOTIFIED (YES/NO)
NAME OF POINT PERSON:	TITLE:		PHONE:

APPENDIX K

STANDARDIZED INCIDENT REPORT

FIRST SECTION (completed within 24 hours)

The First Section is to include the following information:

• DEMOGRAPHICS (pre-populated from HCSIS demographics)

Name of the individual involved/affected by the incident.

Individual's Base Service Unit (BSU) number.[1]

County of Registration.

Gender.

Individual's date of birth.

MR Diagnosis.

Home address of the individual.

Living Arrangement of the individual.

Name and address of the reporting entity.

Location where the incident occurred.

Name of the point person.

• CATEGORIZATION

Date and time when the incident was recognized/discovered.

Primary and secondary category of the incident.

Determination if an investigation is required or desired.

Name of the Certified Investigator assigned, if the incident requires investigation.

• HEALTH AND SAFETY ASSURANCE

Description of the immediate and subsequent steps taken by the point person or other representatives of the provider to ensure the individual's health, safety and response to the incident, including date, time and by whom those steps were taken.

• INCIDENT DESCRIPTION

Narrative description of the incident completed by staff or other person(s) who were present when the incident occurred or who discovered that an incident had occurred.[2]

FINAL SECTION (completed within 30 days)

The reporting entity will complete the Final Section of the incident report within 30 days from the date of the incident or of the date the provider learns of the incident (unless an extension has been made). The Final Section will retain all of the preceding information from the First Section and will add:

Name of the initial reporter.

Name of the individual's supports coordinator (pre-populated).

Whether CPR was administered.

Weather the Heimlich was administered.

If 911 was called, the time, date and person who called.

If the incident involves an illness or injury, the name of the practitioner/facility by whom the individual was treated initially, the date and time of the initial contact with a health-care/medical practitioner, the nature/content of the initial treatment/evaluation, and the nature of, date of, time of, and practitioner involved in any subsequent treatments, evaluations.

In the event of a death, indication if the individual was in hospice care, had a diagnosis of terminal illness, if a "Do Not Resuscitate" order was in effect, if the coroner was contacted, if an autopsy has been or will be performed.

Identification of all persons to whom the incident notification has been (or will be) submitted (i.e., family, law enforcement agency), the date the notification has been made, and the person who has/will notify the necessary parties.

Update of incident description, as needed.

Specific description of any injury received by the individual.

Present status of the individual in reference to the incident.

Identification of other persons who may have witnessed or been directly involved in the incident.

Specific signs and symptoms of any illness (acute or chronic) which may be contributory to the incident.

Any relevant background information on the individual, including medical history and diagnoses.

Date on which the investigation began, if required.

Summary of the investigator's findings and conclusions, if required.

If the incident involves an allegation of abuse or neglect, the conclusion reached on the basis of the investigation (i.e., the allegation is confirmed, not confirmed, inconclusive) and the status of the target.

Description of the steps taken by the provider in response to the conclusions reached as a result of the investigation.

If the incident involves an injury of unknown origin, confirmation of the cause (if one has been identified) and steps taken to prevent recurrence.

Description of any changes in the individual's plan of support necessitated by or in response to the incident.

Verification by the provider that all necessary corrective actions have been identified.

If any corrective action cannot/has not been completed by the time the Final Section is submitted, the expected date of completion must be provided along with the identity of the person responsible for carrying the extended action through to completion.

If the nature of the incident requires contact with local law enforcement, the name and department/office of the person(s) contacted, the date of the contact, the name of the person who initiated the contact, and a description of any steps taken by law enforcement officials.

If the individual has been hospitalized, the date of admission, name of the hospital, the admitting diagnosis(es), indication if the admission was from the emergency room, what occurred during the hospitalization, change in voluntary/involuntary status, the date of discharge, the discharge diagnosis(es), an indication that the Hospital Discharge Instructions were provided, what changed after discharge, current status and any plans for subsequent medical follow-up.

[1] If the individual is not registered with a County MH/MR Program, the report is to list the county or state where the person is/was a resident.

[2] Providers may summarize the narrative description, but the written statements of the person(s) directly involved are to be available for review, if needed.

If the individual is deceased, the Final Section is to be supplemented by a hard copy of the following:[3]

— Lifetime medical history.

— Copy of the Death Certificate.

— Autopsy Report, if one has been completed.

— Discharge Summary from the final hospitalization, if the individual died while hospitalized.

— Results of the most recent physical examination.

— Most recent Health and Medical assessments.

[3] Documents, which are not immediately available, must be forwarded to the appropriate parties (county and/or OMR Regional Office) as they become available. If, after attempting to acquire the document, it is determined to be unobtainable, the expecting party will be notified.

Name of the family member notified of the results of the investigation, if required.

The incident classification the provider believes is most appropriate.

The date and time the provider believes is most appropriate.

After final submission by the provider, the county and OMR will perform a management review and close the incident.

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