INCIDENT / ACCIDENT REPORTING POLICY

Policy Statement: The purposes for reporting, investigating, reviewing, correcting and/or monitoring certain events or situations are to enhance the quality of care provided to persons with developmental disabilities who are in facilities, to protect them (to the extent possible) from harm, and to ensure that such persons are free from mental and physical abuse. The primary function of the reporting of certain events or situations is to enable CWI's governing body, executives, administrators and supervisors to become aware of problems, to take corrective measures, and to minimize the potential for recurrence of the same or similar events or situations. Prompt reporting can ensure that immediate steps are taken to protect persons receiving services from being exposed to the same or similar risk.

Regulatory References: OPWDD requires that all service providers in the OPWDD system adhere to Title 14 of New York Codes, Rules and Regulations Part 624 (14 NYCRR Part 624), a regulation designed to protect people receiving OPWDD services called Implementation of the Protection of People with Special Needs Act and Reforms to Incident Management effective 6/30/2013.

New Part 625 Regulations that apply to events and situations that are not under the auspices of the agency.

Procedures:

1. All incidents/accidents are to be reported as one of the following categories:
   a. CWI Tracked Occurrence
   b. Notable Occurrences
      i. Minor Notable
      ii. Serious Notable
   c. Reportable Incident
      i. Abuse/Neglect
      ii. Significant Incident
   d. * Part 625 Events Not Under Agency Auspices (*Please see separate policy and procedure).

The CWI Incident/Accident report must be completed for all tracked occurrences, notable occurrences, reportable incidents, and events not under the auspices of the agency.

A. CWI Tracked Occurrences:

1. Vehicle Accident/Incidents	Any vehicle accident or ticket issued to a CWI employee while at work/on duty. This includes accidents/tickets either in a CWI or personal vehicle.
2. Medication Errors	Any medication error that occurs that does not have an adverse effect or requires outside medical assessment, treatment or hospitalization. Documentation errors are included in the category. ***An Incident/Accident report does not need to be filled out. Please follow Medication Error policy and procedures.**

B. Notable Occurrences:

1. Consumer Injury	**Minor Notable:** Any suspected or confirmed harm, hurt or damage to a person receiving services, caused by an act of that person or another, whether or not the cause can be identified, which results in a person requiring medical or dental treatment by a physician, dentist, physician's assistant or nurse practitioner, and such treatment is more than first aid. **Serious Notable:** Any injury that results in the admission of a person to a hospital for treatment or observation because of injury.

2. Unauthorized Absence	**Serious Notable:** The unexpected or unauthorized absence of a person after formal search procedures have been initiated by the agency. Reasoned judgments, taking into consideration the person's habits, deficits, capabilities, health problems, etc. shall determine when formal search procedures must be initiated immediately upon discovery of an absence involving a person whose absence constitutes a recognized potential danger to the wellbeing of the person or others.
3. Sensitive Situations	**Serious Notable:** Those situations involving a person receiving services that do not meet the criteria of the definitions of reportable incidents, which may be of a delicate nature to the agency and which are reported to ensure awareness of the circumstances. Sensitive situations shall include, but are not limited to, possible criminal acts committed by any individual who receives services or a serious event/occurrence that may have a negative impact on OPWDD or CWI.
4. Death	**Serious Notable:** The death of any person receiving services, regardless of the cause of death. This includes all deaths of individuals who live in residential facilities operated or certified by OPWDD and other deaths that occur under the auspices of an agency.
5. Theft or Financial Exploitation	**Minor Notable:** Any suspected theft or financial exploitation of a service recipient's personal property (including personal funds or belongings) involving values of more than $15.00 and less than or equal to $100.00 that does not involve a debit, credit or benefit card and that is an isolated occurrence. **Serious Notable:** Any suspected theft or financial exploitation of a service recipient's personal property (including personal funds or belongings) involving a value of more than $100.00; theft involving a service recipient's credit, debit, or public benefit card (regardless of the amount involved); or a pattern of theft or financial exploitation involving the property of one or more individuals receiving services.
6. Choking (no known risk)	**Serious Notable:** Partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food, that leads to a partial or complete inability to breathe.

C. Reportable Incidents:

I. Abuse or Neglect:

1. Physical Abuse	Intentional contact (hitting, kicking, shoving, etc.) corporal punishment, injury which cannot be explained and is suspicious due to extent or location, the number of injuries at one time, or the frequency over time.
2. Sexual Abuse	Inappropriate touching, indecent exposure, sexual assault, taking or distributing sexually explicit pictures, voyeurism or other sexual exploitation. All sexual contact between a Custodian and a service recipient is sexual abuse, unless the Custodian is also a person receiving services.
3. Psychological Abuse	Taunting, name calling, using threatening words or gestures, derogatory comments or ridicule, display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury in a manner that constitutes a threat of physical pain or injury.
4. Deliberate Inappropriate Use of Restraints	Use of these interventions with excessive force, as a punishment or for the convenience of staff. The use of the restraint is deliberately inconsistent with the individual's plan of services or behavior support plan, generally accepted treatment practices except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other party.
5. Use of Aversive Conditioning	The application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services.

6. Obstruction of Reports	Impeding the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of an individual receiving services; actively persuading a custodian or other mandated reported from making a report of a reportable incident with the intent to suppress the reporting of the investigation of such incident; intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with OPWDD regulations, policies or procedures or failing to report a reportable incident upon discovery.
7. Unlawful Use of Controlled Substance	Using, administering or providing any controlled substance contrary to law. Includes administration by a custodian to a service recipient a controlled substance without a prescription or other medication not approved for any use by the FDA and unlawfully using or distributing a controlled substance at the workplace or while on duty.
8. Neglect	Any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Failure to provide supervision, or adequate food, clothing shelter, health care or access to an educational entitlement.

II. Significant Incidents:

1. Conduct Between Persons Receiving Services	that would constitute abuse as described above if committed by a custodian, except sexual activity involving adults who are capable of consenting and consent to the activity.
2. Conduct on the part of a custodian	that is inconsistent with the individual's plan of services, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, and which impairs or creates a reasonably foreseeable potential to impair the health, safety or welfare of an individual receiving services, including but not limited to:
a. Seclusion	The placement of an individual receiving services in a room or area from which he or she cannot, or perceives that he or she cannot, leave at will. OPWDD prohibits the use of seclusion;
b. Unauthorized Use of Time-Out	The use of a procedure in which a person receiving services is removed from regular programming and isolated in a room or area for the convenience of a custodian or as a substitute for programming;
c. Administration of a prescribed or over-the-counter medication	The administration of a prescribed or over-the-counter medication, which is inconsistent with a prescription or order issued for a service recipient by a licensed, qualified health care practitioner and which has an adverse effect on an individual receiving services. Adverse effect shall mean the unanticipated and undesirable side effect from the administration of a particular medication which unfavorably affects the wellbeing of a person receiving services;
d. Inappropriate Use of Restraints	The use of a restraint when the technique that is used, the amount force that is used or the situation in which the restraint is used is inconsistent with the individual's plan of services, behavior support plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies. A restrain shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limits the ability of a person receiving services to freely move his or her arms, legs or body; or
e. Other Mistreatment	Conduct on the part of a custodian that is inconsistent with the individual's plan of services, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, and which impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services, except as described in a. through d. above.
3. Missing person	The unexpected absence of an individual receiving services that based on the person's history and current condition exposes him or her to risk of injury.
4. Choking with known risk	Partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food, which leads to a partial or complete inability to breathe, involving an individual with a known risk for choking and a written directive addressing that risk
5. Self-abusive behavior with injury	A self-inflicted injury to an individual receiving services that requires medical care beyond first aid.

2. Custodian as Mandated Reporter Responsibilities:

a. All CWI custodians (including employees, interns, volunteers, consultants, and contractors) are required to report any event or situation, upon discovery, that meets the criteria of a Reportable Incident or Minor/Serious Notable Occurrence to CWI, and if required, the Vulnerable Persons' Central Register (VPCR) at the Justice Center. Non-certified programs that are not state operated are not required to report to the VPCR at the Justice Center and only Reportable Incidents are required to be reported to the VPCR (not minor/serious notable occurrences).
   i. "Discovery" occurs when the custodian witnesses a suspected reportable incident or when another party, including an individual receiving services, comes before the mandated reporter in the mandated reporter's professional or official capacity and provides the mandated reporter with reasonable cause to suspect that the individual has been subjected to a reportable incident.
   ii. Certified programs responsible to report to the VPCR include Individual Residential Alternatives, Day Habilitation Programs, Intermediate Care Facilities, Day Treatment Centers, Sheltered Workshops, Family Care Homes and Article 16 Clinics. If a Reportable Incident occurs in another program (i.e. community habilitation, supported employment, etc.) the incident is reported to OPWDD Incident Compliance Officer or to the OPWDD Incident Management Unit hotline after normal business hours.

b. It is always the responsibility of the custodian/mandated reporter who discovers a Reportable Incident to ensure the person is immediately safe and is provided medical treatment/care if it is needed;

c. Once the person is safe, immediately report the incident to a supervisor or Quality Assurance staff if a supervisor is not immediately available. If neither a supervisor nor Quality Assurance staff is available, staff must call the administration on-call phone to report the incident. If after normal business hours, or otherwise directed, staff must call the appropriate on-call personnel.

d. If the incident is one that requires reporting to the VPCR hotline, the custodian who discovered the incident, as well as any other custodian who has information about the incident, will be required to call the VPCR hotline or by electronic transmission, in a manner and on forms prescribed by the Justice Center.

e. The first supervisor (or Quality Assurance staff) who is told about the incident is also required to call the VPCR hotline or by electronic transmission, in a manner and on forms prescribed by the Justice Center.

f. Complete part A of a CWI's Incident/Accident Report form.

g. Mandated reporters are also obligated to report Reportable Incidents to the VPCR if the mandated reporter becomes aware that an individual has been subjected to a Reportable Incident at a different facility or program subject to the same requirements (i.e. facilities and program certified or operated by OPWDD, OMH, OASIS, specified residential schools and summer camps for people with developmental disabilities).

3. Supervisor Responsibilities:

a. The person's safety must always be the primary concern. The supervisor will take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse.

b. Notify Quality Assurance staff immediately (or the On-Call administrator if after-hours) and fax a copy of the incident report and other related documents to Quality Assurance staff within the same work day or first business day.

c. Ensure page two of the CWI Incident/Accident Report form is filled out for all consumer/staff injuries as well as vehicle accidents.

4. Quality Assurance and/or Administration On-call Responsibilities:

a. QA / Admin: Review incident information, instruct mandated reporters to call the VPCR when needed, ensure incident report is complete.

b. QA ONLY: Update IRMA after initial information is entered by the Justice Center. Enter minor/serious notable occurrences into IRMA (Incident Reporting Management Application).

c. QA ONLY: Complete the OMR-147 and CWI's Administrative Worksheet.

d. QA / Admin: Ensure that all other administrative notifications of reports are made (i.e. Jonathan's Law phone contacts).

e. QA ONLY: Follow any investigation of the CWI incidents/accidents performed by outside authorities, acting as CWI liaison and facilitating follow-up/corrective action, as needed.