

ACCOUNTABLE BEHAVIORAL HEALTH ALLIANCE

Policy No. 026 Critical Incident Reporting

Original Policy Date:	March 3, 2003
Next Review Date:	December 2009
Revision History (approval):	December 7, 2007
Cross References:	

Purpose:	This policy establishes procedures for the review of unusual and undesirable incidents that adversely affect ABHA members, county partners and subcontracted providers. Critical Incident policy and procedures will be used to assure that a review will occur for 100% of critical incidents involving ABHA members and providers, that data is collected on all critical incidents and is used to continuously improve services to ABHA members and providers, and to comply with applicable Oregon Administrative Rules.
Policy:	Accountable Behavioral Health Alliance shall have in place clear policies and procedures to monitor the health and safety of ABHA members and providers. Serious events which occur during the provision of mental health care by ABHA providers involving ABHA members will be systematically reported and reviewed. This policy establishes the criteria for Critical Incident reporting to ABHA.
Scope:	This policy applies to all ABHA County Partners and subcontracted providers.
Procedure:	<p><u>DEFINITIONS:</u> Critical Incidents include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Client Suicide: Includes current clients and individuals who may not have been clients but had emergency contact with county staff, or those having had contact with an ABHA provider. 2. Attempted Client Suicide: An action that without intervention would likely have resulted in death. 3. Client Death: Includes any current member, or those having had any recent contact with an ABHA provider (when information is available), whose death was unexpected, untimely, unexplained, or suspicious. 4. Client Complaint of Abuse: Includes any client complaint of abuse including a provider staff person or provider contractor. <i>OARS prescribe mandatory abuse reporting for vulnerable populations.</i> 5. Danger to Health and Safety: Includes any member-related violence, injuries occurring on site or during the receipt or provision of services by ABHA members and providers, or unsafe conditions that have resulted in client injury

	<p>6. Alleged homicide of or by a client within six months of discharge: When information is available, Providers will conduct or contribute to a critical incident review involving recently enrolled clients or those having had contact with ABHA providers.</p> <p>PROCEDURES:</p> <ol style="list-style-type: none"> 1. ABHA’s partner counties and subcontracted providers shall establish processes to ensure compliance with this policy. 2. When an incident occurs which meets the definition of a Critical Incident, a Critical Incident Report shall be completed within 24 hours of the incident, or knowledge of the incident, and submitted to the County Director or designee. 3. Procedures shall include review of the Critical Incident by County Program Management staff to determine if the incident meets requirements for Mandatory Abuse Investigation and Reporting as described in the Oregon Statutes and/or Critical Incident Reporting. 4. The County shall review all Critical Incidents meeting Definitions 1-6 above at the next scheduled County meeting for the clinical context of the incident, the appropriateness of the response to the incident, identify trends, and recommend changes if any which would reduce the likelihood of future incidents. 5. Critical Incidents involving an ABHA member shall be reported in summary form to the ABHA Quality Manager within 30 days of the incident or knowledge of the incident. A review of the critical incident will be presented to the ABHA QMC by either the ABHA Quality Manager or the Executive Director. 6. County will be responsible for protecting the confidentiality of ABHA members and provider staff during Critical Incident review and reporting. Names of clients and staff will be edited out prior to forwarding documents to ABHA. Additionally, County shall ensure all forms and documents containing confidential member information are kept in a secure location. 7. Critical Incidents will be reported using the Attached standardized form. <p><u>COMMITTEE PROCESS</u></p> <p>The ABHA Quality Management Committee (QMC) is responsible for continuously monitoring, reviewing and revising the ABHA Critical Incident policy and procedure annually.</p>
Enforcement:	

Seth Bernstein, Executive Director

12/7/07
 Date Approved by the Governing Board

Accountable Behavioral Health Alliance Critical Incident Report



County: Benton Crook Deschutes Jefferson Lincoln

Year: _____ Quarter: Jan-March April-June July-Sept Oct-Dec

Category Codes

1 = Client Suicide	5 = Danger to Health and Safety
2 = Attempted Client Suicide	6 = Alleged homicide of or by a client within six months of discharge
3 = Client Death	7 = Other
4 = Client Complaint of Abuse	

Date of Incident	Brief Description of Incident and Resolution	Category	OHP Y/N	Date Reported to State	Investigated by State Y/N	Date Investigation Closed by State
	Incident: Resolution:					
	Incident: Resolution:					
	Incident: Resolution:					
	Incident: Resolution:					
	Incident: Resolution:					