

Policy:

DMH guidelines require that certain types of events be reported following a certain format within specified time limits. The specified timelines are immediate for critical events and the next business day for all other events. It is required that all Palmer's Home Care, LLC staff be aware of such requirements and that any event in question or known to be in a reportable category be reported immediately according to the following chain of command and Administration will make the determination on if the event is reportable and provide instructions regarding who will complete the event report for DMH and who needs to be contacted (Community RN/Guardian/Case Manager, etc.). If there is ANY question about whether something should be reported, Palmer's Home Care will report the event.

Staff → House Manager/Live-in/Host → Degreed Professional Manager → COO → CEO → Owner

Comments:

All staff are expected to be familiar with events that must be reported and follow the procedure below in ensuring that they are.

STAFF ARE REQUIRED TO REPORT ANY OF THE FOLLOWING EVENTS TO PALMER'S ADMINISTRATION ON DISCOVERY SO THAT APPROPRIATE ACTION CAN BE TAKEN:

1. Reports, Allegations, or Suspicion of Abuse or Neglect of Any Kind

All events where there is a report, allegation or suspicion that a consumer has been subjected to Misuse of Consumer Funds/Property, Neglect, Physical Abuse, Sexual Abuse or Verbal Abuse. (9 CSR 10-5.200, DOR 2.210)

2. All

a) Emergency Room Visits (for any reason)

b) Non-scheduled Hospitalizations

Any event that results in an individual going to the hospital that was not planned. (i.e., **they** go to the doctor's office because of flu like systems, high fever, etc. and the doctor admits the individual into the hospital). Scheduled procedures that require hospitalization such as cancer treatment, surgery, etc. are not reportable as far as DMH is concerned but Palmer's Home Care, LLC administration must be made aware.

c) Deaths of Individuals served.

All employees of Palmer's Home Care, LLC will fully and completely cooperate with any mortality review, investigation, etc. of Department of Mental Health, Law Enforcement, etc. in the event of the death of any individual in care.

d) Medication Errors –that reach the individual. Example if staff forgets to give a med to an individual it is a medication error that reached the individual. Some examples that are NOT considered a med error: a dropped medication, a documentation error on the MAR, or an individual refusing a medication. However, these situations DO need to be documented on the Medication Administration Record appropriately. If we cannot verify that a prescription was given/used, etc. as prescribed by the physician it IS a medication error.

e) Incident of Falling –

The apparent (witnessed, not witnessed or reported) unintentional sudden loss from a normative position for the engaged activity to the ground, floor or object which has not been forcibly instigated by another person.

Uses of Emergency Procedures with an individual--

- **Emergency Procedures** - any restraint/time out used by DMH staff or contracted staff to restrict an individual's freedom of movement, physical activity, or normal access while in DMH services. If any of the following restraint types or time out occurs as defined, they must be reported on an EMT form.

- **Chemical Restraint** - a medication used to control behavior or to restrict the individual's freedom of movement and is not a standard treatment for the individual's medical or psychiatric condition. A chemical restraint would put an individual to sleep or render them unable to function as a result of the medication. (A pre-med for a dental or medical procedure would not be reported as a chemical restraint.)
- **Manual Restraint**- any physical hold involving a restriction of an individual's voluntary movement. Physically assisting someone who is unsteady, blocking to prevent injury, etc. is not considered a manual restraint.
- **Mechanical Restraints** - any device, instrument or physical object used to confine or otherwise limit an individual's freedom of movement that he/she cannot easily remove. (The definition does not include the following: Medical protective equipment, Physical equipment or orthopedic appliances, surgical dressings or bandages, or supportive body bands or other restraints necessary for medical treatment, routine physical examinations, or medical tests; Devices used to support functional body position or proper balance, or to prevent a person from falling out of bed, falling out of a wheelchair; or Equipment used for safety during transportation, such as seatbelts or wheelchair tie-downs; Mechanical supports, supportive devices used in normative situations to achieve proper body position and balance; these are not restraints.)
- **Time Out - removing the individual from one location and requiring them to go to any specified area, where that** individual is unable to participate or observe other people. Time-out includes but is not limited to requiring the person to go to a separate room, for a specified period of time, the use of verbal directions, blocking attempts of the individual to leave, or physical barriers such as doors or ½ doors, etc. or until specified behaviors are performed by the individual. Locked Rooms (using a key lock or latch system not requiring staff directly holding the mechanism) are prohibited.

3. Involvement of Law Enforcement.

All events where there is Law Enforcement involvement when the consumer is either the victim, alleged perpetrator, or when law enforcement is called in support of the event.

4. Disruption of DMH Service.

All events of fire, theft, or natural disaster resulting in disruption of DMH-DD service to consumer/s

5. Sexual Conduct Involving an Individual.

All events where there is sexual conduct involving a consumer and it is alleged, suspected or reported that one of the parties is not a consenting participant.

6. Threat or Action Which Conveys Intent to Harm.

All events where there is realistic threat or physical action, serious self-harm or assault of others.

7. Ingestion of Foreign Objects or Non-Food Items.

All events where the consumer ingests a non-food item. Non-food item-an item that is not food, water, medication or other commonly ingestible items.

8. Life-Saving Intervention or Medical/Psychiatric Emergency Intervention.

All events which result in a need for a consumer to receive lifesaving intervention or medical/psychiatric emergency intervention.

Failure to report an incident, or failure to provide sufficient information needed in order to submit an event report to DMH within a timely manner may result in disciplinary action or termination of employment. If you are unsure whether an event/incident is reportable, contact the on-call or director and ask for assistance in determining whether it is.

Critical Events

Please reference Division Directive 4.070 <https://dmh.mo.gov/media/pdf/directive-4-070>. The Directive states events involving a death of a consumer, events where there is a report, allegation or suspicion of Abuse/Neglect

as defined in 9 CSR10-5.200 & DOR 2.210 and Critical Events are to be immediately reported to the Division of DD.

Critical incident: A critical incident is defined as a significant incident involving department services, facilities or consumers that are to be reported to key department administration locally and in central office. The following incidents shall be classified as critical incidents:

1. Death of a consumer suspected to be other than natural causes; (DD requires ALL Deaths of a consumer to be Immediately reported to the Division)
2. Serious injury to a consumer; (DD Reportable Category #2. b requires reporting of all non-scheduled hospitalizations. If the hospitalization involves a serious injury as defined by DOR 4.270 then it is a critical event and must be immediately reported to DD. DOR 4.270 defines serious injury, as an injury that results in the hospital admission of the injured person.)
3. Death or serious injury to a visitor at department state operated facilities;(This is not a reportable event for community-based providers).
4. Death or serious injury to a department employee or volunteer while on duty; (This is not a reportable event for community-based providers)
5. Serious incident of abuse/neglect, including abuse/neglect involving death, serious injury and sexual abuse; (DD requires ALL Deaths & allegations/complaints/suspicious of abuse-neglect-misuse of funds to be immediately reported to the Division).
6. Suicide attempt resulting in an injury requiring medical intervention (greater than minor first aid); (DD Reportable Category #6 is to report events involving a consumer when there is a realistic threat or physical action of serious self-harm or assault of others. If there is an injury, and it rises above minor first aid it is to be immediately reported to the Division of DD.)
7. Elopement with law enforcement contacted or involved;(DD Reportable Category #3 is to report an event where Law Enforcement is involved when the consumer is either the victim, alleged perpetrator, or when law enforcement is called in support of an event. It is to be reported immediately if L.E. is involved because of an elopement. Please note, elopement itself may not be a reportable event. It must first meet one of the DD Reporting Categories).
8. Criminal activity reported to law enforcement involving consumer as perpetrator or victim when the activity occurs at a facility. If not at a facility, then the criminal activity is serious (felony, etc.); (If reporting because of DD Reportable Category #3 and it rises to the level of a felony, etc. then it is critical and must be reported immediately to the Division of DD)
9. Fire, theft, or natural disaster resulting in extensive property damage, loss or disruption of service in department state operated facilities; and (If reporting because of DD Reportable Category #4, but it rises to the level of extensive property damage then it is critical and must be reported immediately to the Division of DD)
10. Any significant incident the facility head district administrator, district deputy, chief executive officer or designee decides needs to be reported.

Palmer's Home Care staff will immediately contact their Home Manager regarding any reportable events. The Home Manager will immediately contact the Program Manager who will notify executive staff. The immediate staff document thoroughly and accurately with a detailed account of the reportable event and any actions taken. The Program Manager will follow the process and timelines for event direct entry (CIMOR) and notification per Directive 4.070 and will enter the information in the Event report within 24 hours.