New York State Documents

Association for Information and Image Management

MS303-1980

Centimeter

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 mm

1 2 3 4 5

Inches

1.0 1.1 1.25 1.4 1.6 1.8 2.0 2.2 2.5 2.8 3.2 3.6 4.0 4.5 5.0 5.6

Incident Reporting and Management Practices at Five NYS Psychiatric Centers

NEW YORK STATE COMMISSION ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

May 1997

Incident Reporting and Management Practices at Five NYS Psychiatric Centers

Clarence J. Sundram
CHAIRMAN

Elizabeth W. Stack
William P. Benjamin
COMMISSIONERS

May 1997

NEW YORK STATE COMMISSION ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

Executive Summary

Protecting and promoting the well being of the individuals they serve is a fundamental obligation of facilities operated or licensed by New York State to care for people with mental disabilities. The maintenance of an effective incident management system — one in which potentially harmful situations are identified, investigated and remedied — is a critical component of facilities' operations and vital to their fulfilling this basic mission.

The late–1994 homicide of one Kingsboro Psychiatric Center patient allegedly by a fellow patient, and the resulting Commission investigation of incident management practices at that facility,[1] led to a broader Commission inquiry into incident management practices at five other adult psychiatric hospitals in New York City operated by the Office of Mental Health (OMH): Bronx, Creedmoor, Kirby Forensic, Manhattan, and South Beach Psychiatric Centers.

The Commission's review included:

- An examination of State laws, regulations, and policies impacting on facilities' incident management practices, particularly new regulations and an automated and manual Incident Management and Reporting System (IMRS) issued by OMH in mid–1995 (Report pp. 3-10);
- An aggregate data analysis of incidents reported by the facilities in late-1994 and early-1996 (Report pp. 11-13);
- An in-depth review of the management of incidents reported on five sample wards at each facility (Report pp. 14-20); and
- A review of patient records and other documents on the sample wards to determine whether events rising to the level of reportable incidents were duly reported and managed as such (Report pp. 23-27).

Findings

A number of positive findings emerged from the Commission's review.

First, it appeared that when incidents jeopardizing patient safety were identified and reported, facilities took prompt and appropriate action to ensure the patients' immediate well-being: arranging for prompt physical examinations, separating patients where indicated, or increasing supervision. Most incidents were rated by facilities as being low or mild in terms of their severity, ratings with which the Commission agreed. And it should also be noted that the data indicated a significant reduction in patient elopements between 1994 and 1996, reflecting the fruits of OMH's efforts to improve security at centers and accountability for patients' whereabouts (Report pp. 15-16).

Secondly, it was found that all reported incidents were responded to with investigations which, appropriately, varied in terms of their intensity relative to the severity of the event. In 85 percent of the cases, Commission staff were impressed with the quality of investigations. The timeliness of investigations was also noteworthy: 80 percent were completed within 30 days of the event, with 66 percent completed within two weeks (Report pp. 16-18).

Additionally, it was noted that Incident Review Committees — i.e., internal facility

[1] Patient Safety and Services at Kingsboro Psychiatric Center, July 1995.

review panels established to monitor the facility's response to the most serious incidents and incident management practices overall — served as important adjuncts to the incident investigative process. In one-third of the cases reviewed by IRCs, the outcomes of investigations were augmented with additional recommendations for corrective action posed by the committee (Report pp. 19-20).

The Commission's review, however, also surfaced a number of areas in need of improvement.

First, two psychiatric centers Bronx and Manhattan, relative to the others, appeared to experience difficulties in ensuring timely and thorough investigations (Report p. 17).

Secondly, the role and composition of IRCs need to be rearticulated. Under a 10 year-old OMH policy (QA-510), a four-tiered system was used to classify incidents based on their severity. IRCs were expected to review all incidents falling into the two more serious classes and a sample of incidents falling in the two less serious classes.

This classification system, however, was made obsolete with the introduction of the IMRS system in 1995, but QA-510 was not revised to reflect the changes IMRS brought. During the Commission's review it was found that only slightly more than half (53 percent) of the incidents rated as more serious under IMRS were reviewed by IRCs.

The policy also required the participation of therapy aides on IRCs. However, in 1996 not one of the psychiatric centers reported therapy aides serving on its IRC (Report pp. 17-19).

Of utmost concern to the Commission, however, was the apparent underreporting of incidents (Report pp. 23-27). A review of source documents (e.g., patient clinical records, shift logs, etc.) on sample wards across the five facilities revealed that for every 10 events reported and managed as incidents, 4.6 events occurred which appeared to warrant reporting as incidents, but were not. The rate of unreported events to every 10 reported incidents ranged from a low of 1.5 at South Beach Psychiatric Center to a high of 8.2 at Kirby Forensic Psychiatric Center.

Unreported events ranged from patient fights, to allegations of verbal or physical abuse, to cases of self abuse, medication errors or possession of contraband.

Patient fights was clearly the single largest category of unreported events and accounted for 68 percent of the nonreported incidents; for every 10 incident reports of patient fights filed by sample wards, 7 events of patient fights or patient violence went unreported.

In view of Mental Hygiene Law's requirement that incident reporting systems serve as a means of monitoring and managing, among other things, "patient fights" and/or "violent behavior" (see §29.29 MHL), the underreporting of such events to the extent seen by the Commission is a serious flaw in OMH's incident management program.

In 55 percent of the unreported cases cited by the Commission, facilities agreed incident reports should have been filed. In certain cases, facilities indicated that the problem reflected isolated or idiosyncratic lax ward reporting practices. Facilities, however, also indicated a more systemic problem: the OMH's new automated/manual IMRS system rejected as "non-incidents" certain events historically managed as incidents, such as patient fights.

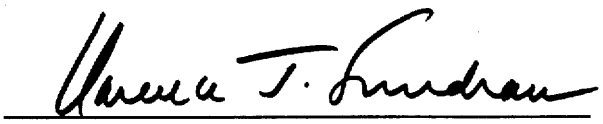
Where facilities disagreed with the Commission about unreported events (in 45 percent of the cases), their responses were revealing, particularly in light of responses from facilities which agreed with our citations. Some facilities agreed patient fights or attacks on staff constituted reportable incidents, other facilities disagreed stating that if there were no injury, patients' violent or assaultive behavior did not warrant an incident report. The opinions expressed by facilities reflected a fundamental lack of consensus as to what constitutes reportable incidents.

RECOMMENDATIONS (Report pp. 29-32)

While suggesting that OMH pay additional attention to the incident management practices at Bronx and Manhattan Psychiatric Centers which appeared to experience difficulty in conducting timely and thorough incident investigations, the Commission's recommendations call for the OMH to address the systemic underpinnings of an effective incident management system. These recommendations call for:

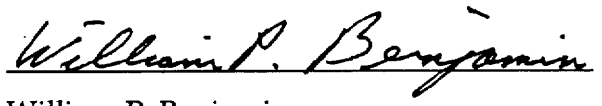
- ❒ Rearticulating what constitutes a reportable incident and facilities' obligation to report, investigate and remedy incidents, regardless of prompts, which may be erroneous, offered by the new automated/manual IMRS system;
- ❒ Convening a workgroup of staff from both state-operated and -certified facilities to critique and offer recommendations on the utility of the new IMRS system, including, most fundamentally, its value in identifying and classifying incidents;
- ❒ Establishing criteria concerning the role and composition of IRCs, which ensure a review of all serious incidents and a sample of less serious ones, and the input of front-line therapy aide staff in the IRC deliberation process; and
- ❒ Requiring facilities' Quality Assurance Programs to conduct periodic audits to detect and remedy lax incident reporting practices on wards.

The findings, conclusions and recommendations of this report reflect the unanimous opinion of the members of the Commission. A draft copy of the report was shared with the Commissioner of the Office of Mental Health whose response indicated substantial concurrence with the Commission's major findings and recommendations. A copy of the OMH's response is presented as an appendix; individual facility comments appended to the official OMH response and summarized in the OMH response have not been included due to space limitations, but are available, upon request.



Clarence J. Sundram
Chairman

Elizabeth Stack
Commissioner



William P. Benjamin
Commissioner

Table of Contents

List of Figures

List of Tables

Staff Acknowledgments

Project Directors

Thomas R. Harmon
Nancy K. Ray*

Project Coordinator

Mark E. Rappaport

Project Staff

Mindy T. Becker
Jacqueline García
Robert McCausland
Karen J. Myers
Gary O'Brien
Cheryl A. Ouimet*
Natalie J. Russo*
Laurie A. Trojnor
Rhonda Wallach

Production Staff

Gail P. Fetsko*
Anne Harrienger
Kathleen A. Runkle*
Joyce A. Salazar

*Former Commission staff members.

Chapter I
Introduction

In November 1994, the Commission on Quality of Care for the Mentally Disabled commenced an investigation into the homicide of a Kingsboro Psychiatric Center patient. The patient was allegedly stabbed to death by another patient who had escaped hours earlier from the facility and returned with the knife. In addition to examining the circumstances surrounding the fatal incident, the Commission critiqued the adequacy of the facility's overall incident reporting and management practices by reviewing the facility's handling of 254 untoward events jeopardizing patient safety which occurred during the 46 day period (November 1 – December 16, 1994) surrounding the November 20 fatal incident.

As detailed in its 1995 report, *Patient Safety and Services at Kingsboro Psychiatric Center*, the Commission's investigation revealed a series of clinical, security and supervisory lapses which preceded the November 20, 1994 homicide. Moreover, the Commission found that a number of factors undermined the effectiveness of the facility's incident management system to serve as a vehicle for protecting patients from harm. These included:

- The misclassification of incidents within a classification system designed by the Office of Mental Health (OMH) to guide the intensity of incident investigations and levels of review by senior management staff;
- Extraordinary delays in the completion of investigations; and,
- The inattention of facility administrators to serious events, and needed corrective or preventive actions, due, in part, to the misclassification of incidents, untimely investigations, and ineffective reviews by the facility's Incident Review Committee.

In light of the findings at Kingsboro Psychiatric Center, the Commission initiated a review of incident reporting practices at the five other state psychiatric centers serving adults in New York City: Bronx Psychiatric Center, Creedmoor Psychiatric Center, Kirby Forensic Psychiatric Center, Manhattan Psychiatric Center, and South Beach Psychiatric Center.

The review was temporarily suspended when, in mid-1995, new incident reporting and management regulations by the Office of Mental Health became effective. Allowing facilities the opportunity to implement the OMH's new requirements, the Commission renewed its inquiry in the spring of 1996.

The review of incident management practices at Bronx, Creedmoor, Kirby Forensic, Manhattan, and South Beach Psychiatric Centers included:

- Site visits, interviews with facility staff and reviews of facilities' incident management policies;
- A review of aggregate incident data for the month of January 1996; and,
- An in-depth examination of the handling of incidents occurring on five sample wards at each facility during January 1996, including a review of incident and investigation reports and minutes of Incident Review Committee meetings. With the exception of Kirby Forensic Psychiatric Center where all wards provide a secure level of care, the sample wards selected at facilities reflected a cross section of their patient populations

and service levels, and included admission, intermediate, long term, secure and community preparation care-settings.

At each facility, Commission staff also visited the five sample wards and reviewed two patient records, ward logs, change of shift or other communication journals, and safety/security reports to determine whether untoward events were appropriately reported, investigated, reviewed and addressed in keeping with OMH incident management standards.

This report presents the Commission's findings, conclusions and recommendations. Chapter II provides an overview of incident reporting and management standards. A description of the reported incidents occurring at the five facilities and the nature and adequacy of the facilities' response to such is presented in Chapter III. Chapter IV offers a discussion of events occurring at the five facilities which suggest underreporting of incidents or confusion about incident reporting standards. Finally, the Commission's conclusions and recommendations are presented in Chapter V.

Chapter II
Incident Reporting and Management Standards: An Overview

The protection of consumers of mental hygiene services through the reporting, investigation and correction of situations which may cause them harm has long been valued by New York State. Prior to the division of the Department of Mental Hygiene into three autonomous offices—an Office of Mental Health, an Office of Mental Retardation and Developmental Disabilities and an Office of Alcoholism and Substance Abuse Services—the obligation of all facilities to report and investigate incidents, particularly those in which employee culpability might be a factor, was articulated in the Department's regulations (Title 14 NYCRR 24).

Since the creation of the three Offices in the late 1970s, new laws, regulations and policies have come into effect expanding on this quality assurance function and shaping today's incident reporting and management practices at facilities.

In the early 1980s, §29.29 of the Mental Hygiene Law was enacted requiring the Commissioners of OMH and OMRDD to establish policies and uniform procedures for the compilation and analysis of incident reports, which were defined as reports of accidents and injuries affecting the health and welfare of patients of state facilities. The policies and procedures, according to §29.29, were to include:

- The establishment of a team of clinical and direct care staff, including a therapy aide, at each facility to investigate and report to the director on matters such as suicides or suicide attempts, violent behavior displayed by patients or employees, the frequency and severity of injuries, leaves without consent, and/or medication errors;
- The maintenance of cumulative records on incidents which identify patient and employee involvement;
- The compilation of facility-specific and system-wide data on the numbers and types of incidents of violence and injury; and,
- The periodic reporting of aggregate incident data to the Commissioners of each Office and the Commission on Quality of Care.

Other sections of law required the immediate or prompt reporting of certain types of incidents (e.g., allegations of abuse or neglect and deaths) to external monitoring bodies (e.g., Boards of Visitors, Mental Hygiene Legal Services and the Commission on Quality of Care).

OMH Policy

In 1987, the Office of Mental Health further delineated the incident reporting and management obligations of its state psychiatric centers in Policy Directive: QA-510, *Incident Reporting and Investigation*.

Defining an incident as any untoward event adversely affecting the well-being of a patient and listing a series of possible incident types,[1] the policy established a framework for the proper reporting, investigation and review of incidents to protect the health and safety of patients and to ensure that necessary corrective actions are taken when needed.

Among the key elements of the policy's framework on incident management were:

- A four-tier classification system by which incidents were classified based on their seriousness for investigation and review purposes, with Class A incidents being the most serious and Class D the least (Figure 1);
- Standards for the investigation of all incidents as well as for the utilization of Special Investigators for certain incidents; and,
- Criteria for the review of certain incidents by an Incident Review Committee (IRC) composed of management, clinical and therapy aide staff to ensure that incidents are appropriately addressed and that corrective measures are identified (Figure 2).

Figure 1
1987 OMH Policy on Incident Classification

CLASS	DEFINITION OF CLASSES
A	Incidents which result in death or cause such serious harm that a patient's life is in jeopardy. May include, but are not limited to, homicide, homicide attempt, unexpected death and suicide.
B	Incidents which are not life-threatening but require swift investigation, may include, but are not limited to, allegation of patient or child abuse or neglect, sexual assaults, aggravated assaults, missing patients-escape, serious unexplained injuries and suicide attempts.
C	Incidents which seriously affect or have the potential to seriously affect the health or well-being of the individual(s) involved. Fire setting, sexual contacts involving one or more patients who are under the age of 18, and medication errors must be at least Class C incidents. Accidental injury, assaults, missing patients—LWOC and self-abuse are Class C or may be Class D incidents only if they result in no injury or in minor injuries that don't seriously affect the patients' health.
D	Incidents which result in no injury or in bruises, scrapes, or minor injuries which do not seriously affect the health or well-being of the individual(s) involved and which do not involve employee culpability, may include, but are not limited to, accidental injury, fights, missing patients—LWOC and self-abuse.

[1] Among the incident types identified were forms of patient abuse or neglect; patient fights, assaults and sexual encounters; accidental injuries; self abuse and suicide attempts; certain deaths, including suicides, homicides, accidental deaths, and deaths due to unexplained causes or occurring within 24 hours of admission; and two forms of missing patients: escapes (meaning the patient is considered dangerous or admitted for care pursuant to Criminal Procedure Law or Family Court) and leaves without consent (meaning the missing patient does not meet the escape criteria).

Figure 2
1987 OMH Policy on Incident Investigation and Review Processes

INVESTIGATION PROCESS

Investigations

- All incidents, regardless of classification, are investigated.
- Intensity of investigation reflects seriousness of incident.
- Components of an investigation may include preservation of evidence, interviewing witnesses, interrogation of employees.
- There can be unit investigations (completed by the Unit Chief or responsible person) or special investigations (completed by a special investigator) if ordered by the facility director.

Special Investigators

- Nominated by the facility director with approval given by OMH's Bureau of Employee Relations.
- Special investigators complete a training program provided by the OMH Bureau of Employee Relations.
- Investigate serious incidents (Class A or B) at the direction of the facility director/designee.

Responsibilities

- Review preliminary investigation findings.
- Interview and take statements from witnesses.
- Interrogate employees.
- Collect physical and written evidence.
- Provide a written report which includes an analysis of the incident, a summary of findings related to the incident, any recommendations for corrective or disciplinary action.

INCIDENT REVIEW PROCESS

Incident Review Committee

- Members include the Director for Quality Assurance, the Clinical Director, the Director of Administrative Services, the Affirmative Action Officer, as well as a physician, nurse, social worker, and therapy aide.
- Meets at least monthly.
- Must appropriately address incidents that adversely affect the care and safety of patients.
- Must assure that preventive and corrective measures are identified.

Responsibilities

- Reviews all Class A and B incidents and a sufficient sampling of Class C and D incidents to ensure appropriate classification, documentation, and investigation.
- May review any incident, initiate further investigation, or refer any incident back to the Unit Chief or Special Investigator for further investigation.
- Complete the review of all Class A and Class B incidents within 30 days. If there is a delay in the completion, a written explanation must be included in the meeting minutes.
- Identify preventive or corrective actions to reduce the likelihood of similar incidents from reoccurring.
- May recommend disciplinary action against an employee.
- Report all recommendations to the facility director; keep written minutes on the status of all incidents reviewed; prepare quarterly reports on trends of incidents.

Overall, the policy's thrust was to ensure that while all incidents were to be reported, investigated and reviewed, the intensity of investigation and review activities would be driven by the seriousness of the event. For example, the facility director or his or her designee was to decide if Class A or B incidents (i.e., the most serious) warranted the assignment of a Special Investigator. And while IRCs were to review a sample of Class C and D incidents, IRCs were to review all Class A and B incidents within 30 days.

Recent Regulations on Incident Reporting

Incident reporting and management standards for state psychiatric centers remained unchanged until 1995 when the Office of Mental Health issued new regulations on incident management and a new system for classifying incidents.

In 1988, the OMH promulgated regulations on incident reporting (14 NYCRR 524). Although applicable to all mental health programs, the regulations (Part 524) had little impact on state psychiatric center practices, as they were less prescriptive and detailed than Policy Directive: QA-510 which governed state-operated programs' operations. Part 524, for example, did not prescribe an incident classification system or the role of review committees relative to certain classes of incidents—key elements of QA-510. In fact, Part 524 only identified a subset of events defined as incidents in QA-510 (e.g., allegations of abuse, injuries requiring more than first aid, etc.) as incidents. Events such as patient fights, medication errors, episodes of self abuse, and certain accidental injuries, which were identified as incidents under QA-510, were not defined as such under Part 524.

While not as stringent as the OMH's policy governing state-operated programs, Part 524 underscored the obligation of non-state programs (e.g., not-for-profit residential and outpatient programs, private hospitals and psychiatric units of general hospitals) to report, investigate and correct situations jeopardizing patient safety.

1995 Initiatives

The Office of Mental Health issued a revised Part 524, which became effective in mid-1995. At the same time, the OMH also introduced an automated (and manual) Incident Management and Reporting System (IMRS).

According to staff of OMH's Central Office, the intent behind these initiatives was to promote facilities' attention to the management of serious incidents by clarifying definitions of incidents, reducing unnecessary reporting and paperwork, and providing support to programs in their management of incidents.

The revised, or new, Part 524, entitled "Incident Management," required facilities to develop incident management programs which provided for the identification, investigation and review of individual incidents and the review of incident patterns and trends to ensure appropriate preventive or corrective action.

Whereas the old Part 524 narrowly defined what constituted an incident, the new Part 524 defined an incident as "any event which has or may have an adverse effect on the life, health or welfare of the client or another person." New Part 524 identified a series of events which facilities were required to treat as incidents (Figure 3), a number of which were not considered to be incidents under the old Part 524. The events identified as incidents in new Part 524 were generally consistent with those articulated in OMH's 1987 Policy Directive: QA-510, which had long governed incident management practices in state psychiatric centers.

The new Part 524 also required Incident Review Committees to review individual incidents and incident patterns to determine the timeliness, thoroughness and appropriateness of the facility's response. This role of individual incident and incident pattern oversight, new to non-state facilities, was very similar to the

Figure 3
Reportable Incidents
New Part 524

- ❑ *Abuse/Neglect Allegations*: Reasonably reliable statements that an employee may have physically, psychologically or sexually abused a client, or intentionally administered a medication not in compliance with orders, or acted or failed to act in a way which impairs or creates a risk of impairing the physical, mental or emotional condition of a client.
- ❑ *Adverse Drug Reaction*: Unanticipated and undesirable side effect of a medication.
- ❑ *Assault*: Physical attack using force or violence; assaults are not limited to events which may be crimes.
- ❑ *Crime*: Event which appears to violate state or federal law in which a client is a victim or perpetrator; crimes include but are not limited to arson, assault weapon or narcotics possession, robbery, sexual offences.
- ❑ *Fight*: Physical altercation between two or more clients other than an assault.
- ❑ *Injuries of Accidental or Unknown Origin*: Injury means harm, pain or impairment requiring medical or dental treatment in excess of first aid.
- ❑ *Medication Error*: Error in prescribing, dispensing or administering a drug.
- ❑ *Missing Client*: A client who has not been accounted for when expected to be present or who is known to have left facility grounds without permission*
- ❑ *Self Abuse*: Deliberate self-inflicted harm by a client not intended to result in death.
- ❑ *Suicide Attempt*: An act by a client intended to cause his or her death.
- ❑ *Reportable Deaths*: Deaths of minors; deaths due to homicide, suicide, unexplained or accidental causes, or related to substandard treatment; and deaths occurring within 30 days of admission or discharge.
- ❑ Other events identified by the facility as incidents.

---

*This includes incidents of missing patients who are dangerous, endangered, or remanded for care pursuant to Criminal Procedure or Correction Law or Family Court Act (referred to as Escapes in QA-510), and missing patients who do not meet the forgoing criteria (LWOCs).

one played by IRCs in state psychiatric centers since 1987 and the issuance of OMH's Policy Directive: QA-510.

Among its other provisions, the new Part 524 re-articulated agencies' responsibilities to notify external parties and oversight bodies of the occurrence of certain incidents (Figure 4). Such notification obligations had been specified in prior regulations and various sections of law.

While certain definitions and expectations of the new Part 524 mirrored many provisions of QA-510 which had long governed psychiatric centers' incident management practices, the OMH's concomitant issuance of an Incident Management and Reporting System, to accompany the new Part 524, changed incident reporting and classification practices at state centers.

Figure 4
External Notifications

Abuse/Neglect Allegations:	OMH Central Office, Commission on Quality of Care, MHLS and BOV if state-operated inpatient facility, Child Abuse and Maltreatment Register if client under age 18, and Clients' Next of Kin or Guardian*
Reportable Deaths:	OMH Central Office, Commission on Quality of Care,** Coroner or Medical Examiner.
Attempted Suicides:	OMH Central Office, Clients' Next of Kin or Guardians if injury resulted.
Crimes:	OMH Central Office, District Attorney or Law Enforcement Official, Clients' Next of Kin or Guardians if injury resulted.
Incidents Which Jeopardize Clients' Lives:	OMH Central Office, Clients' Next of Kin or Guardians if injury resulted.
Injuries:	Clients' Next of Kin or Guardians.
Missing Clients:	
❑ *Who pose a danger to self*:	OMH Central Office, law enforcement authorities if appropriate, and next of kin or guardian.
❑ *Who pose a danger to others*:	OMH Central Office, law enforcement authorities, endangered persons, and next of kin or guardian.
❑ *Who are admitted under Criminal Procedure Law or Family Court Act*:	OMH Central Office, Family Court, other parties identified in CPL, and next of kin or guardian.

*Whenever contact with next of kin/guardian is indicated, it should not be made if a capable adult client objects.

**The Commission on Quality of Care is to be notified of all other deaths as well (§45.19 MHL).

To assist facilities in their management of incidents, the OMH developed an automated Incident Management and Reporting System (IMRS). A central feature of the IMRS is an algorithm and classification matrix which enables users to determine whether an event is an incident, the severity of the incident and which external parties warrant notification.

Under the system, allegations or observed or reported events are weighted based on their nature and a severity scale (Figure 5), and the weights are adjusted by other applicable factors such as whether the client: is a child or adult; is receiving certain medications; or, is considered dangerous or carries a Corrections or Criminal Procedure Law designation.

In addition to recording the nature and severity of incidents, the system allows facilities to collect clinical data (in addition to basic demographic data) concerning the individuals involved in incidents including, but not limited to, diagnostic, medication, length of stay, and retention status information. The system also allows facilities to transmit incident reports to OMH's Central Office electronically.

In support of the IMRS system, the OMH redesigned its standard incident report form (OMH-147) so that facilities could use it both to record basic information about an incident and as a data entry document. The revisions to the OMH-147 tripled its length from two to six pages; however, two of the six pages which pertain to physical examinations and physician's findings are optional for facilities' use.

In addition to the IMRS software package, the OMH developed hard copies of its incident classification matrix and severity rating scales as well as an incident classification work sheet to assist facilities, choosing not to use the automated system, apply the algorithm and classify incidents manually.

Figure 5
Incident Severity Scale for
Physical Injury/Emotional Distress*

SEVERITY LEVEL	INDICATOR
None	No physical or psychological harm. No need for first aid or other medical intervention.
Mild	Physical harm evidenced by medical interventions limited to first aid. Psychological harm evidenced by emotional distress; client may need reassurance and support. Little risk of complications or more serious harm.
Moderate	Physical harm evidenced by the need for first aid and active involvement of physician (e.g., significant bleeding, need for stitches, uncomplicated fracture, etc.). Psychological harm evidenced by negative mental changes; may require psychotropic medication changes and other intervention to prevent more serious harm.
Severe	Life threatening situations or injuries requiring emergency medical or life saving interventions or intense psychiatric intervention (e.g., restraint, STAT medication) in the case of psychological harm.

*Similar scales exist for medication errors, fire-setting and self harm.

In the summer of 1995, use of the automated IMRS system became mandatory for OMH psychiatric centers. Certified facilities were required to use either the automated system or the manual tools developed by OMH for the classification of incidents. The IMRS software package was made available to certified facilities free of charge. All State psychiatric centers are currently using the automated system as are 30 certified facilities; the remaining nearly 1,500 certified facilities are using OMH's manual tools to classify incidents.

According to OMH Central Office staff, the promulgation of the new Part 524 and the implementation of an automated incident classification system overrode many of the standards of Policy Directive: QA-510 which had guided incident management practices at state psychiatric centers since 1987. Reportedly, the OMH intended to rescind QA-510; however, such has not been done as of the fall of 1996.

Impact on State Psychiatric Centers

Senior staff interviewed during the Commission's review of incident management practices at five state psychiatric centers indicated that the new Part 524 and IMRS system had little impact on many aspects of their existing incident management practices. The new Part 524 mirrored many elements of Policy Directive: QA-510 which had guided practices for years: the definitions of incidents were essentially the same; the centers had been operating Incident Review Committees which reviewed serious (formerly Class A and B) incidents individually and a sample of less serious incidents; and the centers were used to the concept of classifying incidents based on their seriousness—with IMRS superseding QA-510, the classification system had merely changed from a manual (Class A, B, C, and D) to an automated one.

Staff at several facilities, however, indicated that when they used the automated system to classify some events which they had historically managed as incidents, the IMRS system rejected the events as "Not An Incident," particularly if there was no or only minor injury.[2] This is an issue which will be revisited in Chapter IV.

Staff at several facilities also expressed concern over the OMH's new incident report form as being too long, cumbersome, or time-consuming to complete. They indicated that direct care staff who typically complete incident reports don't have quick access to all the data required by the form. Thus completion of the forms required extra steps by either the direct care staff or other parties. During their visits, Commission staff noted that not all wards of all facilities were using the new OMH-147s.

Facility staff, however, were positive over other aspects of OMH's IMRS initiative. The automated system, they indicated, allowed "open" cases to be more easily tracked; captured more demographic and clinical information which could be analyzed once users became more proficient with the system; facilitated more timely data entry and transmission; and generally made incident data more accessible.

---

[2] To become familiar with new Part 524 and the IMRS system, in October 1995 Commission staff used the manual tools developed by OMH to classify incidents which the Commission had on file. In several cases of alleged physical abuse of patients by employees where there was no apparent injury, the algorithm, once applied, indicated that the allegations were not incidents. Commission staff met with OMH Central Office staff and the data on the alleged abuses were entered into the automated IMRS system with similar results: the automated system indicated the abuse allegations were not incidents. The OMH promptly issued a notice to the field that the automated and manual IMRS systems may erroneously label abuse allegations as non-incidents. The OMH's notice advised facilities that all allegations of abuse are incidents and should be managed accordingly, regardless of what the IMRS system indicates.

Chapter III
Incident Management: January 1996

In reviewing incident reporting and management practices at Bronx, Creedmoor, Kirby Forensic, Manhattan and South Beach Psychiatric Centers, Commission staff requested aggregate data on all incidents occurring at the facilities during January 1996. The period was selected to ensure that facilities would have had a sufficient opportunity to investigate, review and close all investigations into incidents reported within the period. Commission staff also requested and reviewed incident and investigation reports and minutes of Incident Review Committee meetings pertaining to incidents occurring during January 1996 on five sample wards at each facility.

This chapter presents a description of the incidents which were reported in January 1996 and the facilities' responses to the reported incidents occurring on the sample wards.

Data provided by the five psychiatric centers in the spring of 1996 indicated that 450 incidents were reported at the centers in January 1996 (Table 1). Patient assaults and fights were the most frequently occurring types of incidents and accounted for nearly 40 percent of the incidents across the five facilities, constituting a high of 48 percent of the incidents at Manhattan and a low of 17 percent of the incidents at South Beach Psychiatric Center. Accidental injuries, including injuries of un-

Table 1
Incidents by Type at Five NYS Psychiatric Centers for January 1996

Incident Type	*Bronx* # (%)	*Creedmoor* # (%)	*Kirby* # (%)	*Manhattan* # (%)	*S. Beach* # (%)	*Total* # (%)
Escape	3(2)	4(2)	0(0)	2(2)	0(0)	9(2)
LWOC	8(7)	1(<1)	0(0)	17(15)	0(0)	26(6)
Assaults/Fights[1]	46(38)	62(37)	9(47)	54(48)	5(17)	176(39)
Accidental Injury[2]	33(27)	38(23)	7(37)	19(17)	19(66)	116(26)
Self Abuse/Suicide Attempt	14(12)	20(12)	1(5)	2(2)	3(10)	40(9)
Abuse/Neglect	3(2)	6(4)	0(0)	6(5)	0(0)	15(3)
Other[3]	14(12)	37(22)	2(11)	13(12)	2(7)	68(15)
Total	121(100)	168(100)	19(100)	113(100)	29(100)	450(100)

[1]Includes patient-to-patient and patient-to-staff assaults and fights and patient-to-patient sexual assaults and contacts.

[2]Includes injuries of unknown origin.

[3]Includes contraband, medication errors, fire-setting, deaths, etc.

known origin, were the next largest category of incidents and constituted more than a quarter of the incidents at the five centers.

Interestingly, the data for January 1996 indicate a significant decline in the number of incidents reported at the five centers from the number reported 13–14 months earlier. At the time of the Commission's investigation of incident management practices at Kingsboro Psychiatric Center, other state psychiatric centers in the New York City region were asked to provide data on the number and types of incidents reported during the 46 day period of November 1 – December 16, 1994.

quently reported incidents and constituted 26 percent of incidents reported in late 1994.

To adjust for declining patient census and the different number of days in the two review periods (i.e., 46 days in 1994 and 31 days in 1996), Commission staff calculated incident rates per 1,000 patient days at the five centers using their average daily census during the two different review periods.

This indicated a nearly 40 percent reduction in the rate of incidents, from 8.92 incidents in 1994 to 5.54 incidents in 1996 per 1,000 patient days (Table 3). The most dramatic reduction was in the rate of patient escapes and leaves without consent—an 82 percent drop. This reduction in the rate of missing persons is probably the result of OMH initiatives to improve security at facilities and promote accountability for patient whereabouts following two highly publicized deaths allegedly

Table 2
Incidents by Type at Five NYS Psychiatric Centers
for November 1 – December 16, 1994

Incident Type	*Bronx* # (%)	*Creedmoor* # (%)	*Kirby* # (%)	*Manhattan* # (%)	*S. Beach* # (%)	*Total* # (%)
Escape	3(1)	34(7)	0(0)	31(13)	2(3)	70(6)
LWOC	57(25)	94(18)	0(0)	70(28)	14(21)	235(20)
Assaults/Fights[1]	84(37)	162(31)	49(50)	74(30)	12(18)	381(33)
Accidental Injury[2]	39(17)	68(13)	20(20)	29(12)	22(33)	178(15)
Self Abuse/Suicide Attempt	19(8)	44(8)	27(27)	10(4)	7(11)	107(9)
Abuse/Neglect	7(3)	18(3)	2(2)	6(2)	3(5)	36(3)
Other[3]	16(7)	106(20)	1(1)	26(11)	6(9)	155(13)
Total	225(100)	526(100)	99(100)	246(100)	66(100)	1,162(100)

[1]Includes patient-to-patient and patient-to-staff assaults and fights and patient-to-patient sexual assaults and contacts.

[2]Includes injuries of unknown origin.

[3]Includes contraband, medication errors, fire-setting, deaths, etc.

At that time, 1,162 incidents were reported at the five facilities currently under review (Table 2). Then, as in January 1996, patient assaults and fights were the most frequently reported type of incident, accounting for one-third of the reports. Missing patients (i.e., escapes and LWOCs) were the next most fre-

Table 3
Incident Reporting Rates Per 1,000 Patient Days by Type at Five NYS Psychiatric Centers[1], 1994 and 1996[2]

Incident Type	*Rate 1994*	*Rate 1996*	*Change*
All Incident Types	8.92	5.54	-38%
Escape/LWOC	2.34	.43	-82%
Assaults/Fights[3]	2.93	2.16	-26%
Accidental Injury[4]	1.37	1.42	+ 4%
Self Abuse/Suicide Attempt	.82	.49	-40%
Abuse/Neglect	.27	.18	-33%
Other[5]	1.19	.84	-29%

[1]Bronx, Creedmoor, Kirby Forensic, Manhattan and South Beach Psychiatric Centers.

[2]November 1 – December 16, 1994 and January 1 – 31, 1996.

[3]Includes patient-to-patient and patient-to-staff assaults and fights and patient-to-patient sexual assaults and contacts.

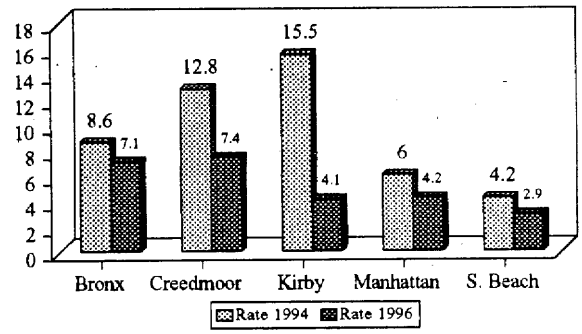
[4]Includes injuries of unknown origin.

[5]Includes contraband, medication errors, fire-setting, deaths, etc.

caused by patients who had eloped from Kingsboro and Manhattan Psychiatric Centers in late 1994.[3] Whereas patient elopements accounted for more than a quarter of the incidents in late 1994, in early 1996 they constituted only eight percent.

In January 1996, incident reporting rates per 1,000 patient days at the five centers ranged from a low of 2.9 at South Beach to a high of 7.4 at Creedmoor. As indicated in Figure 6, 1996 incident reporting rates reflect reductions over 1994 rates ranging from a low of 17 percent at Bronx to a high of 74 percent at Kirby. It is not clear why incident reporting rates overall have dropped between 1994 and 1996 and why there was such a wide variation in the rates of reductions among the facilities or why, in 1996, there existed such a wide disparity among facilities' incident reporting rates, such that Bronx and Creedmoor would have more than twice the number of incidents per 1,000 patient days

Figure 6
Incident Reporting Rates Per 1,000 Patient Days by Facility at Five NYS Psychiatric Centers



[3] See Commission reports: *In the Matter of R.H.: A Patient at Manhattan Psychiatric Center*, April 1995, and *Patient Safety and Services at Kingsboro Psychiatric Center*, July 1995.

than South Beach. The data, however, indicate that facilities with the highest rates of incidents in 1994 (Kirby and Creedmoor) had the largest reduction in incident rates by 1996 (74 and 42 percent, respectively); and that the disparity among facilities' 1994 rates (which ranged from 4.2 to 15.5 incidents per 1,000 patient days) had narrowed somewhat by 1996.

As will be discussed in Chapter IV, there appears to be some underreporting of incidents among facilities; however, there did not appear to be a consistent correlation between low incident rates and high underreporting rates among the facilities.

Incidents on Sample Wards

In January 1996, 162 incidents were reported on the sample wards of the five facilities (Table 4). Again patient assaults and fights were the most frequently reported events (45 percent) followed by accidental injuries (25 percent). Aside from 20 percent of the incidents occurring on Mondays, most of the incidents were fairly evenly distributed among the other days of the week (12 – 14 percent per day). Most reported incidents occurred on day (46 percent) and evening (44 percent) shifts and aside from 10 percent of all incidents occurring between noon and 1:00 p.m., there did not seem to be a discernable pattern around the time incidents occurred.

Of the 162 incidents, 66 (41 percent) resulted in no injury, three resulted in fractures, two in concussions, six in lacerations requiring sutures and the remaining 77 (48 percent) in lacerations not requiring sutures and other bumps, bruises and abrasions.

Across the facilities, 11 percent of the incidents were rated as moderate or severe in terms of their degree of severity (Table 5).

It should be noted that there appeared to be an inverse relationship between the preponderance of moderate or severe incidents on the sample wards of the facilities and the facilities' overall reporting rates. Facilities with a greater percentage of serious incidents on sample wards

Table 4
Incidents by Type on Sample Wards at Five NYS Psychiatric Centers for January 1996

Incident Type	*Bronx* # (%)	*Creedmoor* # (%)	*Kirby* # (%)	*Manhattan* # (%)	*S. Beach* # (%)	*Total* # (%)
Escape	0(0)	1(2)	0(0)	0(0)	0(0)	1(<1)
LWOC	2(4)	1(2)	0(0)	5(15)	0(0)	8(5)
Assaults/Fights[1]	21(46)	21(46)	9(53)	18(55)	4(20)	73(45)
Accidental Injury[2]	10(22)	8(17)	7(41)	3(9)	12(60)	40(25)
Self Abuse/Suicide Attempt	8(17)	7(15)	1(6)	1(3)	4(20)	21(13)
Abuse/Neglect	1(2)	2(4)	0(0)	3(9)	0(0)	6(4)
Other[3]	4(9)	6(13)	0(0)	3(9)	0(0)	13(8)
Total	46(100)	46(100)	17(100)	33(100)	20(100)	162(100)

[1]Includes patient-to-patient and patient-to-staff assaults and fights and patient-to-patient sexual assaults and contacts.

[2]Includes injuries of unknown origin.

[3]Includes contraband, medication errors, fire-setting, deaths, etc.

Table 5
Incident Severity Rating on Sample Wards
for January 1996
N = 162

Severity	*Bronx* n=46	*Creedmoor* n=46	*Kirby* n=17	*Manhattan* n=33	*South Beach* n=20	*Total* N=162
Low	52%	59%	18%	46%	15%	44%
Mild	44%	28%	71%	42%	60%	43%
Moderate	2%	9%	—	12%	20%	8%
Severe	—	2%	12%	—	5%	3%
Not Coded	2%	2%	—	—	—	1%

had lower overall incident reporting rates, suggesting that perhaps these facilities tend to report the more serious incidents while not reporting all the less serious ones (Table 6).

Reviewing the nature and extent of injuries documented on the incident reports from the sample wards at the five facilities, Commission staff concurred with the severity ratings in all but two cases.

Facilities' Responses

In reviewing incident and investigation reports, Commission staff were of the opinion that facilities took prompt and appropriate action to ensure the patients' immediate well-being in the vast majority of cases. In 71 percent of the cases, physicians were notified of the incidents within a half hour. In only 4 cases (or 2.5 percent) were physicians notified of the incident in more than two hours. Due to the lack of documentation, it was difficult to determine when physicians were notified of the incident in 15 percent of the cases, but in the remaining 12 percent, it appeared that physician notification occurred within a half hour to two hours. In 94 percent of the cases, physicians documented the nature and extent of injuries (if any) and the treatments rendered.

Table 6
Rank Order of Facilities by Percent of
Moderate to Severe Incidents on Sample Wards and
Their Overall Incident Rates Per 1,000 Patient Days

Facility	*Moderate to Severe Incidents Sample Wards January 1996*	*Overall Incident Rate Per 1,000 Patient Days January 1996*
S. Beach	25%	2.9
Kirby	12%	4.1
Manhattan	12%	4.2
Creedmoor	11%	7.4
Bronx	2%	7.1

In all but four cases, Commission reviewers were of the opinion that facilities took appropriate and prompt action to protect the patient involved in the incident from further immediate harm. These actions usually entailed increasing levels of supervision, separating clients, placing an assaultive individual in restraint or seclusion, etc. (Figure 7).

To varying degrees, all the incidents were investigated by facilities. Investigations ranged from simple recordings of observed events and interventions to immediately eliminate hazardous situations (e.g., the separation or isolation of two assaultive clients) to lengthy inquiries and fact-finding involving interviews of patients, interrogations of staff and the collection of written statements. Most investigations (80 percent) were completed within 30 days; 17 percent, however, took considerably longer (Figure 8). Bronx Psychiatric Center appeared to have a particularly difficult time completing timely investigations. Thirty-five percent of its investigations took more than one month to complete, compared with Manhattan (21 percent) and South Beach (15 percent) and Creedmoor (2 percent). All Kirby's investigations were completed within 30 days.

Although each facility had a complement of Special Investigators (i.e., staff who work in other clinical/administrative capacities but who are specially trained by OMH Central Office to investigate serious incidents), the documents provided by the facilities on the 162 incidents occurring on the sample wards in January indicated that only one incident was investigated by a Special Investigator. This was an incident of alleged abuse occurring at Creedmoor Psychiatric Center.[4]

Figure 7
Inadequate and Adequate Protection From Harm

Inadequate Protection From Harm

K.M., a 25-year-old patient, claimed she fell out of bed at 6:15 p.m. She complained of pain in her right wrist. The doctor was notified. There was no head injury, the patient's right wrist was slightly swollen, and the doctor prescribed elevation and a cold compress. The incident report did not address possible causes of the fall or measures that could be implemented to prevent future falls, e.g., increased monitoring of the patient or protective guardrails for the patient's bed.

Adequate Protection From Harm

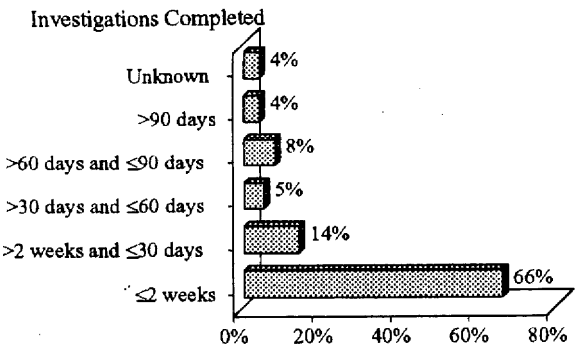
J.M. was found with a plastic knife hidden in his clothing on 1/9/96 at 4:00 p.m. The patient denied taking the knife from the dining room and insisted that somebody had "planted" it in his pants pocket. J.M. was counseled about his behavior, and the doctor ordered 1:1 observation during meals until the patient could be re-evaluated.

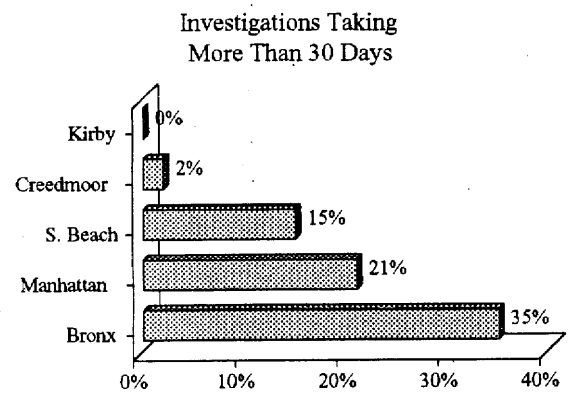
In the case of P.R., staff noticed that the patient had something white tied around his neck. When staff questioned him about it, P.R. said that he had torn off the bottom of his tee shirt and tied it around his neck. When staff removed the cloth, the patient's neck was very red, and the doctor was notified. Although P.R. was compliant when staff removed the cloth, he threatened to use the rest of his clothing to commit suicide. The patient believes he is HIV positive and wants to die. The patient was placed in four-point restraint for his protection, and he was evaluated by the treatment team the next day. It was decided that the patient be placed in PADS during the day shift and on 1:1 during the evening and night shifts. P.R. was also placed on In-View observation.

---

[4] Unit Chiefs or Treatment Team Leaders for all units at Manhattan Psychiatric Center are trained as Special Investigators. Incidents at Manhattan Psychiatric Center tended to be investigated by Unit Chiefs or Treatment Team Leaders, but the forms did not indicate whether these investigations were Special Investigations. Special Investigations are typically conducted by staff who are specially trained *and* who have a more than arm's-length distance from (and thus a reduced conflict of interest with) the situation they are called on to investigate. Usually, Special Investigations are conducted by staff not associated with the unit where the incident occurred.

Figure 8
Investigation Time Frames





Although facilities' policies indicated that Special Investigators are deployed to investigate serious incidents, the decision as to whether an event warrants a Special Investigation is left to the discretion of the facility director or his or her designee, according to QA-510. Interviews with senior facility staff indicated that no further guidelines exist as to which serious incidents (e.g., all allegations of abuse, serious injuries of unknown origin, etc.) should be assigned for Special Investigation, although Special Investigators are trained to investigate all such events.

In reviewing the investigative materials submitted by facilities, Commission reviewers were impressed that in 85 percent of the cases, investigations answered basic questions to explain what had transpired, reached reasonable conclusions and, in 78 cases, posed what appeared to be appropriate recommendations where such seemed indicated to remedy correctable situations (Figure 9). Most typically, recommendations called for additional clinical interventions (Figure 10).

Figure 9
Investigations Appearing Thorough,
Reaching Sound Conclusions

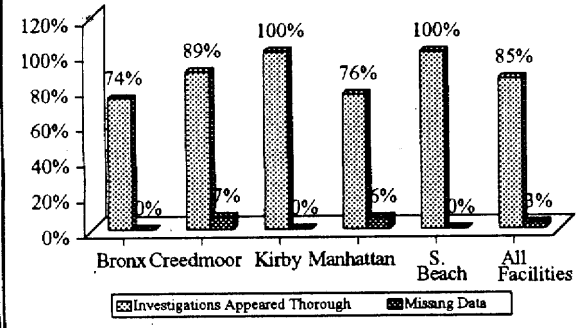
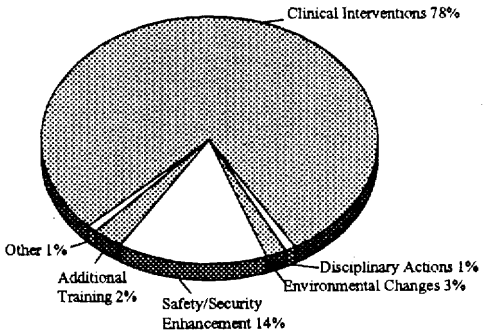


Figure 10
Distribution of 88 Recommendations
Emanating From 78 Investigations
N=88



Where investigations seemed to miss the mark, their shortcomings were exemplified by failures to explore more broadly the roles played by staff in possibly allowing the incident to occur and in neglecting to identify needed corrective action. In response to a draft copy of this report, one facility commented that minor incidents require "no documented written investigation" and requested clarification of the Commission's method for assessing thoroughness. The Commission notes, however, that all incidents require a written statement of findings and recommendations for remedial action; the extent of the documentation may vary, according to the seriousness of

the incident which should drive the intensity of investigative efforts. At a minimum, however, the investigative record or report should address issues such as staff responsibility and needed corrective/remedial action.

The shortcomings noted are put in relief by examples of investigations which, in their documentation, exemplified adequate fact-finding and appropriate recommendations for corrective actions (Figures 11 and 12).

Each facility reported operational Incident Review Committees consisting of administrative and clinical staff. (Notably, no facility reported therapy aide staff participation on the IRC, although such was mandatory under the OMH Policy Directive: QA-510. And although

Figure 11
Inadequate Responses to Events

C.R. was placed in the Quiet Room at 4:45 p.m. C.R. was crying, screaming, wanting to go back to his room. Soon he began banging his nose on the floor. The patient was bleeding from both nostrils, which stopped spontaneously when pressure was applied. C.R. received an IM injection. This was C.R.'s third episode of self-abuse in eight days, and it appeared that staff were aware of his precursors. However, the investigation did not address the level of supervision given the patient while in the Quiet Room or whether any intervention was attempted prior to and during the self-abuse to prevent the patient from injuring himself due to his severe agitation. Additionally, the patient's mental status, risk of self-harm, and treatment plan were not reviewed.

E.B. was returning to the ward with staff and two other patients on 1/16/96. When the group reached the lobby of the building, the staff and two of the patients got on one elevator without E.B. Not considered a danger to herself or others, the patient was placed on a missing person status and all appropriate parties were notified. E.B. returned to the facility the next day. The investigation did not address how the incident happened, nor why the patient was allowed to be separated from the rest of the group. Additionally, the patient's privilege level, e.g., staff supervision required to maintain her safety, was not discussed.

When F.V. came into the dining room for lunch, staff noticed his face was badly bruised. When staff questioned him about his injuries, he said that he had been hit by another patient at 3:00 a.m., that day. Additionally, he said that staff had seen his injuries in the morning. The investigation report addressed the cause of the altercation as "a one-time problem"—F.V. was "looking in other people's closets," and the second patient had an "impulse control problem." However, the investigation report did not address why the incident report was not completed when staff first noticed the injuries.

When L.K., an elderly gentleman, fell early in January, he sustained only minor injuries. At the time, use of a walker was recommended; L.K. had a history of shuffling and tripping when he walked. Two weeks later L.K. fell again, in the bathroom, banging his head and knee. The resulting investigation failed to address whether L.K. was using a walker as previously recommended, or whether he needed further medical work-ups to determine the etiology of his falls.

C.C., smelling of urine, was brought to the shower and temporarily left by himself. A second patient was sent to shower for the same reason (urine smell). When staff returned, both patients were in the shower; a small blood stain was found by the shower bench. C.C. had sustained a laceration under his chin. C.C. was sent to the ER and received three sutures. Concluding that C.C. fell in the shower area, the facility's investigation did not reflect interviews with the second patient, or reasons why C.C. could not himself report what happened; a review of C.C.'s history of falls, if that was what was believed to have happened; or an assessment of the appropriateness of staff placing and leaving two clients alone in a shower area, particularly if one is prone to falls.

Figure 12
Appropriate Responses to Events

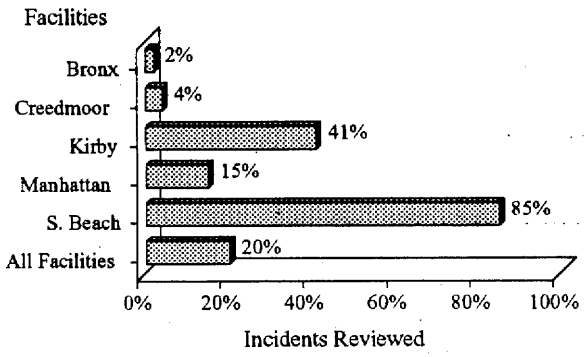
On 1/19/96, L.J. scratched the right side of her face. The scratches were superficial and were appropriately treated. The patient claimed she was "paranoid," and therefore scratched herself. L.J. had a long history of superficial, self-abusive acts associated with attention seeking behaviors. Although not a serious incident in itself, the investigation report documented a number of remedial actions that were taken to safeguard the patient. The patient's privilege level was adjusted to provide increased supervision as needed. Her medications were reviewed, although the doctor opted not to change them at that time. The patient's current life situation was reviewed to identify potential stressors and opportunities for positive outlets for L.J.

On 1/17/96, it was found that C.M. was not receiving his medications as prescribed. He was not receiving multivitamins or his Valproic Acid at the proper dosage level. The patient's doctor was notified and determined that the patient did not suffer harm from not receiving all his medications as ordered. The investigation revealed that nurses failed to transcribe orders to the Medex correctly and that doctor's orders were not reviewed to check for inaccuracies and inconsistencies. The employees were sent to a medication refresher course and at the time of the Commission's review, further disciplinary action was being considered.

Policy Directive: QA-510 required facilities to review all Class A and Class B incidents (which roughly equate to severe and moderate incidents under the IMRS system), as well as a sample of less severely rated incidents, documents provided by facilities indicated that only 32 (or 20 percent) of the 162 incidents occurring on sample wards in January 1996 were reviewed by the facilities' IRCs. Of the 17 incidents rated as moderate to severe in terms of their severity, only nine (or 53 percent) were reviewed by the IRCs. With the exception of events at South Beach, most incidents, and a significant minority of the most serious ones, evidently did not receive scrutiny by facilities' specially constituted committees to ensure the appropriateness of the facilities' responses to such (Figure 13).

In one-third of the events reviewed by Incident Review Committees, the committees made additional recommendations calling for increased or modified clinical interventions in four cases, administrative or disciplinary actions in two cases, enhanced safety/security precautions in three cases and additional staff training in one case.

Figure 13
IRC Reviews



While the Commission believes that all incidents rated as most serious should have been reviewed by IRCs, it was also noted that IRCs rarely looked at cases involving patients repeatedly involved in less serious incidents. Three patients at the Bronx were involved in 35 percent of the incidents occurring on the five wards during January; two patients accounted for 28 percent of the incidents occurring on five wards at Creedmoor. Yet these patients and their repeated involvement in incidents were not reviewed by the facilities' IRCs. While it

appeared that each individual incident in which these patients were involved was appropriately responded to by unit staff, one questions whether the IRCs, reviewing the clusters of incidents or their repeated nature, could have offered additional recommendations on the patients' overall management and safety (Figure 14).

Minutes of Incident Review Committee meetings rarely mentioned whether IRC recommendations were implemented. However, staff of Bronx, Creedmoor and Kirby Forensic Psychiatric Centers indicated that treatment units are responsible for responding to IRC recommendations in writing.

Figure 14
Examples of Two Patients in Repeated Incidents

M.W., a patient at Creedmoor, was involved in six reported incidents of self-harm, victimization, or assaultiveness during the month of January 1996.

On 1/3/96, M.W. was found with two plastic caps she had removed from furniture on the secure care unit, stating she was going to swallow them in an effort to kill herself. An evaluation assessed her as not suicidal, but engaging in attention-seeking behavior, for which she has a long history. She was counselled as to the dangerousness of this behavior, and the remaining plastic caps were removed from the furniture to prevent similar occurrences.

On 1/8/96, M.W. told staff that she bit herself on her breast while in the shower. She was seen by a physician, and was found with a new bite on her right breast and a reopened wound on her left breast. Both wounds were treated. She was given PRN medication and placed on 1:1 observation for self-destructive behavior. She stated she would try to kill herself if she was not on 1:1.

On 1/11/96, M.W. got up from a chair in the day room and for no apparent reason, slapped another patient in the face. Both patients were examined and no injuries were found. M.W. was interviewed and said she was hearing voices telling her to harm the other patient involved. She was given PRN medication and placed on 1:1 observation for unpredictable behavior.

On 1/18/96, M.W. was punched in the eye by another patient when he returned to the unit. The aggressor in this incident had been yelling obscenities at M.W., and despite staff's verbal attempts to calm him, without provocation, he punched her in the eye, knocking her to the floor. M.W. sustained a slight contusion to the right cheek, treated with an ice pack. The aggressor was placed in seclusion.

On 1/24/96, M.W. found an empty soda can in the garbage behind the nurses' station and used it to scratch herself on her thumb. She was examined, and found to have a superficial scratch treated with an ice pack and antibiotic ointment. M.W. said she had been thinking about killing herself, but no longer wanted to. There is no indication she was put on any type of observation.

On 1/27/96, M.W. reported to staff that she had swallowed a game piece. Although this was not witnessed by staff, the incident report states that a game piece was missing. Follow-up x-ray revealed no evidence of the missing game piece.

A.N., a patient at Bronx, was involved in four incidents including assaults and self abuse during the month of January 1996.

On 1/9/96, A.N. reported to staff that he was assaulted by another patient. The patients were separated and ice was applied to A.N.'s face.

On 1/17/96, at 1:00 a.m., A.N. requested PRN medication and "time out." While in the time-out room, he became angry and punched the door, sustaining superficial abrasions on both hands. The wounds were treated with antibiotic ointment. It was noted on the incident report that he had been in seclusion within the previous 24 hours.

On 1/18/96, at 7:30 a.m., A.N. attacked another patient (C.R.). Neither patient sustained injuries. The incident report notes that these two patients have little frustration tolerance and provoke each other.

Later the same day (1/18/96), at 4:00 p.m., A.N. alleged he was hit on the face while he was sleeping in the time-out room. No treatment was deemed necessary. A.N. could not identify the person who hit him. The treatment team noted that he has a history of making false accusations, but stated they would continue to monitor and observe him.

Chapter IV
Events Not Reported

During the review of incident management practices at the five psychiatric centers, Commission staff visited the five sample wards at each facility which had generated the 162 incident reports in January 1996 to determine whether any other events had occurred on the wards during that month which should have been reported as incidents, but were not. On each ward, which typically housed between 20 to 30 patients, Commission staff reviewed two patient records, change of shift reports, nursing or ward logs, and other communication journals for the month of January to identify events which should have been reported as incidents. Commission staff also reviewed journals maintained by the facilities' Safety Departments to see if they documented events occurring on the sample wards in January which should have been reported as incidents.

These review activities identified 73 events across the total of 25 sample wards which, in the Commission's opinion, appeared to constitute reportable incidents but were not reported as such (Table 7).

These events ranged from patient fights to clients alleging verbal threats (or psychological abuse) by staff, to medication errors, to patient claims of theft of funds (in one case up to $100), to possession/consumption of alcohol (or other contraband, e.g., a piece of broken glass by a patient intent on self harm), to cases of client self abuse.

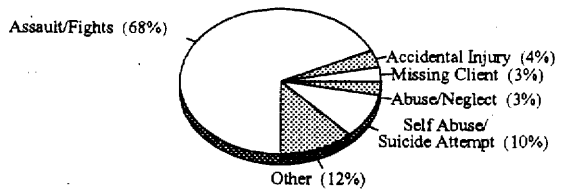
Patient-to-patient fights and assaultive behavior constituted the largest category of events not reported as incidents and accounted for 68 percent of the events discovered by Commission staff which appeared to warrant reporting

Table 7
Events Appearing to Be Incidents but Not Reported
by Facility and Type
for January 1996
N=73

	Bronx	*Creedmoor*	*Kirby*	*Manhattan*	*S. Beach*	*Total*
Missing Patients	1	—	—	1*	—	2
Assaults/Fights	13	17	12	6	2	50
Accidental Injury	1	1	—	1	—	3
Self Abuse/Suicide Attempt	2	3	1	—	1	7
Abuse/Neglect	1	—	—	1	—	2
Other	1	1	1	6	—	9
Total	19	22	14	15	3	73

*In response to a draft copy of this report, the facility reported that this elopement occurred from a different ward and was reported as an incident by that ward.

Figure 15
Events by Type Not Reported on Sample Wards
for January 1996
N = 73



and handling as incidents (Figure 15). Source documents reviewed by Commission staff frequently referenced events of patients punching, kicking or otherwise assaulting other patients, patients being placed in restraint or seclusion for assaultive behavior, or patients assaulting or attempting to assault staff, which were not reported as incidents.

Considering that events on the 25 sample wards in January 1996 generated 162 incident reports, the discovery by Commission staff of 73 additional events that month which appeared to be incidents, but were not reported as such, would indicate that for every ten incidents reported on the sample wards across the five facilities, 4.6 incidents went unreported; this rate of non-reporting ranged from a high of 8.2 at Kirby to a low of 1.5 at South Beach (Figure 16).

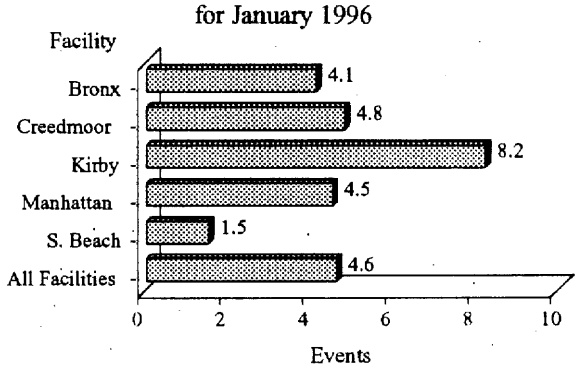
The underreporting rates for patient fights, assaults or assaultive behavior is higher. For every 10 incident reports of fights or assaults filed by the sample wards of the five facilities, seven events of patient-to-patient (and in some cases, patient-to-staff) violence, or assaultiveness went unreported.

Considering that, in addition to reviewing various communication journals, Commission staff conducted complete record reviews of only 50 patients on the 25 sample wards which may have served in excess of several hundred patients during January 1996, the above estimates on the underreporting of incidents and incident types should be viewed as conservative at best.

The Commission shared its findings concerning unreported events on the sample wards with the facilities involved, inviting their comments. In 55 percent of the events cited by the Commission, facilities agreed that the situation discovered by the Commission warranted reporting and handling as an incident. In the remaining cases, nearly half of which (42 percent) occurred at Kirby Forensic Psychiatric Center, facilities disagreed with the Commission's assessment.

The facilities' responses, both when they agreed or disagreed with the Commission's opinion whether events should have been reported and managed as incidents, are revealing and reflect a level of uncertainty or confusion within and among facilities as to what events should be reported and handled within an incident management system (Figures 17 and 18).

Figure 16
Events Not Reported for Every Ten
Incidents Reported on Sample Wards
for January 1996



In certain cases, facilities agreed that patients attacking staff constituted incidents; in other cases, facilities disagreed, stating an employee accident report should have been completed. A patient scratching her wrist with a pen, inflicting a minor skin abrasion, it was agreed at one facility, constituted an incident; while at another facility, a patient repeatedly banging his head against a wall to the point that four-point restraint was required was not considered an incident.

Figure 17
Sample of Unreported Events That Facilities Agreed Were Incidents

South Beach

"A.L. scratched self on her right inner wrist with a pen. Minor skin abrasion." (Source: Patient Record)

Creedmoor

"J.C. attacked H.A. during dinner, but no injuries were sustained." (Source: Nurse Administration Log, Patient Record)

"J.B. sticking staples into and tying things around her neck, and trying to swallow objects. Patient assigned 1:1." (Source: Patient Record)

"R.M. fighting with other patients; spit in T.K.'s face. Hit another patient and was hit by another patient—received STAT medication." (Source: Nurse Administration Log, Patient Record)

"B.M. punched L.F. in the mouth after L.F. grabbed her by the hair—PRN given." (Source: Nurse Administration Log, Communication Book, Patient Record)

Manhattan

"T.P. scratched MHTA." (Source: 24-Hour Nursing Log, Safety Log)

"M.R. allegedly hit J.S. in the rear day room. No injuries." (Source: Communication Journal, Ward Log)

Bronx

"Bruise on G.F.'s nose. Old wound? But area appeared red. Nurse evaluation. Please have MD re-evaluate." (Source: Communication Journal)

"Altercation between N.O. and I.R. No injury. I.R. complained of hair being pulled and headache. No PRNs." (Source: Nursing Supervisor Report, Communication Journal, Patient Record)

"D.C. punched S.P. in the face for no apparent reason. Medical doctor saw him. No treatment given." (Source: Nursing Supervisor Report, Communication Journal)

Figure 18
Sample of Unreported Events That Facilities Disagreed Were Incidents

South Beach

"J.G. placed in quiet room because she was loud, irrational, and assaultive." (Source: Patient Record) Facility response: Record review reveals the above but does not document any physical contact with another patient or staff. This does highlight a semantic problem which we have uncovered, i.e., the use of the word "assaultive" when a patient was threatening rather than physically assaulting another person.

"J.G. was verbally assaultive to another patient, threatening, and grabbed another patient's arm." (Source: Patient Record) Facility response: Record review shows that Ms. G. did grab another patient's arm and screamed at her. Rapid intervention by staff led to a PRN and time in the quiet room with good effect. Brief contact with no physical injury does not reach the threshold of an assault so staff did not file 147.

Creedmoor

"M.B. attacked an employee." (Source: Nursing Log) Facility response: An employee accident report would have been completed if the employee was injured.

"Patient C. was put in 4-point restraint for assaultive behavior and then was secluded for disruption." (Source: Communication Book) Facility response: No injury was sustained, therefore, no incident report was completed.

Kirby

"Patient hit another patient in the back of the head with his fist. No injury noted." (Source: Overall 24-hour Nursing Log, Ward 24-Hour Nursing Log, Ward Log, Patient Record) Facility response: Patient sustained no injury after assault by patient V.R. Incident report not required.

"Patient was banging head on wall. 4-point restraint." (Source: Overall 24-Hour Nursing Log, Ward 24-Hour Nursing Log, Ward Log) Facility response: Nursing note indicates that there was no apparent injury to patient V.R. Incident report not required.

"Two patients in a fight in the day room, punches were thrown before staff could intervene." (Source: Ward Log, Patient Record) Facility response: No injury to either patient. Incident report not required.

Bronx

"A.A. attempted to choke Dr. Y." (Source: Communication Journal) Facility response: Not an incident.

"C.R. was agitated. Hit his head, punched window, trying to harm himself. Camisoled." (Source: Patient Record) Facility response: No injury noted. Handled clinically.

In certain cases, patients striking each other, but inflicting no obvious physical injury, and requiring no extraordinary interventions such as restraint or extra medications, were considered incidents; yet in other cases, assaultive behavior and self-abusive behavior serious enough to warrant placement in a camisole or seclusion (in one case for up to 24 hours) were not considered incidents. The use of restraint or seclusion is considered an intervention of last resort, to be used when all else fails, to protect patients from harming self or others. In a number of cases the Commission found clients restrained or secluded for "assaultive" behavior, yet facilities disagreed that these episodes warranted incident reports; they indicated that the use of the word "assaultive" in the journals reviewed by the Commission represented a semantic problem or that the "assaultive" behavior displayed by patients triggering the need for restraint or seclusion resulted in no injury. Their responses raise a two-fold question: if the patient's behavior was hazardous enough, shouldn't an incident report have been completed; and if not, was restraint or seclusion warranted?

The absence of physical injury was often, but inconsistently across facilities, cited as the reason why events discovered by the Commission were not considered to be, and reported as, incidents.

At Kirby Forensic Psychiatric Center, for example, the Commission found 14 episodes not reported as incidents involving patients punching, kicking or otherwise assaulting each other, or being secluded for up to 24 hours for assaultive behavior. In one case a patient was found with contraband, a piece of glass, and planning to harm himself. The facility disagreed that these 14 events constituted incidents and in its response reported: "Unless it is an allegation of abuse, the completion of an incident report is not required when there is no injury."

In other cases, at other facilities, the centers concurred with the Commission that episodes of assaultive behavior which apparently did not result in physical injury warranted reporting as incidents.

Chapter V
Conclusions and Recommendations

A fundamental obligation of psychiatric hospitals is to protect the well-being of the individuals they serve. The maintenance of an effective incident management system—one in which actual or potentially harmful situations are identified, reported, investigated and remedied—is vital to facilities' fulfillment of this obligation and is intended to complement and enhance other aspects of facilities' operations, i.e., clinical, medical, environmental, administrative, etc. The maintenance of incident management systems is also required by state law and regulations promulgated by the Office of Mental Health, which recently developed and mandated the use of an automated (and manual) Incident Management and Reporting System (IMRS) to assist facilities in their incident management practices.

The Commission's review of incident management practices at five state psychiatric centers in New York City offers some good news, critiques from which certain centers can learn, and issues which the Office of Mental Health should further explore to clarify incident reporting standards and refine its IMRS system.

First, it appeared that when incidents jeopardizing the safety of patients were identified, the facilities and their staff took prompt and appropriate action to ensure the patients' immediate well-being: arranging for prompt medical examinations and treatment, increasing supervision, separating patients if that was called for, etc. It should be noted that most (87 percent) of the incidents occurring on the sample wards studied were rated by the facilities as "low" or "mild" in terms of their severity, resulting in no or only minor injury (bumps, bruises or lacerations not requiring sutures) – ratings with which the Commission concurred upon reviewing supporting documents. It should also be noted that patient elopements from the centers, which accounted for more than one-quarter of the incidents occurring in late 1994, were drastically reduced (by more than 80 percent) by early 1996.

Secondly, when incidents were identified, it appeared they were promptly investigated in the vast majority of cases. Most investigations (66 percent) were completed within two weeks; an additional 14 percent took two to four weeks to complete. However, with 80 percent of investigations being completed within 30 days, two centers appeared to have difficulty completing timely investigations: Bronx and Manhattan Psychiatric Centers where, respectively, 35 and 21 percent of incident investigations on sample wards took longer than 30 days to complete.

Overall, Commission staff were impressed with the quality of investigations, based on the documents provided. In 85 percent of the cases, investigations appeared thorough, reaching sound conclusions. Bronx and Manhattan Psychiatric Centers, however, did not rate as well as the other centers in this regard. And it was also noted, based on the documents reviewed, that of the 162 incidents occurring on the sample wards of the five facilities, only one special investigation was conducted and that was into an allegation of abuse at Creedmoor Psychiatric Center.

The Office of Mental Health has no guidelines on when to conduct special investigations; this is left to the descretion of the facility director. However, considering that each facility has a complement of specially trained investigators and that 11 percent of the incidents on the sample wards were considered "moderate" or "severe," it is unclear why more investigations by specially trained staff were not

undertaken. However, as noted earlier, the absence of special investigations did not appear to compromise the quality of the investigations performed.

The OMH similarly has no standards as to what incidents should be reviewed by Incident Review Committees, and the Commission found that facility practices varied in this regard. Under Policy Directive: QA-510, the OMH required that psychiatric center IRCs review all serious (formerly Class A and Class B) incidents and a sample of less serious ones. With the promulgation of new incident reporting regulations (Part 524) and the IMRS system superseding QA-510, there appear to be no uniform guidelines as to what incidents go before IRCs.

Only 20 percent of the 162 incidents occurring on sample wards were reviewed by IRCs; and only nine of the 17 most serious incidents were reviewed by IRCs. Individual facility practices reflected the absence of uniform guidelines. Whereas 85 percent of the incidents at South Beach received IRC scrutiny, less than five percent of those at Bronx and Creedmoor received this extra level of review. It should be noted that at both Bronx and Creedmoor, several patients were repeatedly involved in incidents on the sample wards in January 1996 and accounted for, respectively, 35 and 28 percent of the incidents on those wards; yet the incidents were not reviewed by the IRCs. Thus the patients, who undoubtedly pose treatment challenges, did not receive the level of clinical and administrative review which could be offered by senior staff who sit on IRCs.

When IRCs did review incidents, they posed recommendations above and beyond the investigators' recommendations in one-third of the cases. This illustrates the value of IRCs as vehicles to complement and enhance the outcomes of individual incident investigations. Most typically, IRC recommendations called for increased or modified clinical interventions and enhanced safety or security precautions.

Although it appeared that, overall, facilities responded well to identified incidents, with room for improvement at certain facilities in regard to the timeliness and thoroughness of investigations and roles of IRCs, the Commission's review of incident management practices at the five psychiatric centers indicated that not all events which pose threats to patient safety are identified and appropriately managed as incidents.

The facilities had widely divergent incident reporting rates. It was noted that those facilities with the lower rates of incidents per 1,000 patient days (South Beach, Kirby and Manhattan) had the higher percentages of the more severe incidents on the sample wards reviewed. This suggests that perhaps these facilities are reporting the more serious events while not reporting all the less severe ones.

However, in reviewing patient records and other source documents on the sample wards, the Commission found events at all five facilities which appeared to warrant reporting as incidents, but were not. The rates of non-reporting on the sample wards did not correlate with the facilities' overall rankings in terms of reported incidents per 1,000 patient days. That is, those facilities with lower overall incident reporting rates did not necessarily have higher non-reporting rates on the sample wards.

While at a loss to explain the divergent incident reporting rates, the Commission believes the Office of Mental Health must attend to events not being reported as incidents and the underlying reasons. Staff at two facilities, Kirby and South Beach, which coincidentally had the lowest incident reporting rates, reported that with OMH's new IMRS system, events which historically had been treated as incidents are no longer considered such. Patient fights, which were defined as incidents under QA-510 and are defined as incidents in new Part 524, were the most frequent type of event occurring and not reported as incidents on the sample wards. Some facility staff claimed pa-

tient fights resulting in no injury are not considered incidents under the new system. Kirby claimed that events without injury were not incidents unless they were allegations of abuse.[5] Yet this opinion or viewpoint, evidently, was not consistently applied within or among facilities, and Commission staff found a variety of fights and other events at the facilities reported as incidents even though no injury occurred. Considering that §29.29 Mental Hygiene Law, which serves as the legal base for incident reporting regulations, calls for the monitoring of violence in psychiatric centers, confusion as to whether patient fights are incidents is a serious matter; and to the extent that they are not regarded and handled as incidents, patients are not afforded the level of protection they deserve.

If, as some facility staff claim, events including patient fights, are not being treated as incidents because of the OMH's new IMRS system, this has statewide implications as the Office has mandated use of the IMRS system in its automated or manual form for all facilities.

Recommendations

To build upon many of the already positive features of incident reporting practices at the five facilities examined, the Commission recommends that the Office of Mental Health:

- Establish criteria for which incidents require review by IRCs. The criteria which existed under QA-510 seemed reasonable: all serious incidents and a sample of less serious events. Clearly, patients repeatedly involved in incidents could benefit from review by facilities' more senior and administrative staff.
- Ensure the participation of direct care staff on IRCs.
- Review incident investigation practices at Bronx and Manhattan Psychiatric Centers which, relative to other centers, had difficulty in completing timely and thorough investigations.

The apparent underreporting of incidents at all five facilities signifies a serious and more complex problem which the OMH should address. The fact that all of the facilities, save Kirby, agreed with the Commission that 55 percent of the events uncovered in ward journals and patient records on sample wards warranted reporting and handling as incidents, but were not, suggests, on one level, lax reporting practices on facility wards and units and the need for OMH to strengthen its monitoring of incident reporting practices at its facilities. The fact that facilities, in a number of cases, were divided in their opinion as to whether certain events uncovered by the Commission constituted incidents, and one facility, Kirby, steadfastly claimed that none of its untoward events, including fights and attempts at self harm, constituted incidents because there was no injury, suggests a problem at a different level: the absence of a common understanding as to what constitutes identification and resolution within an incident management system. That staff of certain facilities implied that OMH's new IMRS system has muddied the waters of what constitutes an incident by rejecting as "non-incidents" events jeopardizing patient well-being which historically were viewed and treated as incidents constitutes a problem at still a different level, as the new IMRS system is now operational statewide and is influencing incident reporting and management practices at all mental health programs in New York.

---

[5] As reported on page 10, shortly after the implementation of IMRS, the Commission found that the system was rejecting allegations of patient abuse as "non-incidents" if there was no injury. The OMH corrected this by issuing a notice to the field clarifying that all allegations of abuse must be treated as incidents, regardless of the prompts offered by IMRS.

To address this multifaceted problem, the Commission recommends that the Office of Mental Health:

- Require Quality Assurance Programs to regularly review at periodic intervals events occurring at their facilities which may be highlighted in patient records or other source documents, to ensure that those events constituting incidents were identified, investigated and otherwise handled as such. The facilities should provide the OMH with reports of their findings and corrective actions planned to address deficiencies.
- Re-articulate expectations as to what constitutes a reportable incident and facility obligations to report, investigate and remedy/resolve incidents, regardless of prompts, which may be erroneous, offered by the automated (and manual) IMRS system.
- Convene a work group of state psychiatric center staff and staff of certified facilities to review, critique and offer recommendations on the utility of the new IMRS system, including most fundamentally its value in identifying and classifying incidents and its "friendliness" to users.

Appendix
Response From the Office of Mental Health

NEW YORK STATE
OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229

James L. Stone, MSW, Commissioner

March 17, 1997

Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
One Commerce Plaza, Suite 1002
Albany, New York 12210

Dear Mr. Sundram:

I have reviewed the draft report of the Commission entitled "Incident Reporting and Management Practices at Five NYS Psychiatric Centers." The attached document represents the Office of Mental Health's (OMH) comments on the draft report. Comments provided by the individual facilities which were reviewed are appended to OMH's general comments.

I am pleased that the report identifies positive aspects of OMH's efforts in this area as well as identifying opportunities for improvement. The Commission's report challenges the OMH to continue to review and improve its incident management and reporting practices. We look forward to working with you in this important area.

Sincerely,

James L. Stone
Commissioner

Attachment

Response to the CQC Report Titled: "Incident Reporting and Management Practices at Five NYS Psychiatric Centers"

March 5, 1997

Prepared for
James L. Stone, Commissioner, Office of Mental Health

by
Bureau of Quality Management

TABLE OF CONTENTS

Background

Notification by CQC

In a letter dated February 3, 1997, Chairman Sundrum of the Commission on Quality of Care for the Mentally Disabled submitted a confidential draft report summarizing the results of the Commission's review of incident reporting practices at five psychiatric centers in New York City. The draft report is entitled *"Incident Reporting and Management Practices at Five NYS Psychiatric Centers"*. Chairman Sundram's letter solicited the comments of the Office of Mental Health on the draft report. This document constitutes OMH's response to the draft report.

Preparation of OMH Comments

In preparing these comments, OMH solicited specific reactions to the CQC draft report from the five facilities that were investigated. These facility comments were integrated into the OMH response and are also attached in their entirety as Appendix A. The draft report was also reviewed and discussed by OMH Quality Management Staff from Albany and the OMH New York City Field Office and by an OMH workgroup for improving incident management and reporting practices.

Review of Findings

Positive Findings

The Office of Mental Health was pleased to see the extent to which this CQC investigation resulted in positive findings regarding the incident management and reporting practices of our New York City psychiatric centers. Positive findings from the review include:

- ✔ That staff acted quickly and appropriately to prevent harm to recipients of care.

  "...it appeared that when incidents jeopardizing the safety of patients were identified, the facilities and their staff took prompt and appropriate action to ensure the patients' immediate well-being..."[1]

[1]This and the quotations which follow are from the CQC's confidential draft report.

- ✔ That incident severity was rated consistently by OMH staff.

  "...most (87 percent) of the incidents occurring on the sample wards studied were rated by the facilities as "low" or "mild" in terms of severity....ratings with which the Commission concurred upon reviewing supporting documents."

- ✔ That the missing patient incidents have declined greatly over the past two years.

  "...patient elopements from the centers, which accounted for more than one quarter of the incidents occurring in late 1994, were drastically reduced (by more than 80 percent) by early 1996."

- ✔ That incidents were promptly investigated.

  "...when incidents were identified, it appeared they were promptly investigated in the vast majority of cases...with 80 percent of investigations being completed within 30 days..."

- ✔ That investigations were thorough, professional and of high quality.

  "...Commission staff were impressed with the quality of the investigations... In 85 percent of the cases, investigations appeared thorough, reaching sound conclusions."

The OMH has made a concerted effort in recent years to improve these practices and views them as major tools in protecting recipients of service from harm and continuously improving the quality of care provided in our facilities. It is gratifying to see that these efforts have been recognized by the CQC. They have also been recognized by other external review agencies during inspections of NYS psychiatric centers. For example, the United States Department of Justice (DOJ) is on record as stating that the OMH incident management system and computer software are ... "state-of-the-art in comprehensively managing this important aspect of resident care." DOJ has been recommending the OMH system to residential care providers throughout the country for possible use.

Areas for Improvement

The draft report also contains some findings that identify areas of OMH's incident management procedures that warrant improvement. These findings were on two levels, the individual facility and system-wide. OMH agrees with the observations stated in the report and has already addressed or begun

to address many of these areas through staff projects and workgroups. Those which have not yet been addressed will be considered and included in future plans for policy and procedure adjustments and software improvements.

These areas, as identified by the CQC, are as follows:

- **System-wide Issues**
  - The OMH has no guidelines on when to conduct special investigations.
  - The OMH has no standards as to what incidents should be reviewed by Incident Review Committees.
  - Not all events which pose threats to patients' safety are identified and appropriately managed as incidents.
- **Facility-specific Issues**
  - Two centers (Bronx and Manhattan) appear to have difficulty completing timely investigations.
  - Not all incidents are reviewed by the Incident Review Committee (Bronx and Creedmoor).
  - There is wide diversity in the rate of incidents reported by the five facilities (South Beach, Kirby and Manhattan have the lowest rates).

These findings were translated into six recommendations by the CQC. The findings and recommendations will be addressed below.

OMH's Response

System-Wide Issues

The CQC report identified several system-wide issues and recommendations which have been considered by OMH. Each of these is responded to separately below:

- The OMH has no guidelines on when to conduct special investigations.

Response: As pointed out in the draft report, OMH policy QA-510 has not been rescinded and is still in force for OMH facilities. This policy describes the special investigation process and gives facility directors authority to order a special investigation, at their discretion, for any incident. In addition, the OMH Manual for Special Investigations specifies that special investigation techniques be used for the following types of incidents:

~ Deaths, assaults and injuries of patients, staff or visitors, due to suspected employee misconduct and/or incompetence.

~ Incidents of alleged patient abuse by staff.

~ Incidents involving death or serious injury to patients, under suspicious or unexplained circumstances.

It should also be noted that every incident is investigated at the unit level with an intensity matching the seriousness of the incident. In many cases, these unit investigations are conducted by the same trained individuals who also conduct special investigations. CQC findings confirm that investigations are promptly and professionally done, whether they are designated "special" or not. The special investigation category is usually reserved for cases in which the normal unit investigation would represent a conflict of interest, as when unit staff are targets of the investigation.

- The OMH has no standards as to what incidents should be reviewed by Incident Review Committees.

Response: Part 524 mandates a standing incident review committee responsible for reviewing individual incidents and incident patterns and trends and for monitoring general compliance of the program's incident management practices with the requirements of Part 524.

OMH Policy, QA-510 requires review of all serious (i.e., former class A & B) incidents and a sampling of less serious (class C & D) incidents.

The incident review committees at OMH psychiatric centers meet the requirements of these two sources.

- Not all events which pose threats to patients' safety are identified and appropriately managed as incidents.

Response: OMH agrees that there may be reportable events at facilities which have not been treated as incidents. However, the CQC draft report exaggerates the number of these "un-reported" incidents by including such events as "attempted assault", "disruption", and other events which may prompt the clinical interventions of seclusion or restraint. Seclusion and restraint are last resort interventions for behavior such as threatening, menacing or failure to calm down after less intrusive interventions have been tried. They serve to *prevent* incidents of assault and are not of themselves considered reportable incidents. Episodes of restraint and seclusion are of course recorded and monitored by facilities through means other than the incident reporting system. For example, PC-701 requires facility staff to:

~ record assessments of patients' physical status and continued need for restraint or seclusion;

~ review each episode of restraint or seclusion with the patient;

~ submit daily utilization reports to the head of the clinical staff;

~ investigate unusual or unwarranted patterns of restraint or seclusion;

~ review multiple episodes of use by a single individual with the treatment team; and

~ monitor the incidence of violent behavior and the associated use of restraint or seclusion.

The OMH does agree with CQC that past (QA-510) and current guidelines (IMRS system) that classify altercations between patients in which no injury occurs as "not an incident" should be revised. Part 524 does not contain the qualifier that injury must occur for an event to meet the

definition of a fight or assault. OMH supports modifying procedures to include any physical altercation as a reportable fight incident and any physical attack using force or violence as an assault, independent of whether or not an injury occurs as a result of the event. Such changes have already been incorporated into revisions to the IMRS system which are in process.

It must also be pointed out that the IMRS allows non-incident events to be input into the database and analyzed for patterns and trends. All of the facilities in NYC that were reviewed for the draft report, with the exception of Kirby, utilize the system for this purpose.

For example, in 1996, the following number of altercations that were ***not*** considered to be incidents (i.e., no injury was involved) and the total number of non-incident events were reported:

Facility 1996 Data	Non-Incident Altercations -	Total Non-Incident Events -
Kingsboro	366	557
Creedmoor	372	774
Manhattan	82	138
Bronx	302	573
South Beach	56	157
Kirby Forensic	0	4
Total	**1178**	**2203**

With the exception of Kirby, the NYC facilities are using the capabilities of the IMRS system to record and track sub-threshold, non-incident events.

Facility Specific Issues

A number of facility-specific issues were identified in the draft report. Each facility has independently responded to these and other issues, and their

responses are included in Appendix A. A brief synopsis of responses to the three main facility-specific issues follows:

- Two centers (Bronx and Manhattan) appear to have difficulty completing timely investigations.

  Response: Manhattan PC has also identified this as a problem and has taken steps to address it. Changes in the composition of the IRC and establishment of an extended number of trained facility special investigators is expected to improve the situation greatly.

  Bronx PC took steps to reduce the delay in completing investigations by assigning a Lead Investigator to conduct all significant investigations. Previously, Treatment Team Leaders conducted special investigations in addition to their regular duties.

- Not all incidents are reviewed by the Incident Review Committee (Bronx and Creedmoor).

  Response: Creedmoor states that its IRC reviews all original incident reports for moderate and severe incidents on a regular basis, but has not noted this review in its minutes. Procedures will be changed to include this activity in the minutes.

  At Bronx PC, all incidents are reviewed by the Lead Investigator, frequently in collaboration with the Deputy Executive Director, prior to data entry. The IRC reviews all incident reports resulting in a "moderate" or "severe" outcome. The incident review office also reviews the 24 nursing reports to cross check for events that should be treated as incidents but were not reported.

- There is wide diversity in the rate of incidents reported by the five facilities (South Beach, Kirby and Manhattan have the lowest rates). The CQC also noted that the facilities with lower rates of incidents per 1000 patient days had higher percentages of the more severe incidents on the sample wards reviewed. The draft report suggests that these facilities are reporting only the more serious events.

Response: This conclusion is not supported by the data collected by CQC. Table 5 in the draft report notes that incidents of low and mild severity represented the largest percentage of incidents reported by the sample wards in each of the facilities suspected of reporting only more serious events (SBPC-75%, MPC-88%, Kirby-89%). Thus the suggestion that less severe incidents are not being reported by these facilities is not supported by the data.

Response to Recommendations

The draft report contained six recommendations for improvements to the OMH's incident management and reporting practices. The six recommendations and OMH's response to each are listed below.

Establish criteria for which incidents require review by facility IRCs.

Response: Part 524 currently requires IRCs to review all events classified as incidents pursuant to that regulation. QA-510 is undergoing a revision which will establish consistent requirements.

Ensure the participation of direct care staff on facility IRCs.

Response: QA-510 requires at least a physician, nurse, social worker and therapy aide to sit on the IRC. Part 524 requires that at least two members of the clinical staff and at least one member of the professional staff serve on the IRC. Policy should be reviewed and amended, as noted for the previous recommendation.

Review incident investigation practices at Bronx and Manhattan PCs for timeliness and thoroughness issues.

Response: Both facilities acknowledge that the timeliness of completing incident investigations can be improved. There is, however, some question regarding the basis on which the CQC evaluated the "thoroughness" of investigations. Since the majority of incidents at Manhattan (88%) and Bronx (96%) sampled by CQC were of low or mild severity, one may question how "thorough" an investigation is warranted. The Commission's methodology for evaluating the quality of investigations relative to the severity of the incidents being investigated needs to be clarified in the draft report. This aspect of the recommendation should be revised or eliminated in the final report.

Given the above, both facilities have taken steps to improve the quality and timeliness of investigations. Manhattan PC has made the Director of Treatment Services a co-chair of the IRC. The DTS supervises the Program Administrators (Treatment Team Leaders) who are responsible for the majority of investigations and will ensure timely completion of these investigations. Manhattan PC has also established a number of Facility Special Investigator (FSI) positions. These individuals will be under QA supervision and will have no operational responsibilities in the facility. They will have responsibility for investigation of all serious incidents at the facility, not just those designated as special investigations. In the future, all incidents that come to the IRC will have first been investigated by a trained FSI.

At Bronx PC, the Lead Investigator has assumed responsibility for the conduct of all significant investigations, thereby reducing delays in investigation completion. In addition, all investigations handled by Special Investigators must be completed at a maximum of four weeks, with weekly status reports to the Lead Investigator. This replaces a system in which Treatment Team Leaders, trained as special investigators, were routinely assigned special investigations in addition to their regular duties.

Require facility QA programs to regularly review non-reported events to assure that reportable incidents are not going unreported.

Response: Facilities currently are able to and do use the IMRS system to record and analyze non-incident events. Guidance will be issued to increase use of the system for this purpose. In addition, a sample of non-incident events should be reviewed by the IRC of each psychiatric center for each

calendar quarter to assure that reportable events are not being ignored. Audits by OMH Central Office will verify that this happens.

Re-articulate expectations as to what constitutes a reportable incident.

Response: The OMH has a workgroup that has been working on revisiting the entire incident management process and all of its policies and procedures. This workgroup's report, due by June of 1997, will contain clarified expectations about what constitutes a reportable incident. Changes for the IMRS system are also currently in process and will incorporate the workgroup's recommendations.

Convene a workgroup to critique and evaluate the IMRS system.

Response: A workgroup met in 1996 to review and revise the IMRS incident classification system. Its recommendations are currently being incorporated into a new release of the IMRS. A second workgroup, described above, was convened in late 1996 to review all aspects of OMH's incident management practices. This group issued a survey on the IMRS to OMH facility users, began interviews on need for incident data with OMH senior managers, closely reviewed Mental Hygiene Law, regulations and policies on incident management and reporting, and reviewed incident classification rules. It continues to meet and work on these and related issues.

Summary and Conclusion

In summary, OMH is pleased that the positive aspects of its Incident Managment procedures, as implemented in New York City psychiatric centers, were noticed and highlighted by the Commission in its draft report. Several areas for improvement were also identified. The OMH continuously reviews, evaluates, and revises its incident managment practices.

OMH agrees with and has already addressed or begun to address many of these areas through staff projects and workgroups. Those which have not yet been addressed will be considered and included in future plans for policy and procedure adjustments and software improvements. The specific areas where improvements can be made were outlined above. Individual responses from the five psychiatric centers reviewed by CQC for this report are attached in Appendix A.

Copies of this report are available in large print, braille, or voice tape. Please call the Commission for assistance in obtaining such copies at 518-473-7538.

The Commission on Quality of Care for the Mentally Disabled is an independent agency responsible for oversight in New York State's mental hygiene system. The Commission also investigates complaints and responds to requests concerning patient/resident care and treatment which cannot be resolved with mental hygiene facilities.

The Commission's statewide toll-free number is for calls from patients/residents of mental hygiene facilities and programs, their families, and other concerned advocates.

Toll-free Number: 1-800-624-4143 (Voice/TDD)

In an effort to reduce the costs of printing, please notify the Commission if you wish your name to be deleted from our mailing list or if your address has changed. Contact:

Commission Publications
NYS Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12210-2895

Tel. (518) 473-7538