Alabama Department of Mental Health

Division of Developmental Disabilities

Incident Prevention and Management System (IPMS) Manual

Revised 06/10/2022

Table of Contents

SECTION 1 – WHY IS INCIDENT PREVENTION AND MANAGEMENT NECESSARY?

1.1 Introduction

The Code of Alabama §580-5-30-.05(1) directs the Alabama Department of Mental Health Developmental Disabilities Division (ADMH-DDD) to establish and maintain an Incident Prevention and Management System (IPMS) to provide guidance for community providers for the implementation of their IPMS to protect waiver participants from potential harm. Those agencies are required to implement this plan as a part of their provider certification requirements. This IPMS manual describes the critical incident management system employed by the ADMH-DDD, its Regional Community Services (RCS) offices, and its contracted service providers to ensure critical incident identification, reporting, investigation, and analysis procedures are consistently implemented to protect waiver participants from harm. The manual includes definitions of critical incidents, related terminology, and a description of required procedures to be followed to identify, classify, report, and investigate critical incidents accurately and consistently. The manual also includes a description of required follow-up actions that the provider, regional office, and state office must take to identify and remedy, through analysis of incident data, situations that may lead to harm. This IPMS is one component of the Division's larger Quality Improvement System designed to measure and evaluate the effectiveness of processes and procedures that support achievement of the major functions and responsibilities of the Division.

An effective incident management system seeks to promote an environment that is free from harm. Toward that end, the Developmental Disabilities Division is committed to the following principles:

- All waiver participants are entitled to appropriate services that enable support and promote dignity, respect, and opportunities for personal growth and development that prevent harm without restricting individual freedoms and rights.
- Providers must eliminate, wherever possible, the occurrence of preventable incidents without unnecessarily restricting individual freedoms and choices.
- Providers must identify and respond appropriately to all types of incidents.
- Reducing the number of incidents, particularly serious incidents, helps create and perpetuate safe environments in which waiver participants are supported to live, work, and learn.

1.2 Code of Alabama Requirements-Risk & Critical Incident Prevention and Management

The Code of Alabama establishes the following requirements relating to risk and critical incident prevention and management:

1.2.1 §580.5.30-.05, Abuse/Neglect/Mistreatment/Exploitation.

The Alabama Department of Mental Health Developmental Disabilities Division (ADMH-DDD) preserves the safety, protection, and well-being of all waiver participants receiving services through its contracted and certified public and private provider organizations and takes appropriate action with a contracted provider to address any confirmed abuse, neglect, mistreatment, or exploitation of waiver participants enrolled in their programs. The ADMH-DDD maintains a Community Incident Prevention and Management System (IPMS) that provides guidance for community providers to implement an incident prevention and management system S successfully and consistently to protect waiver participants from potential harm, and those agencies are required to implement this plan as a part of their ADMH certification and contract requirements.

1.2.2 §580-5-30-.10, Contracted Intellectual Disabilities Services.

This section requires that the ADMH-DDD contract with certified public and private provider organizations to deliver intellectual and developmental disability services. Under the terms of this contract, the certified provider organization must have written policies and procedures that are effectively implemented in such a way as to assure the health, safety, and individual security of waiver participants. The certified and contracted provider organization's written policies and procedures will be approved, reviewed, and updated by the governing board, as appropriate, but at least annually, and must be made available to all employees and waiver participants. All employees will be trained on these policies and procedures including what constitutes effective and appropriate implementation of each policy and procedure.

1.2.3 §580-5-30-.10(5) Protection from Abuse, Neglect, Mistreatment, and Exploitation.

This section requires that all providers of services contracted with the ADMH-DDD implement a local IPMS policy to protect waiver participants, to improve the organization's responsiveness to incidents, and to manage risk efficiently and effectively. The purpose of the provider's local IPMS policy is to prevent harm and provide a framework for an effective approach to risk and incident management that takes appropriate account of dignity of risk. The provider's local IPMS policy, and practices associated with its implementation, must identify, define, prohibit, and prevent abuse, neglect, mistreatment, unauthorized or inappropriate use of restraints, exploitation and other critical incidents defined in this ADMH-DDD IPMS Manual. The definitions in the

provider's local IPMS policy must be comprehensive, specific, and consistent with the definitions of critical incidents and other terms in this ADMH-DDD IPMS Manual. Regarding "dignity of risk," a reasonable amount of planned risk is recognized as being essential for human growth and development. Dignity of risk recognizes there are justifiable risks associated with living life, pursuing goals, and exploring opportunities. Justifiable risks are those a reasonable person would otherwise expect are necessary, based on having specific goals and interests.

1.2.4 §38-9-8 Requirement to Report Suspected Abuse, Neglect, Mistreatment, and Exploitation to the Alabama Department of Human Resources.

The Code of Alabama, §38-9 authorizes the Alabama Department of Human Resources (DHR) to receive and investigate allegations of suspected abuse, neglect, mistreatment, or exploitation reported to them. §38-9-8 requires that any caregiver having reasonable cause to believe that any protected person has been subjected to physical abuse, sexual abuse, emotional abuse, verbal abuse, neglect, mistreatment, or exploitation shall report or cause a report to be made to DHR. A "protected person" includes any person with intellectual disabilities and/or developmental disabilities. A "caregiver" is defined as an individual who has the responsibility for the care of a protected person as a result of contract or employment.

SECTION 2 – DEFINITIONS OF TERMS USED IN THIS MANUAL

The following definitions are provided for terms used in this manual.

1) **Agent** – A person who is authorized to act for another through contract or agreement rather than employment.
2) **Alabama Department of Human Resources** - The state agency that is authorized by the APS Act of 1976 to receive and investigate reports of suspected abuse, neglect, or exploitation involving citizens of the state "who because of the infirmities of age, disabilities or like incapacities, are in need of protective services." This state agency comprises both "Adult Protective Services" and "Child Protective Services" in Alabama.
3) **Altercation** - Two or more waiver participants engaging in intentional, reckless, and/or aggressive behavior that results in no injury or minor injury to another waiver participant.
4) **Approved Restrictive Intervention** – A manual, mechanical, or chemical restraint procedure that has been incorporated into a Behavior support plan (BSP). The BSP must have been approved by the interdisciplinary team, the Chair of the Behavior Program Review Committee, and the Human Rights Committee. Consent for the BSP must also have been obtained from the waiver participant or parent/guardian within the past twelve months or when any changes are made in the BSP.
5) **Behavioral Support Plan (BSP)** – A documented plan that is incorporated into the waiver participant's person-centered plan (PCP) that describes the process or processes that direct support professionals (DSPs) can use to change or eliminate undesirable behaviors and increase the menu of preferable behaviors a waiver participant can use to get what he or she wants or to avoid what he or she does not want. The BSP provides guidance to staff in dealing with situations of danger to the waiver participant or others and of property destruction. The BSP is developed and implemented to remove barriers to reaching the goals of the PCP.
6) **Change of Condition** - A change in a waiver participant's health or his/her functional or psychosocial condition that causes either an improvement or a deterioration in his/her condition.
7) **Comprehensive Mortality Review** – A report that documents the provider's investigation if the death of a waiver participant. The Comprehensive Mortality Review includes relevant demographic data, health information, information related to hospital admission (if death occurred at a hospital), any emergency medical care/treatment provided, medications prescribed at the time of death, circumstances of the death, autopsy findings if one was conducted, and recommendations for policy, procedure or process changes relevant to the investigation of the death.
8) **Contraband** - Items prohibited by statute or policy, or deemed a risk to the safety, security, or therapeutic environment impacting the program or a waiver participant.
9) **Employee** – An individual who is either: (a) hired directly or through a contract by a service provider who has duties that involve, or may involve, one-on-one contact with a waiver participant; or (b) a volunteer who has duties that involve, or may involve, one-on-one contact with a waiver participant.
1) **First Aid** - First aid refers to immediate one-time or short-term treatment after an injury. Examples of first aid include, but are not limited to, cleaning minor cuts, scrapes, or scratches; treating a minor burn; applying band aids, the use of non-prescription medication, rinsing debris from the eyes, and providing fluids to relieve heat stress.
2) **General Event Report (GER)** – A web-based incident reporting tool in the Therap® system used for the mandatory reporting, investigation, and resolution of critical incidents involving one or more waiver participants.
3) **General Event Report (GER) Resolution** – A completed critical incident investigation report in the Therap® system.
4) **Harm** – Any physical or psychological injury or damage to the physical or mental health of a waiver participant, including both temporary and permanent injury, or damage to a person's residence or personal property.

5) **Incident Review Committee** – a group of professional staff members who meet at a designated frequency to review critical incident data and information to identify relevant trends, patterns, or issues that require corrective action. Both the waiver provider and the Regional Community Services office are required to have an Incident Review Committee (see §6.1 below for additional details).
6) **Infestation** - The presence of an unusually large number of insects or animals in a place, typically so as to cause damage or disease.
7) **Intentionally** - A person acts intentionally with respect to a result or to conduct when his or her purpose is to cause that result or to engage in that conduct.
8) **Mandatory Reporter** – Under Alabama law (Adults-Alabama Code Title 38. §38-9-8 or Children-Alabama Code Title 26. §26-14-3), Any physician or other practitioner of the healing arts or any caregiver of a person with an intellectual or developmental disability having a reasonable cause to believe that any protected person has been subjected to physical abuse, sexual abuse, emotional abuse, mistreatment, neglect, or exploitation must make a report of that suspicion to the Department of Human Resources and to the ADMH-DDD Regional Office.
9) **Medication Administration** - Removal of an individual dose of medication, from a previously dispensed, properly labeled container, verifying it with the prescriber's orders, and giving the correct medication and correct dosage, to the correct person, at the correct time, in the correct way, and recording the administration appropriately.
10) **Medication Administration Record (MAR) –** A medical record where all drugs administered are recorded. The MAR must be retained by the provider as a required part of the medical record.
11) **Medication Assistant, Certified (MAC) Worker** – A mental health worker or unlicensed assistive personnel who has successfully completed an Alabama Board of Nursing-approved curriculum for assistance with medications, or a comparable program in another state, and holds a valid medication assistant certification to work under the direction of a licensed nurse.
12) **Medication Assistance Supervising (MAS) Nurse** – A licensed nurse who has successfully completed the ADMH approved Nurse Delegation Program (NDP) training and Medication Administration Supervisor (MAS) training and who delegates specific limited nursing care tasks including medication administration/supervision to designated unlicensed MAC Workers. MAS Nurses are accountable and responsible for the outcome of the delegated nursing care delivered by unlicensed MAC workers.
13) **Minor Injury -** An injury in that does not require treatment by a physician, licensed nurse, or other healthcare professional. Minor injuries are entered as a GER into the Therap® system as a Notification Level-Low. All relevant fields in the Basic Information, Event Information, and Actions Taken sections must be completed. Minor injuries are not considered critical incidents and do not require reporting to ADMH-DDD.
14) **Non-Preventable Incident** – Any occurrence involving an accident/incident in which everything that could have been reasonably done to prevent it was done and the accident/incident still occurred.
15) **Peer-to-Peer Assault** – Two or more waiver participants engaging in intentional, reckless, or aggressive behavior that results in a moderate or major injury to another waiver participant.
16) **Person-Centered Plan (PCP)** – A support plan that is centered on the waiver participant and is used as a life planning process to enable the waiver participant to increase personal self-determination and to exercise more choice and control. The choice of services is guided by the hopes, dreams, preferences, values, and desires of the waiver participant. The choice of services is also made considering the waiver participant's health and safety needs and concerns and the availability or potential development of resources including natural supports, funding source rules, procedures which match mental health/developmental conditions to appropriate levels of treatment, and best practice standards.
17) **Preventable Incident** - An incident in which the provider failed to do everything reasonable to prevent it.
18) **Proper Procedures for Use of Restrictive Interventions** – Proper procedures include all of the following: (1) If the restraint procedure is incorporated into a behavior support plan (BSP), the person(s) implementing the restraint must follow all specific instructions outlined for its use in the BSP; (b) the staff member(s) who is implementing the restraint must have received training on its appropriate and correct use prior to using the technique; (c) the restraint procedure is used only to protect the waiver participant or others from injury; (d) prior to initiating the restraint, specific approval for its use must be obtained from a Qualified Developmental Disabilities Professional (QDDP), Program Director, or Physician; (e) for mechanical restraints, the following devices are the only ones that can be used – arm splints, wrist cuffs, or four- and five-point restraint devices with a quick-release (e.g., Posey stockinette or Velcro wrist/ankle cuffs); (f) for chemical restraints, the use of the psychotropic medication must be ordered by a physician; and (g) the specific details of the restraint incident must be fully documented and accurately described in a General Event Report (GER) in the Therap® system.
19) **Property Damage** – The damage or destruction of property belonging to a waiver participant, damage of the home, or damage to a vehicle.
20) **Protected Person (Adult)** – As defined in the Code of Alabama, Chapter 38-9 which governs the roles and responsibilities of the Alabama Department of Human Resources Adult Protective Services Division, a protected person is any person over

18 years of age subject to protection under Code of Alabama Chapter 38-9, or any person, including, but not limited to, persons with a neurodegenerative disease, persons with intellectual/developmental disabilities, or any person over 18 years of age that is mentally or physically incapable of adequately caring for himself or herself and his or her interests without serious consequences to himself/herself or others.

21) **Protected Person (Child)** – Anyone under 18 years of age.
22) **Qualified ADMH Regional Community Services (RCS) Staff Member** – An ADMH-DDD Regional Community Services office staff member who has completed the "Conducting Serious Incident Investigations" instructor-led training developed by Labor Relations Alternatives, Inc., and approved by ADMH. The instructor-led training is available to ADMH staff through the Relias Training System.
23) **Recklessly** - A person acts recklessly with respect to a result or to a circumstance when he or she is aware of and consciously disregards a substantial and unjustifiable risk that the result may occur or that the circumstance exists. The risk shall be of such nature and degree that its disregard constitutes a gross deviation from the standard conduct that a reasonable person would observe in the situation.
24) **Regional Incident Review Committee** – A group of regional office staff that includes, at a minimum, the Regional Community Services Director, Regional Incident Management Coordinator, Regional Nurse, Regional Quality Enhancement Specialist, a Community Services Specialist, a Certification Specialist representative, a Behavioral Services representative, a representative from the ADMH Advocacy Program, and the Statewide Incident Management Coordinator.
25) **Restrictive Intervention** – A manual restraint, mechanical restraint, or chemical restraint. Each of these types of restraints is defined in Section 4 below.
26) **SComm Module (Therap) -** The Secure Communications (SComm) module in the Therap® system is designed to facilitate the exchange of information among Therap® users in a secure, HIPAA compliant way. A Therap® user uses the Secure Communications (SComm) module to communicate with a user or group of colleagues when you want to share information about a General Event Report (GER) or GER Resolution.
27) **Sensitive Situation** – An event or incident that may draw attention of the media, government officials, or parents/family members.
28) **Sentinel Event** - Any critical incident that results in premature death, permanent harm, or severe temporary harm to a waiver participant.
29) **Statewide Incident Review Committee** – A group of ADMH-DDD state office staff that includes, at a minimum, the ADMH-DDD Associate Commissioner, Statewide Incident Management Coordinator, Community Program Director, Quality and Planning Director, Psychological & Behavioral Services Director, ADMH Advocacy Program Director, and Bureau of Special Investigations representative. Other members may be appointed at the discretion of the ADMH-DDD Associate Commissioner. The Regional Community Services Directors and Regional Incident Management Coordinators serve as ad hoc members of this committee and will be asked to participate on an as-needed basis.
30) **Systemic Intervention** – An action initiated by ADMH-DDD or the Alabama Medicaid Agency including, but not limited to, regional or statewide training initiatives; regional or statewide enhanced monitoring; regional or statewide technical assistance; regional or statewide issuance of written operational guidelines, policies/procedures, or other written guidance; and/or regional or statewide implementation of corrective action plans.
31) **Theft/Larceny** - Taking a property/personal possession unlawfully, without the intention of returning it.
32) **Treatment** – The use of an agent, procedure, or regimen, other than first aid, performed by a physician, licensed nurse, or other healthcare professional to cure or mitigate an illness, condition, or injury.
33) **Unapproved Restrictive Intervention** – A manual, mechanical, or chemical restraint procedure that has not been incorporated into a Behavior support plan (BSP).
34) **Vehicular Accident** - When a motor vehicle strikes or collides with another vehicle, a stationary object, a pedestrian, or an animal. All vehicular accidents involving a waiver participant must be reported in the Therap® system as Event Type: "Other-Vehicular Accident" regardless of whether or not the waiver participant sustained any type of injury.
35) **Volunteer** - A person who performs or offers to perform voluntary service often without compensation or remuneration.

SECTION 3 – INCIDENT PREVENTION AND MANAGEMENT SYSTEM OVERVIEW

3.1 – Critical Incident Types, Definitions, and Descriptions

A **critical incident** is any unplanned occurrence that has the potential to affect the health, safety, and/or welfare of a waiver participant. This section contains definitions for each critical incident type. A more detailed table containing these critical incident definitions, Therap® data entry instructions, required notifications and timelines, Level of Harm designation(s), and identification of who conducts the investigation can be found in Appendix A – Critical Incident Crosswalk Table.

1) Abuse-Emotional –The willful or reckless infliction of emotional or mental anguish or the use of a physical or chemical restraint, medication, or isolation as punishment or as a substitute for treatment or care of any protected person.
2) Abuse-Physical - The intentional infliction of physical pain, injury, or willful deprivation of services necessary to maintain physical and mental health by a caregiver or other person. **Guidance***: Physical abuse may be perpetrated by anyone including, but not limited to, an employee, volunteer, family member, or another waiver participant. Physical abuse includes, but is not limited to, assault by an employee, volunteer, or another waiver participant; an employee or volunteer hitting, kicking, pinching, slapping, or otherwise striking a waiver participant or using excessive force regardless of whether an injury results; or utilizing treatment techniques, e.g., restraints, seclusion, etc., in violation of the prohibitions contained in the restraint definitions in this IPMS manual. Any incident of peer-to-peer assault is considered physical abuse.*
3) Abuse-Sexual - Any conduct that is a crime as defined in Sections 13A-6-60 to 13A-6-70, inclusive of the Code of Alabama. Forms of sexual abuse include, but are not limited to, unwanted or non-consensual sexual contact or activity using force, coercion, or threats, rape, incest, sodomy, and indecent exposure. **Guidance:***. Sexual contact is defined as intercourse or any sexual act, regardless of the sex of either participant, involving the genitals of one person and the mouth or anus of another person, or any act that a reasonable person would consider to be sexual. Coercion is defined as the practice of persuading someone to do something by using force or threats.* S*exual abuse may be perpetrated by anyone including but not limited to an employee, volunteer, family member, or another waiver participant. Sexual abuse also includes any incitement of a waiver participant to engage in any form of sexual activity with any other person. Any incident of non-consensual sexual contact between waiver participants is considered sexual abuse.*
4) Abuse-Verbal - The infliction of disparaging and angry outbursts such as name calling, blaming, threatening, or making derogatory comments that demean or could reasonably be expected to cause shame, ridicule, humiliation, or emotional distress.
5) Behavioral Issue - Exhibiting behaviors, such as physical aggression resulting in injury, self-injurious behavior requiring medical attention, suicide threats or attempts, or property damage resulting in injury or destruction. A General Event Report is required for behavioral issues even if those behaviors are addressed in an approved behavioral support program.
6) Choking - Gagging or choking on food, liquid, a foreign object, or material that requires the Heimlich maneuver or other method of dislodging the object. Any choking incident involving use of the Heimlich Maneuver or other method of dislodging the object requires the individual be evaluated by a licensed nurse and sent to the Emergency Room for evaluation.
7) COVID 19 Testing and Diagnosis – Both testing for COVID-19 and diagnosis of COVID-19 should be reported as "Other" in the Therap® system. **Guidance:** *Testing for COVID-19 will be a classified as Level of Harm-2 and diagnosis of COVID-19 will classified as Level of Harm-3. A death resulting from COVID-19 is to be reported as an unexpected death classified as Level of Harm-4.*
8) Death-Natural - The permanent suspension of consciousness and the end of life due to natural causes that does not meet the criteria for an Unexpected Death. **Guidance:** *Natural deaths, in any setting, are to be reported within 24 hours to the Regional Community Services (RCS) Office by the provider or person notified of the death. The RCS office reports the death to the ADMH-DDD State Office. A GER for the death and a Comprehensive Mortality Review are required for all natural deaths. If the death occurred while the waiver participant was not in the provider's care, or if the waiver participant lives in a relative's home, it is understood certain information may not be readily available.*
9) Death-Unexpected - The permanent suspension of consciousness and the end of life due to an unknown or unanticipated cause. At a minimum, unanticipated causes include those that resulted from suicide, homicide or other criminal activity, medical error or complications, undiagnosed conditions or accidents, or those that were suspicious for possible abuse or neglect. **Guidance:** *Unexpected deaths, in any setting, are to be reported within one hour to the Regional Community Services (RCS) Office by the provider or person notified of the death. The RCS office reports the death to the ADMH-DDD State Office. A GER for the death and a Comprehensive Mortality Review arerequired for all unexpected deaths. If the death occurred while the waiver participant was not in the provider's care or, if the waiver participant lives in a relative's home, it is understood certain information may not be readily available.*
10) Emergency Room Visit - Any Hospital Emergency Room visit for a waiver participant, but not including visits to community urgent care centers.
11) Exploitation - The expenditure, diminution, or use of the property, assets, or resources of a person subject to protection under the provision of Sections 38-9-1 through 11, Code of Alabama, without the express voluntary consent of that person or legally authorized representative. **Guidance:** *Exploitation includes, but is not limited to, improperly requesting a waiver participant to perform an employee's work responsibilities, services or tasks for the employee; requesting, taking or receiving money, gifts, or other personal possessions from a waiver participant; or utilizing a waiver participant to engage*

in conduct with other waiver participants that would be prohibited if performed by an employee. Waiver participants may be exploited by those who are not employees, and such incidents should also be reported.

12) Fall - A sudden and involuntary drop from an upright position to a lower surface or the ground. The following types of falls must be reported: falls witnessed by a direct service worker, falls with moderate to major injuries which require assistance from medical personnel, or three or more falls in a consecutive 90-day period from a client who has limited support or who lives alone. **Guidance:** *All falls, including falls reported by the individual or staff, regardless of whether an injury results, must be reported as a GER in the Therap® system. See guidance for determining the level of harm (1-4).*

13) Fire - A situation in which a person, object, building, or area of land is injured, destroyed or damaged by burning. **Guidance:** *See guidance for determining the level of harm (1-4).*

14) Hospital Admission - A medical occurrence that cannot be characterized by any other medical emergency category above that requires an unscheduled hospital admission. A major injury may result in hospitalization.

15) Injury-Moderate - Any observable and substantial impairment of a person's physical health requiring medical treatment that is not considered a major injury and that does not cause a substantial risk of death, a permanent disfigurement, or a protracted loss or impairment of the function of a bodily member or organ. **Guidance:** *Medical treatment includes treatment by a physician, licensed nurse, or other healthcare professional. Examples of moderate injuries include, but are not limited to an abrasion, laceration, bruise, or contusion that requires treatment or a sprain or other similar suspected injury where a fracture is suspected but an x-ray is ordered and there is no fracture.*

16) Injury-Major - Any observable and substantial injury that is not considered moderate injury and that results in permanent or protracted impairment, such as a fracture, a wound requiring sutures, injury to an internal organ, a burn, or a physical disfigurement of the body. These injuries typically require medical treatment and may result in hospitalization.

17) Medication Error-Level 1- A Level 1 medication error is a "monitoring error" and is defined as an incident in which the person experienced no or minimal adverse consequences and no treatment or intervention other than monitoring or observation is required. **Guidance:** *The MAS Nurse must be notified immediately upon discovery of any medication error, including but not limited to a documentation error. This immediate notification is necessary to allow the MAS Nurse to determine whether assessment/treatment is necessary. When completing the GER related to a Level 1 medication error, the provider must accurately complete all data fields related to the medication error including "Type", "Cause" "Medical Attention Required", "Person Responsible", "Prescriber Notified", "Error Description", "Treatment By", "Witnesses", and "Additional Notifications".*

18) Medication Error-Level 2 – A Level 2 medication error is a "treatment/intervention error" and is defined as an incident in which the person experienced short-term, reversible adverse consequence(s) and treatment or intervention in addition to monitoring is required. **Guidance:** *The MAS Nurse must be notified immediately upon discovery of any medication error. This immediate notification is necessary to allow the MAS Nurse to determine whether assessment/treatment is necessary and to initiate investigation of the error. Sending a waiver participant to the emergency room (but not subsequently being admitted to the hospital) in response to a medication error would be an example of a Level 2 medication error. When completing the GER related to a Level 2 medication error, the provider must accurately complete all data fields related to the medication error including "Type", "Cause" "Medical Attention Required", "Person Responsible", "Prescriber Notified", "Error Description", "Treatment By", "Witnesses", and "Additional Notifications". A Level 2 medication error must also be reported on a Medication Error Report (Form NDP-4 – Appendix G) completed by the MAS RN/LPN. When completed, the Medication Error Report should be emailed or faxed directly to the Alabama Department of Mental Health Nurse Delegation Program (AMH/NDP) Office within 24 hours after notification/discovery of the error. All requested information should be provided with a description of the error focusing on the outcome to the waiver participant – signs, symptoms, ER visit, etc. A copy of the completed Medication Error Form must also be attached electronically to the GER.*

19) Medication Error-Level 3 – A Level 3 medication error is a "sentinel event" and is defined as an incident in which the person experienced life threatening and/or permanent adverse consequence(s). **Guidance:** *The MAS Nurse must be notified of any medication error immediately upon discovery of the error. This immediate notification is necessary to allow the MAS Nurse to determine what assessment/treatment is necessary and to initiate investigation of the error. A waiver participant requiring a hospital admission or loss of bodily function in response to a medication error would be an example of Level 3 medication error. When completing the GER related to a Level 3 medication error, the provider must accurately complete all data fields related to the medication error including "Type", "Cause" "Medical Attention Required", "Person Responsible", "Prescriber Notified", "Error Description", "Treatment By", "Witnesses", and "Additional Notifications". A Level 3 medication error must also be reported on a Medication Error Report (Form NDP-4 – Appendix G) completed by the MAS RN/LPN. When completed, the Medication Error Report should be emailed or faxed directly to the Alabama Department of Mental Health Nurse Delegation Program (AMH/NDP) Office within 24 hours after notification/discovery of the error. All requested information should be provided with a description of the error focusing on the outcome to the*

waiver participant – signs, symptoms, hospital admission, etc. A copy of the completed Medication Error Form must also be attached electronically to the GER.

20) Missing/Eloped Individual – A person who cannot be located and there is reason to believe the person may be lost or in danger. **Guidance:** *A incident involving a waiver participant who is missing or has eloped must be reported whether or not this behavior is addressed in the waiver participant's Behavior support plan. The provider staff must immediately report to police and the Regional Community Services (RCS) office. The notification must include the suspected time of departure, where the waiver participant possibly went, what the waiver participant was wearing, a description of the waiver participant's behavior/attitude prior to disappearance, and what actions were taken to locate the waiver participant.*

21) Mistreatment – Any act or threat of intimidation, harassment, or similar deed to cause harm or create the fear of harm to a vulnerable person by the caregiver or another person. **Guidance:** *Mistreatment includes but is not limited to using physical or non-verbal gestures as a means of intimidation, withholding of or the threat of withholding physical necessities, or personal possessions as a means of intimidation for control of the person, or making false statements as a means of confusing, frightening, or badgering the waiver participant.*

22) Natural Disaster – A situation in which a person is injured, killed, displaced, or evacuated from his/her home due to damage or risk of damage resulting from a natural hazard such as tornadoes, hurricanes, floods, power outages, and winter weather. **Guidance:** *The provider must be familiar with disaster procedures in the home and be prepared to evacuate to a shelter if needed. Notify the Regional Community Services (RCS) office after evacuation is completed and safety of waiver participant(s) is ensured.*

23) Neglect – The intentional or unintentional failure of a caregiver to provide food, shelter, clothing, medical services, supervision, or basic needs for safety for an individual who is unable to care for himself or herself. **Guidance:** *Neglect includes but is not limited to (a) not providing the level of supervision and support required in an individual's support plan; (b) failing to ensure the individual's basic needs for safety, nutrition, medical care, and personal attention are met; or (c) failing to provide supports in accordance with the person-centered plan.*

24) Neglect-Self - The failure of the person to provide for their own basic needs when the failure is the result of the person's mental or physical inability and such failure substantially endangers a person's health, safety, welfare, or life.

25) Other Incident - Any occurrence that requires the notification of agencies such as Police or Fire Department, but not including ambulance or paramedic services or any event resulting in Department of Human Resources (DHR) involvement/notification not already listed. **Guidance:** *Incidents that are to be reported as "Other Incident" in the Therap® system include, but are not limited to, "Change of Condition, "Complaint and/or Possible Litigation", "Confidentiality/Privacy Breach", "Contraband", "Inappropriate Alcohol/Drug Use", "Infestation", "Misconduct/Possible Criminal Activity", "Property Damage", "Security Breach", "Sensitive Situation", "Theft/Larceny Attempt", "Relocation" (for reasons other than fire or natural disaster), and "Vehicular Accident".*

26) Seizure - An unexpected or uncharacteristic seizure of any duration, regardless of whether an injury occurs. **Guidance:** *See guidance for determining the level of harm (1-4).*

27) Restraint-Chemical-Emergency – Administration of a medication, not specifically authorized and described in a waiver participant's behavior support plan (BSP) or psychotropic medication plan, prescribed to modify, control, or alter a specific behavior. Chemical restraint does not include medications prescribed for the treatment of a diagnosed disorder identified in the "Diagnostic and Statistical Manual of Mental Disorders" (fifth edition), medications prescribed for treatment of a seizure disorder, or a medication that is routinely prescribed in conjunction with a medical procedure for persons without developmental disabilities. The use of a chemical restraint that is medically contraindicated, that causes pain or harm to a waiver participant, or if used as punishment, retaliation, or for the convenience of staff, is prohibited. Any type of restraint must only be used as a method of last resort and only when necessary to protect the waiver participant or others from injury. Any emergency use of a chemical restraint requires a physician's order and approval by a Qualified Developmental Disabilities Professional (QDDP), Program Director, or Physician. **Guidance:** *A waiver participant who has been administered a chemical restraint for emergency use must be observed by staff as written in the physician's order for the medication. A GER is required for all chemical restraints. Any emergency use of a chemical restraint without a physician's order and the approval from a QDDP or Program Director should be reported as an allegation of physical abuse. When completing the GER in Therap® for use of a chemical restraint, each of the fields under "Event Information" must be completed including the specific type of chemical restraint used (medication, dosage, etc.). Any additional information about the restraint not detailed in the specific fields referenced above must be fully described in the "Summary" field. Refer to additional requirements for use of an emergency chemical restraint three or more times in a six-month period in Section 5.6.4 below.*

28) Restraint-Chemical-Programmatic –Administration of a medication, specifically authorized and described in a waiver participant's behavior support plan (BSP) or psychotropic medication plan, prescribed to modify, control, or alter a specific behavior. Chemical restraint does not include medications prescribed for the treatment of a diagnosed disorder identified in the "Diagnostic and Statistical Manual of Mental Disorders" (fifth edition), medications prescribed for treatment of a seizure disorder, or a medication that is routinely prescribed in conjunction with a medical procedure for persons without developmental disabilities. The use of a chemical restraint that is medically contraindicated, that causes pain or harm to a waiver participant, or if used as punishment, retaliation, or for the convenience of staff, is prohibited. Any type of restraint must only be used as a method of last resort and only when necessary to protect the waiver participant or others from injury. **Guidance:** *A waiver participant who has been administered a chemical restraint for programmatic use must be observed by staff as described in the waiver participant's behavior support plan (BSP) and/or in the manner written in the physician's order for the medication. A GER is required for all chemical restraints, even if the use is identified and authorized in the waiver participant's BSP or psychotropic medication plan. When completing the GER in Therap® for use of a chemical restraint, each of the fields under "Event Information" must be completed including the specific type of chemical restraint used (medication, dosage, etc.). Any additional information about the restraint not detailed in the specific fields referenced above must be fully described in the "Summary" field.*

29) Restraint-Manual-Emergency – Use of a holding procedure that lasts more than five consecutive seconds, that is not specifically authorized and described in a waiver participant's behavior support plan (BSP), to control an identified action by restricting the movement or function of a waiver participant's head, neck, torso, one or more limbs, or entire body. Manual restraint also includes holding or disabling a waiver participant's wheelchair or other mobility device. Manual restraint does not include a method that is routinely used during a medical procedure for persons without developmental disabilities. Any type of restraint must only be used as a method of last resort and only when necessary to protect the waiver participant or others from injury. Use of the following types of manual restraint procedures are prohibited:

a) Any maneuver or technique that does not give adequate attention and care to protection of the head.
b) Any maneuver or technique that places pressure or weight on the chest, lungs, sternum, diaphragm, back, or abdomen.
c) Any maneuver or technique that places pressure, weight, or leverage on the neck or throat, on any artery, or on the back of the head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway, such as straddling or sitting on the torso, or any type of choke hold.
d) Any maneuver or technique that involves pushing into a person's mouth, nose, or eyes.
e) Any maneuver or technique that utilizes pain to obtain compliance or control, including punching, hitting, hyperextension of joints, or extended use of pressure points.
f) Any maneuver or technique that forces a person to remain in a prone (face down) position.
g) Any maneuver or technique that forcibly takes a person from a standing position to the floor or ground. This includes taking a person from a standing position to a horizontal (prone or supine) position or to a seated position on the floor.
h) Any maneuver or technique that creates a motion causing forcible impact on the person's head or body, or forcibly pushes a person against a hard surface.
i) Any maneuver or technique used as punishment, retaliation, or for the convenience of staff.

Guidance: *Manual restraint must cease immediately once risk of harm has passed. An emergency manual restraint may only be applied by a staff member who has received specific training and has demonstrated competency in applying that specific manual restraint technique. Any emergency use of a manual restraint requires approval by a Qualified Developmental Disabilities Professional (QDDP), Program Director, or Physician. A GER is required for all manual restraints. Any emergency use of a manual restraint without the approval from a QDDP, Program Director, or Physician or use of any of the prohibited restraint procedures listed above should be reported as an allegation of physical abuse. When completing the GER in Therap for use of a manual restraint, each of the fields under "Event Information" must be completed and the type of "holding procedure" should be specified in the "Restraint Type" field. In addition, the specific "holding procedure" and how it was used should be fully described in the "Summary" field. Refer to additional requirements for use of an emergency manual restraint three or more times in a six-month period in Section 5.6.4 below.*

30) Restraint-Manual-Programmatic – Use of a holding procedure that lasts more than five consecutive seconds, specifically authorized and described in a waiver participant's Behavior support plan (BSP), to control an identified action by restricting the movement or function of the waiver participant's head, neck, torso, one or more limbs, or entire body. Manual restraint also includes holding or disabling a waiver participant's wheelchair or other mobility device. Manual restraint does not include a method that is routinely used during a medical procedure for persons without developmental disabilities. Any type of restraint must only be used as a method of last resort and only when necessary to protect the waiver participant or others from injury. Use of the following types of manual restraint procedures are prohibited:

a) Any maneuver or technique that does not give adequate attention and care to protection of the head.

b) Any maneuver or technique that places pressure or weight on the chest, lungs, sternum, diaphragm, back, or abdomen.
c) Any maneuver or technique that places pressure, weight, or leverage on the neck or throat, on any artery, or on the back of the head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway, such as straddling or sitting on the torso, or any type of choke hold.
d) Any maneuver or technique that involves pushing into a person's mouth, nose, or eyes.
e) Any maneuver or technique that utilizes pain to obtain compliance or control, including punching, hitting, hyperextension of joints, or extended use of pressure points.
f) Any maneuver or technique that forces a person to remain in a prone (face down) position.
g) Any maneuver or technique that forcibly takes a person from a standing position to the floor or ground. This includes taking a person from a standing position to a horizontal (prone or supine) position or to a seated position on the floor.
h) Any maneuver or technique that creates a motion causing forcible impact on the person's head or body, or forcibly pushes a person against a hard surface.
i) Any maneuver or technique used as punishment, retaliation, or for the convenience of staff.

Guidance: *Manual restraint must cease immediately once risk of harm has passed. A programmatic manual restraint may only be applied by a staff member who has received specific training and has demonstrated competency in applying that specific manual restraint technique prescribed in the waiver participant's BSP. A GER is required for all manual restraints, even if the use is identified and authorized in the waiver participant's BSP. Any use of a manual restraint that does not follow the requirements for its use in the waiver participant's BSP or use of any of the prohibited restraint procedures listed above should be reported as an allegation of physical abuse. When completing the GER in Therap® for use of a manual restraint, each of the fields under "Event Information" must be completed and the type of "holding procedure" should be specified in the "Restraint Type" field. In addition, the specific "holding procedure" and how it was used should be fully described in the "Summary" field.*

31) Restraint- Mechanical-Emergency – Restricting a waiver participant's movement or function by use of an approved mechanical restraint device, not specifically authorized and described in the waiver participant's behavior support plan (BSP), to control an identified action. Approved mechanical restraint devices include arm splints, wrist cuffs, or four- and five-point restraint devices of the quick-release type (e.g., Posey stockinette or Velcro wrist/ankle cuffs). Mechanical restraint does not include a seatbelt of a type found in an ordinary passenger vehicle or an age-appropriate child safety seat, a medically necessary device (such as a wheelchair seatbelt or a gait belt) used for supporting or positioning the waiver participant's body, or a device that is routinely used during a medical procedure for persons without developmental disabilities. The use of a mechanical restraint that has the potential to inhibit or restrict a waiver participant's ability to breathe or that is medically contraindicated, that has the potential to cause pain or harm, or if used as punishment, retaliation, or for the convenience of staff, is prohibited. Any type of restraint must only be used as a method of last resort and only when necessary to protect the waiver participant or others from injury. **Guidance:** *A waiver participant in a mechanical restraint must be under constant visual supervision by staff. An emergency mechanical restraint may only be applied by a staff member who has received specific training and has demonstrated competency in applying that specific mechanical restraint device. Any emergency use of a mechanical restraint requires approval by a Qualified Developmental Disabilities Professional (QDDP), Program Director, or Physician. Mechanical restraint must cease immediately once risk of harm has passed. A GER is required for all mechanical restraints. Any emergency use of a mechanical restraint without the approval from a QDDP, Program Director, or Physician or use of a mechanical restraint device not specified in the list above should be reported as an allegation of physical abuse. When completing the GER in Therap® for use of a mechanical restraint, each of the fields under "Event Information" must be completed and the specific restraint device used should be fully described in the "Summary" field. Refer to additional requirements for use of an emergency mechanical restraint three or more times in a six-month period in Section 5.6.4 below.*

32) Restraint-Mechanical-Programmatic – Restricting a waiver participant's movement or function by use of an approved mechanical restraint device, specifically authorized and described in the waiver participant's behavior support plan (BSP), to control an identified action. Approved mechanical restraint devices include arm splints, wrist cuffs, or four- and five-point restraint devices of the quick-release type (e.g., Posey stockinette or Velcro wrist/ankle cuffs). Mechanical restraint does not include a seatbelt of a type found in an ordinary passenger vehicle or an age-appropriate child safety seat, a medically necessary device (such as a wheelchair seatbelt or a gait belt) used for supporting or positioning the waiver participant's body, or a device that is routinely used during a medical procedure for persons without developmental disabilities. The use of a mechanical restraint that has the potential to inhibit or restrict a waiver participant's ability to breathe or that is medically contraindicated, that has the potential to cause pain or harm, or if used as punishment, retaliation, or for the convenience of staff, is prohibited. Any type of restraint must only be used as a method of last resort and only when necessary to protect the waiver participant or others from injury. **Guidance:** *Mechanical restraint must*

cease immediately once risk of harm has passed. A programmatic mechanical restraint may only be applied by a staff member who has received specific training and has demonstrated competency in applying that specific mechanical restraint device prescribed in the waiver participant's BSP. Any programmatic use of a mechanical restraint requires approval by a Qualified Developmental Disabilities Professional (QDDP), Program Director, or Physician. A waiver participant in a mechanical restraint must be under constant visual supervision by staff. A GER is required for all mechanical restraints, even if the use is identified and authorized in the waiver participant's BSP. Any use of a mechanical restraint without the approval from a QDDP, Program Director, or Physician or use of a mechanical restraint device specified in the list above should be reported as an allegation of physical abuse. When completing the GER in Therap® for use of a mechanical restraint, each of the fields under "Event Information" must be completed and the specific restraint device used should be fully described in the "Summary" field.

3.2 Level of Harm / Therap® Notification Level

The determination of "level of harm" is based on an assessment of the degree to which the waiver participant sustained a physical injury, was harmed emotionally/psychologically, or the waiver participant's residence or personal property was harmed. The Level of Harm assigned to each incident is entered into the Therap® system as noted in the second column of the table below. For a more detailed identification of the Level of Harm assigned to each critical incident type, refer to Appendix A – Critical Incident Crosswalk Table.

Level of Harm	Therap® Notification Level	Level of Harm Description
1	Low	None
2	Medium	Injury or harm requiring treatment up to and including first aid
3	High	Injury or harm requiring medical treatment beyond first aid, including, but not limited to, incidents requiring an emergency room visit or hospital admission.
4	High	Injury or harm resulting in death

3.2.1 Level of Harm Descriptions

3.2.1.1 Description and Examples of Level of Harm-1 Incidents

An incident categorized as Level of Harm-1 is an incident that does not result in injury requiring treatment by a physician, licensed nurse, or other healthcare professional or any type of physical or emotional harm to a waiver participant. Examples of Level of Harm-1 incidents include, but are not limited to:

1) An injury that does not require treatment of by a physician, licensed nurse, or other healthcare professional;
2) A behavioral issue involving two or more waiver participants that does not result in physical or emotional injury or damage to property that costs less than $50;
3) A natural disaster that does not result in property damage to a waiver participant's home that requires evacuation or relocation;
4) A fire that does not result in injury to a waiver participant or damage to an object, building, or area of land;
5) A fall resulting in no injury or injury that does not require treatment of a licensed nurse or other medical professional; or
6) A Level 1 medication error that does not result in any adverse consequences for the waiver participant and no treatment other than monitoring or observation.

3.2.1.2 Description and Examples of Level of Harm-2 Incidents

An incident categorized as Level of Harm-2 is an incident that results in a minor or moderate injury requiring minimal (first aid) treatment or that results in minor property damage. Examples of Level of Harm-2 incidents include, but are not limited to:

1) An injury that requires treatment of a licensed nurse or other medical professional;
2) A fall resulting in an injury that requires treatment of a licensed nurse or other medical professional;
3) A behavioral issue that results in minor or moderate injury or property damage that costs more than $50 but less than $250;
4) A fire resulting in minor damage to an object, building, or area of land but no injury to a waiver participant or destruction of property;
5) An emergency room visit;
6) An unexpected or uncharacteristic seizure that results in no injury, minor injury, or moderate injury;

7) A Level 2 medication error in which a waiver participant experienced short term, reversible adverse consequences and required treatment or intervention in addition to monitoring and observation. If an individual is subject to a level 2 medication error, that individual must be sent to an Emergency Room for evaluation;
8) A choking incident that requires the Heimlich maneuver or other similar intervention but does not require hospitalization or result in death; or
9) Use of any type of restraint that does not result in a major injury.

3.2.1.3 Description and Examples of Level of Harm-3 Incidents

An incident categorized as Level of Harm-3 is an incident that results in harm requiring medical treatment beyond first aid. Examples of Level of Harm-3 incidents include, but are not limited to:

1) Any incident for which there is suspicion of physical, sexual, verbal, or emotional abuse, mistreatment, neglect, or exploitation;
2) A major injury;
3) Ahospital admission;
4) An incident involving a waiver participant who cannot be located and there is reason to believe he/she may be lost or in danger;
5) A behavioral issue that results in major injury or property damage that can be repaired/replaced at a cost more than $250;
6) A natural disaster resulting in a major injury, or evacuation/relocation from the waiver participant's home;
7) A fire resulting in injury to a waiver participant or destruction of property;
8) A fall resulting in a major injury to a waiver participant;
9) A seizure resulting in a major injury;
10) Any type of incident that requires the involvement of police or law enforcement;
11) A Level 3 medication error in which a waiver participant experienced life threatening and/or permanent adverse consequence(s);
12) A choking incident requiring hospitalization;
13) A behavioral incident resulting in major injury, significant damage to property, or the involvement of police/law enforcement; or
14) Use of any type of restraint that results in a major injury.

3.2.1.4 Description and Examples of Level of Harm-4 Incidents

An incident categorized as Level of Harm-4 is any incident that results in death of a waiver participant, whether from natural causes or one that is unexpected.

3.2.2 Mandatory Level of Harm 3 or Level of Harm 4 Rating for Certain Critical Incidents

3.2.2.1 Mandatory Level of Harm 3 Rating for Certain Critical Incidents

The following critical incident types are classified as Level of Harm 3 regardless of the circumstances or level of injury/harm sustained by the waiver participant:

1) Any critical incident that requires notification of the Department of Human Resources (DHR) including, but not limited to:
   a) Physical Abuse
   b) Sexual Abuse
   c) Verbal Abuse
   d) Emotional Abuse
   e) Neglect
   f) Mistreatment
   g) Exploitation
2) An incident involving a waiver participant who cannot be located and there is reason to believe he/she may be lost or in danger; or
3) Any incident that requires the involvement of Law Enforcement

3.2.2.2 Mandatory Level of Harm 4 Rating for Certain Critical Incidents

1) All deaths are categorized as Level of Harm 4 including natural deaths and unexpected deaths

3.2.3 Designation of Level of Harm in the Therap® system:

When entering a critical incident into the Therap® system, the Level of Harm is entered in the "Notification Level" field as follows:

1) Level of Harm 1 critical incidents are entered in Therap® as "Low" in the "Notification Level" field.
2) Level of Harm 2 critical incidents are entered in Therap® as "Medium" in the "Notification Level" field.
3) Level of Harm 3 critical incidents are entered in Therap® as "High" in the "Notification Level" field.
4) Level of Harm 4 critical incidents (deaths) are entered in Therap® as "High" in the "Notification Level" field.

SECTION 4 – MANDATORY REPORTERS, REQUIRED NOTIFICATIONS, REPORTING TIMELINES, AND THERAP® DATA ENTRY

4.1 Mandatory Reporters

4.1.1 What is a mandatory reporter?

Pursuant to requirements for reporting, investigation, and follow-up to critical incidents described in this IPMS manual and in accordance with ADMH-DDD program regulations, all certified community providers, support coordinators, and their staff members are mandatory reporters of all critical incidents involving a waiver participant receiving services from a contracted community residential and/or day program provider regardless of the location where the incident occurred. This includes incidents that occur during overnight visits or at other locations away from the provider's residential or program site. The initial critical incident report should include information that is readily available including but not limited to a description of the circumstances surrounding the incident, reports from staff, other waiver participants, family members, and any other persons who have information relevant to the incident.

4.1.2 Reporting Suspected Abuse, Neglect, Mistreatment, or Exploitation to the Department of Human Resources

Any caregiver or mandatory reporter having reasonable cause to believe that a waiver participant has been subjected to any type of physical abuse (including any peer-to-peer assault), sexual abuse (including any peer-to-peer unwanted or non-consensual sexual contact), verbal abuse, mistreatment, neglect, or exploitation must make an immediate report, followed by a written report using the "Report of an Adult Suspected To Be Abused, Neglected, or Exploited" form (Appendix H), to the County Department of Human Resources. To make the report you may:

1) Call the Alabama Adult Abuse Hotline at 1-800-458-7214 or contact the County Department of Human Resources (DHR)
2) Provide name, DOB, and address of the waiver participant(s) who was the alleged victim of the abuse, neglect, or exploitation
3) Provide name of service provider (residential, day program, other)
4) Provide a detailed description of the details of alleged abuse, neglect, or exploitation

4.2 Therap® Incident Management System Overview

In 2016, ADMH adopted the Therap® incident management system, a web-based system to document relevant information about reporting, investigation, and follow-up of critical incidents for agencies providing services and supports for waiver participants. The Therap® system provides 24-hour access for all users to facilitate real-time critical incident reporting. The system provides a structured framework and process for providers to thoroughly and accurately document all information related to each critical incident including date, time, and person making the report; required notifications; identification of witnesses and persons having relevant knowledge of the incident who are interviewed; the processes and procedures used to conduct the investigation; the findings of the investigation; and any and all immediate and longer-term corrective actions resulting from the investigation. The Therap® system also serves as the repository of all documents associated with the critical incident investigation. In the Therap® system, critical incident reports are referred to as General Event Reports (GERs) and completed investigations and related documentation are referred to as GER Resolutions.

4.2.1 General Event Reports (GERs) - A General Event Report (GER) contains three basic components:

1) **Initial Event Entry** – Creating a new GER as soon as possible after occurrence to document relevant information about what happened before the event; basic descriptive information about the event itself; immediate corrective actions taken; documentation of whether abuse/neglect/exploitation is suspected; and documentation of all required immediate notifications including identification of the person, date, and time of the notification.
2) **Event Review** - Documentation of the initial investigation of the incident; additions/modifications to the event description; description of planned future corrective actions; verification that all required notifications regarding the event have been completed; verification that the name of each person notified, and the date and time of each notification is documented; and any review and follow-up comments relevant to the initial investigation of the incident.

3) **Approval** – Final review of the content of the GER, verification that all required information is included and that the information is accurate. Approval is completed by and individual in the provider organization designated as responsible for the final review, accuracy/completeness verification, and approval process. The GER approval cannot be completed by the same person who initiated the GER.

4.2.2 General Event Report (GER) Resolutions

- A General Event Report (GER) Resolution is the documentation of the investigation process, findings, and recommendations for an incident involving suspected abuse, neglect, mistreatment, or exploitation. The GER Resolution contains the name of the person who completed the investigation, the details of the investigation, the persons involved in the investigation, the findings of the investigation, whether or not the suspected abuse, neglect, mistreatment, or exploitation was confirmed, the recommendations identified from the investigation, the supporting documents related to the investigation, and any general comments about the investigation process, findings, or recommendations.

4.2.3 Entering Critical Incidents in Therap® That Involve Multiple Events.

When entering a critical incident into the Therap® system that involves multiple related events, each of the related events must be entered into a single GER by using the "Add Another Event" button. By using this feature, all of the information linked to the critical incident is contained in a single GER saving time and effort in the data entry, in the subsequent investigation of the critical incident, and the immediate corrective actions and planned follow-up actions will relate to all of the events included in the GER rather than having to repeat them in multiple GERs. When entering each event, you must complete all of the fields related to that specific event type including whether or not there is suspected abuse, suspected neglect, or suspected exploitation related to that event.

1) **Example 1 (Two Event Types In One GER):**
   a) **Scenario:** A waiver participant falls, sustains a laceration to the head from the fall, is sent to the ER for evaluation and is subsequently admitted to the hospital to be observed for issues related to a diagnosed concussion.
   b) **Process for Entry Into Therap®:** The fall and subsequent treatment would be entered as "Event Type-Injury", "Notification Level-High", "Type-Laceration", "Cause-Fall", "Severity-Severe (Hospital/ER Admission)", "Treatment By-ER/Hospital". Upon completing all of the fields necessary to describe the fall and resulting injury, you would then use the "Add Another Event" button and begin entry of the hospital admission. That event would be entered as "Event Type-Other", "Type-Hospital", "Event Subtype-Admission", "Department-Medical". Both of these events would now become a part of the single GER and your immediate corrective actions and planned corrective actions can be added to address both in a single set of entries on the final GER screen. You must complete all data fields for each type of incident including, but not limited to, those noted above.

2) **Example 2 (Three Event Types In One GER):**
   a) **Scenario:** A waiver participant chokes on food at the breakfast meal resulting in aspiration, 911 is called, is transported to the Emergency Room, and is admitted to the hospital with a diagnosis of aspiration pneumonia and dies 2 hours after admission to the hospital.
   b) **Process for Entry Into Therap®:** The choking incident is entered as "Event Type-Injury", "Notification Level-High", "Type-Choking", "Cause-Other", "Severity-Severe (Hospital/ER Admission)", "Treatment By-ER/Hospital". You then use the "Add Another Event" button and begin entry of the hospital admission. That event would be entered as "Event Type-Other", "Event Type-Hospital", "Event Subtype-Admission", "Department-Medical". You then use the "Add Another Event" button again and begin entry of the death. That event would be entered as "Event Type-Death", "Notification Level-High", "Specific Location-Hospital", "Cause of Death-Sudden/Unexpected". You must complete all data fields for each type of incident including, but not limited to, those noted above.
   c) **Note:** In this scenario, if the waiver participant had been admitted to the hospital but did not die within 24 hours, you would complete one GER for the choking incident and the hospital admission. When the death occurs more than 24 hours later, you would initiate a separate GER to enter the details of the death referencing information from the original GER in the narrative sections.

4.2.4 Required Notifications and Therap® Data Entry Instruction Table

- The following table provides detailed guidance that identifies persons/entities that are required to be notified for critical incidents that fall into each Level of Harm category. The table also provides specific instructions as to how these notifications must be recorded in the Therap® system. It is important that providers assure their SCOMM notification is turned on in the Therap® system to ensure receipt of all communications regarding a GER or GER Resolution.

Level of Harm	Required Notifications	All required notifications are to be made <u>as soon as possible but not later than</u>:	How to enter into Therap® in the "Additional Notifications" field – complete all required sub-fields
1	Supervisor/Manager/Administrator	Within 1 hour after the occurrence or discovery of the incident	Manager or Day Program Manager
1	Behavior Specialist (if it is a behavioral issue)	Within 48 hours after the occurrence or discovery of the incident	Behavior Specialist
1	Family/Guardian/Designated Contact	Within 48 hours after the occurrence or discovery of the incident	Family/Guardian
1	Support Coordinator	Within 48 hours after the occurrence or discovery of the incident	Case Manager
1	Medication Assistance Supervising (MAS) Nurse	Immediately for determination of the need for assessment/treatment	Nurse/Medical Personnel
2	Medication Assistance Supervising (MAS) Nurse (if assessment or treatment may be required or if the incident is a Level 2 medication error)	Immediately for determination of the need for assessment/treatment and initiation of the investigation regarding the Level 2 medication error	Nurse/Medical Personnel
2	Alabama Adult Abuse Hotline at 1-800-458-7214 or County Department of Human Resources (if self-neglect is alleged)	Within 1 hour after the occurrence or discovery of the incident	Adult/Child Protective Services
2	Supervisor/Manager/Administrator	Within 1 hour after the occurrence or discovery of the incident	Manager or Day Program Manager
2	Behavior Specialist (if it is a behavioral issue or restraint)	Within 24 hours after the occurrence or discovery of the incident	Behavior Specialist
2	Family/Guardian/Designated Contact	Within 24 hours after the occurrence or discovery of the incident	Family/Guardian
2	Regional Community Services (RCS) Office	Within 24 hours after the occurrence or discovery of the incident	Other (enter RCS Office in description field)
2	Support Coordinator	Within 24 hours after the occurrence or discovery of the incident	Case Manager
3	Medication Assistance Supervising (MAS) Nurse (if assessment or treatment may be required or if the incident is a Level 2 or 3 Medication Error)	Immediately for determination of the need for assessment/treatment and initiation of the investigation regarding the Level 2 or 3 medication error	Nurse/Medical Personnel
3	Fire Department (if the fire department is requested to come to the site of the incident related to a fire – does not include EMS/ambulance request)	Immediately	Police (designate fire department in description field)

Level of Harm	Required Notifications	All required notifications are to be made <u>as soon as possible but not later than</u>:	How to enter into Therap® in the "Additional Notifications" field – complete all required sub-fields
3	Law Enforcement (if law enforcement is requested to come to the site of the incident)	Immediately	Police
3	Emergency Medical Services (EMS) if the waiver participant requires ambulance transport to an emergency room or hospital.	Immediately or upon instruction from Nursing/Medical personnel	Other (enter "EMS" in description field
3	Alabama Adult Abuse Hotline at 1-800-458-7214 or County Department of Human Resources	Within 1 hour after the occurrence or discovery of the incident	Adult/Child Protective Services
3	Supervisor/Manager/Administrator	Within 1 hour after the occurrence or discovery of the incident	Manager or Day Program Manager
3	Regional Community Services (RCS) Office	Within 1 hour after the occurrence or discovery of the incident	Other (enter RCS Office in description field)
3	ADMH Bureau of Special Investigations (BSI) (***notification done by RCS Office staff***)	Within 1 hour after receiving the incident notification from the program provider	RCS staff enters Police (enter "ADMH-BSI" in description field)
3	Support Coordinator	Within 1 hour after the occurrence or discovery of the incident	Case Manager
3	Family/Guardian/Designated Contact	Within 24 hours after the occurrence or discovery of the incident	Family/Guardian
3	State Office Incident Management Coordinator (***notification done by RCS Office staff***)	Within 24 hours after the occurrence or discovery of the incident	RCS staff enters Other (enter "State Office IMC" in description field)
4	Medication Assistance Supervising (MAS) Nurse	Immediately	Nurse/Medical Personnel
4	Fire Department (if the fire department is requested to come to the site of the incident related to a fire – does not include EMS/ambulance request)	Immediately	Police (designate fire department in description field)
4	Law Enforcement (if law enforcement is requested to come to the site of the incident)	Immediately	Police
4	Emergency Medical Services (EMS) if the waiver participant requires ambulance transport to an emergency room or hospital.	Immediately or upon instruction from Nursing/Medical personnel	Other (enter "EMS" in description field
4	Alabama Adult Abuse Hotline at 1-800-458-7214 or County Department of Human Resources	Immediately (within 1 hour)	Adult/Child Protective Services
4	Supervisor/Manager/Administrator	Immediately (within 1 hour)	Manager or Day Program Manager
4	Family/Guardian/Designated Contact	Immediately (within 1 hour)	Family/Guardian
4	Regional Community Services (RCS) Office	For unexpected deaths – immediately (within 1 hour) For natural deaths - within 24 hours	Other (enter RCS Office in description field)

Level of Harm	Required Notifications	All required notifications are to be made as soon as possible but not later than:	How to enter into Therap® in the "Additional Notifications" field – complete all required sub-fields
4	ADMH Bureau of Special Investigations (BSI) **(*notification done by RCS Office staff for unexpected deaths only)***	RCS staff will notify BSI within 1 hour after receiving the incident notification of the unexpected death from the program provider	RCS staff enters Police (enter "ADMH-BSI" in description field)
4	Support Coordinator	For unexpected deaths – immediately (within 1 hour) For natural deaths - within 24 hours)	Case Manager
4	• State Office Incident Management Coordinator (for unexpected deaths only) • Associate Commissioner (for unexpected deaths only) (***notification done by State Office Incident Mgt Coordinator***)	Notification of State Office IMC and Associate Commissioner is required for unexpected deaths only, is done by RCS staff, and must be done within 24 hours of discovery or notification of the unexpected death from the provider or support coordinator.	RCS staff enters Other (enter "State Office IMC" in description field)

SECTION 5 – WHO CONDUCTS THE CRITICAL INCIDENT INVESTIGATION?

1) All critical incidents require some level of investigation.
2) The scope and intensity of the investigation should be commensurate with the incident's Level of Harm determination.
    a. The provider (or the support coordinator if the individual is enrolled in self-directed services or personal care services only) is responsible for reporting and fully completing a GER in the Therap® system for the following critical incident types:
        i. All Level of Harm-1 Incidents
        ii. All Level of Harm-2 Incidents
        iii. Suspected Verbal Abuse
        iv. Suspected Neglect
        v. Suspected Self-Neglect
        vi. Suspected Mistreatment
        vii. Suspected Exploitation
        viii. Moderate Injury
        ix. Emergency Room Visit
        x. Hospital Admission
        xi. Natural Disaster (if Level of Harm-1 or Level of Harm-2)
        xii. Fire (if Level of Harm-1 or Level of Harm-2)
        xiii. Fall
        xiv. Seizure
        xv. Other Incident
        xvi. Medication Error (Level 1 or Level 2)
        xvii. Choking
        xviii. Behavioral Issue
        xix. All types of restraint (Manual, Mechanical or Chemical)
    b. For incidents involving suspected verbal abuse, neglect, self-neglect, mistreatment, or exploitation, unless instructed by law enforcement, the ADMH Bureau of Special Investigations, the Department of Human Resources, or the Regional Community Services office, the provider (or the support coordinator if the individual is enrolled in self-directed services or personal care services only) must complete:
        i. A GER Resolution in the Therap® system, and
        ii. A written investigation report attached to the GER Resolution in the Therap® system.
        iii. The provider may choose to complete a written investigation report on an incident not involving suspected verbal abuse, neglect, self-neglect, mistreatment, or exploitation but one is not required.

c. The provider (or the support coordinator if the individual is enrolled in self-directed services or personal care services only) is responsible for fully completing a GER in the Therap® system and the Regional Community Services Office is responsible for completing the investigation and a GER Resolution in the Therap® system for the following incident types:
    i. Suspected physical abuse
    ii. Suspected sexual abuse
    iii. Suspected emotional abuse
    iv. Major injury
    v. Unexpected Death
    vi. Missing/Eloped Individual
    vii. Natural Disaster (if Level of Harm-3 or Level of Harm-4)
    viii. Fire (if Level of Harm-3 or Level of Harm-4)
    ix. Medication Error (Level 3)
d. The provider is responsible to complete a GER and a Comprehensive Mortality Review for all Level of Harm-4 incidents.

3) The primary focus areas for completing a GER, GER Resolution, or written investigation report include:
    a. Determination of relevant history - whether the current incident may relate to a trend or pattern of similar incidents involving the waiver participant(s) in the past.
    b. Determination of whether staff involved in the incident followed relevant policies and procedures prior to and in response to the incident.
    c. Determination of staff involved in the incident received proper training and instruction.
    d. Determination if changes in policies, procedures, or protocols are warranted based on the results of the investigation.
    e. Identification of any follow-up or corrective actions that may be identified as necessary from the findings of the investigation.
4) If an incident occurs in a day program, the day program provider is responsible for completing the GER in the Therap® system and completing all required follow-up activities including, but not limited to, all required notifications. If the waiver participant is enrolled in residential services, the day program provider must also notify the residential provider of the incident that was reported.
5) If an allegation of abuse, neglect, mistreatment, or exploitation is reported to the day program provider, the day program provider is responsible for reporting the incident to the Department of Human Resources, to the Regional Community Services Office, and to the residential provider. The Regional Community Services Office will be responsible for conducting the investigation for any allegation of abuse, neglect, mistreatment, or exploitation that is reported to or occurs in the day program provider location.
6) If the waiver participant is enrolled in self-directed services, the support coordinator fulfills the responsibilities of the provider.
7) The ADMH Rights Protection and Advocacy Program may also investigate critical incidents. If the Advocacy Program chooses to investigate, they will notify the RCS office.

5.1 Procedures To Be Followed For all Critical Incidents:

1) The provider must take all immediate actions necessary to ensure the safety of all waiver participants involved in or at risk of harm related to the incident.
2) The provider must ensure immediate assessment and treatment of any injuries sustained by waiver participants involved in the incident.
3) The provider must identify any witnesses or potential witnesses to the incident and, as soon as possible, collect relevant information from each of these witnesses as to their knowledge of the precursors to the incident, the incident itself, and any relevant actions or activities that occurred immediately following the incident.

5.2 Level of Harm-1 – Therap® Notification Level-Low

1) **Creation of the General Event Report (GER) –** A provider staff member who has direct knowledge of the incident and the individual(s) involved gathers relevant information about the incident and initiates a General Event Report (GER) in the Therap® system. Each field on the GER must be completed and the GER fields must include:
    a) A full and complete description of relevant information about what happened before the incident;
    b) A full and complete description of the incident itself;

c) Whether abuse, neglect, or exploitation is suspected related to the incident [NOTE: if abuse, neglect, or exploitation is suspected, the incident automatically becomes a Level of Harm-3 and procedures for that type of incident detailed below must be followed];
d) Documentation of all required notifications made regarding the incident; and
e) A description of any immediate follow-up and corrective actions taken related to the incident.
f) The GER must be entered into the Therap® system as soon as possible but must be entered in sufficient time to allow for supervisory/management staff review and approval of the GER not more than 48 hours after the occurrence or discovery of the incident.

2) **Responsible Relative/Guardian/Designated Contact Notification-** The provider must notify the waiver participant's responsible relative/guardian as soon as possible, but no later than 24 hours after the occurrence or discovery of the incident. Documentation of this contact is recorded in the GER in the Therap® system. All fields listed under the contact information (name of person contacted, date and time of notification, who made the notification, and the method of notification) must be completed.
3) **GER Approval –** A supervisory/management staff member (not the person who completed the initial content of the GER) must review the GER and verify that it contains all relevant and required information and that the information is accurate using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide, This verification must be completed in the Therap® system as soon as possible but not more than 48 hours after the occurrence or discovery of the incident.
4) **Regional Office Initial GER Review –** Upon receiving notification of the GER in the Therap® system, the Regional Incident Management Coordinator reviews the GER content to determine if it is complete and accurate using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide, making corrections as deemed appropriate. If there are concerns about the GER content, the Regional Incident Manager contacts the provider via phone with a follow-up email describing what needs to be completed/revised in the GER and informing the provider that those revisions must be completed in the Therap® system as soon as possible but not more than three working days after the notice. The Regional Community Services Director reserves the right to initiate an investigation into any incident as he/she deems necessary.
5) **Final Review, Approval and Closure of the GER –** Upon receiving notification of the address of the questions/recommendation by the provider in the GER, the Regional Incident Management Coordinator reviews the final GER using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. If the GER is complete and contains all required elements, the Incident Management Coordinator documents approval and closure of the GER in the Therap® system by checking the box "I have reviewed and approved this report" and adding a comment to indicate that there is no additional follow-up action pending or needed.
6) **No GER Resolution Required** – GER Resolutions are required only for critical incidents involving suspected abuse, neglect, mistreatment, and exploitation.

5.3 Level of Harm-2 – Therap® Notification Level-Medium

1) **Creation of the General Event Report (GER)** – A provider staff member who has direct knowledge of the incident and the individual(s) involved gathers relevant information about the incident and initiates a General Event Report (GER) in the Therap® system. Each field on the GER must be completed and the GER fields must include:
a) A full and complete description of relevant information about what happened before the incident;
b) A full and complete description of the incident itself;
c) Whether abuse, neglect, or exploitation is suspected related to the incident [NOTE: if any type of abuse, neglect, or exploitation is suspected, the incident automatically becomes a Level of Harm-3 and procedures for that type of incident detailed below must be followed];
d) A description of any immediate nursing/medical assessment and treatment of the waiver participant;
e) Documentation of all required notifications made regarding the incident; and
f) A description of any immediate follow-up and corrective actions taken related to the incident.
g) A description of "Plan for Future Corrective Actions" field under the "Actions Taken" section.
h) The GER must be entered into the Therap® system as soon as possible but allowing sufficient time for supervisory/management staff review and approval of the GER not more than 48 hours after the occurrence or discovery of the incident.

2) **Relative/Guardian/Designated Contact Notification** – The provider must notify the waiver participant's responsible relative/guardian as soon as possible, but not more than 24 hours after the occurrence or discovery of the incident. Documentation of this contact is recorded in the GER in the Therap® system. All fields listed under the contact information (name of person contacted, date and time of notification, who made the notification, and the method of notification) must be completed.

3) **GER Approval –** A supervisory/management staff member (not the person who completed the initial content of the GER) must review the GER and verify that it contains all relevant and required information and that the information included is accurate using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. Upon verifying the accuracy and completeness of the information in the GER, the supervisory/management staff member approves the GER in the Therap® system. The review, verification, and approval of the information in the GER must be documented in the Therap® system as soon as possible but not more than 48 hours after the occurrence or discovery of the incident.
4) **Additional Medication Error Reporting –** If the incident is a Level 2 medication error, it must also be reported on a Medication Error Report (Form NDP-4 – Appendix G) completed by the MAS RN/LPN. When completed, the Medication Error Report should be emailed or faxed directly to the Alabama Department of Mental Health Nurse Delegation Program (AMH/NDP) Office within 24 hours of notification/discovery of the error. All requested information should be provided including a description of the error focusing on the outcome to the consumer – signs, symptoms, ER visit, etc. A copy of the completed Medication Error Form must also be attached electronically to the GER.
5) **Regional Office Initial GER Review –** Upon receiving notification of the GER in the Therap® system, the Regional Incident Management Coordinator reviews the GER content to determine if it is complete and accurate using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide, making corrections as deemed appropriate. If there are concerns about the GER content, the Regional Incident Management Coordinator contacts the provider via phone with a follow-up email describing what needs to be completed/revised in the GER and informing the provider that those revisions must be completed in the Therap® system as soon as possible but not more than three working days after the notice. The Regional Community Services Director reserves the right to initiate an investigation into any incident as he/she deems necessary.
6) **Initial Incident Review in Weekly RCS Incident Review Committee –** The Regional Incident Management Coordinator will review the content of the GER in the next weekly Regional Incident Review Committee Meeting and, if there are any questions/recommendations from the Incident Review Committee, contact the provider to address those questions/recommendations and to note responses in the GER in the Therap® system. The provider is responsible to complete and document their follow-up to the questions/recommendations in the GER in the Therap® system as soon as possible but not more than three working days after the notice. Documentary evidence of address of each of the follow-up actions must be attached electronically to the GER in the Therap® system.
7) **Final Review, Approval and Closure of the GER** – Upon receiving notification of the address of the questions/recommendations by the provider in the GER, the Regional Incident Management Coordinator reviews the answers follow-up questions, if there are any, the Regional Incident Management Coordinator will review the GER in the next Regional Incident Review Committee meeting. If the team agrees that all requested information has been received, the Regional Incident Management Coordinator documents approval and closure of the GER in the Therap® system by checking the box "I have reviewed and approved this report" and adding a comment to indicate that there is no additional follow-up action pending or needed.

5.4 Level of Harm-3 – Therap® Notification Level-High

1) **For all Level of Harm 3 Critical Incidents:**
   a) **Creation of the General Event Report (GER) –** A provider staff member who has direct knowledge of the incident and the waiver participant(s) involved gathers relevant information about the incident and initiates a General Event Report (GER) in the Therap® system. Each field on the GER must be completed and the GER must include:
      i) A full and complete description of relevant information about what happened before the incident;
      ii) A full and complete description of the incident itself;
      iii) Whether abuse, neglect, or exploitation is suspected related to the incident;
      iv) A description of any immediate nursing/medical assessment and treatment of the waiver participant;
      v) Documentation of all notifications made regarding the incident; and
      vi) A description of any immediate follow-up and corrective actions taken related to the incident.
      vii) The GER must be entered into the Therap® system as soon as possible but allowing sufficient time for supervisory/management staff review and approval of the GER not more than 24 hours after the occurrence or discovery of the incident.
   b) **Level of Harm 3 Incidents That Must Be Reported to the Department of Human Resources** – If the incident involves suspicion of physical abuse (including peer-to-peer assault) or sexual abuse (including peer-to-peer unwanted or non-consensual sexual contact), mistreatment, verbal abuse, neglect, self-neglect, or exploitation, the provider staff will notify the Alabama Department of Human Resources (DHR) immediately but not more than one hour after the occurrence or discovery of the incident and provide DHR with relevant information about the incident and the suspicion of abuse, neglect, mistreatment, or exploitation.

c) **ADMH Bureau of Special Investigations Notification by RCS Office Staff**: If the incident involves suspicion of physical abuse (including any peer-to-peer assault), sexual abuse (including any peer-to-peer unwanted or non-consensual sexual contact), verbal abuse, mistreatment, neglect, or exploitation, the RCS office will notify the ADMH Bureau of Special Investigations (law enforcement) immediately but not more than 1 hour after receiving the initial report from the program provider. The ADMH Bureau of Special Investigations will coordinate, as necessary, with local law enforcement regarding the circumstances of the reported incident and any additional law enforcement involvement that may be related to the incident.

d) **Relative/Guardian/Designated Contact Notification** – The provider must notify the waiver participant's responsible relative/guardian as soon as possible, but not more than 24 hours after the occurrence or discovery of the incident. Documentation of this contact is recorded in the GER in the Therap® system. All fields listed under the contact information (name of person contacted, date and time of notification, who made the notification, and the method of notification) must be completed.

2) **Level of Harm 3 Incidents Requiring Regional Community Services (RCS) Office Investigation**:

a) The RCS Office is responsible to initiate and investigate the following types of critical incidents:

i) Suspicion of physical abuse or sexual abuse (including peer-to-peer unwanted or non-consensual sexual contact);
ii) Peer-to-peer assault (resulting in moderate or major injury);
iii) A major Injury;
iv) An incident involving a waiver participant who cannot be located and there is reason to believe he/she may be lost or in danger;
v) A natural disaster resulting in a major injury, evacuation/relocation from the waiver participant's home, or death;
vi) A fire resulting in injury to a waiver participant, destruction of property, or death;
vii) A level 3 medication error in which a waiver recipient experienced life-threatening and/or permanent adverse consequence(s);
viii) A restraint of any type resulting in moderate or major injury; or
ix) An emergency mechanical restraint.

b) The following procedures are to be followed for Level of Harm 3 incidents investigated by the RCS Office:

i) **ADMH-DDD Regional Community Services (RCS) Office Notification** – The provider must notify the RCS office immediately but not more than one hour after the occurrence or discovery of the incident. If outside regular working hours, the provider will call and leave a message on the regional office on-call phone.
ii) **Assignment of RCS Investigator** – The RCS Director will assign a Qualified RCS staff member to conduct the investigation and set a deadline for completion and submission of the investigation report that allows for review and approval of the investigation report by the RCS Director within 15 working days from the date of the incident. An extension of this deadline can only be granted by the RCS Director.
iii) **GER Approval –** A supervisory/management staff member (not the person who completed the initial content of the GER) must review the GER and verify that it contains all relevant and required information and that the information is accurate using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. This verification must be completed in the Therap® system as soon as possible but not more than 24 hours after the occurrence or discovery of the incident.
iv) **Additional Medication Error Reporting –** If the incident is a Level 3 medication error, it must also be reported on a Medication Error Report (Form NDP-4 – Appendix G) completed by the MAS RN/LPN. When completed, the Medication Error Report should be emailed or faxed directly to the Alabama Department of Mental Health Nurse Delegation Program (AMH/NDP) Office within 24 hours of notification/discovery of the error. All requested information should be provided including a description of the error focusing on the outcome to the consumer – signs, symptoms, ER visit, etc. A copy of the completed Medication Error Form must also be attached electronically to the GER.
v) **Regional Office Initial GER Review –** Upon receiving notification of the GER in the Therap® system, the Regional Incident Management Coordinator reviews the GER content to determine if it is complete and accurate using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide, making corrections as deemed appropriate. If there are concerns about the GER content, the Regional Incident Manager contacts the provider via phone with a follow-up email describing what needs to be completed/revised in the GER and informing the provider that those revisions must be completed in the Therap® system as soon as possible but not more than three working days after the notice. The Regional Community Services Director reserves the right to initiate an investigation into any incident as they deem necessary.
vi) **Verification of Assignment of RCS Investigator – The** Regional Incident Management Coordinator will verify that a Qualified RCS staff member has been assigned responsibility to conduct the investigation, will enter the name of the qualified RCS staff member assigned to conduct the investigation, and the date when that investigation is to

be completed in the "Plan for Future Corrective Actions" field under the "Actions Taken" section in the GER, and will notify the provider that the RCS office will be conducting the investigation.

vii) **Initial Incident Review in Weekly RCS Incident Review Committee –** The Regional Incident Management Coordinator will review the content of the GER in the next weekly Regional Incident Review Committee Meeting and, if there are any questions/recommendations from the Incident Review Committee, assure that the qualified RCS staff member responsible for conducting the investigation is made aware of the questions/concerns and addresses them in the investigation report.

viii) **RCS Investigation Completion and Approval –** The qualified RCS staff member conducting the investigation must complete the investigation report by the assigned date and submit the report to the RCS Director for review and approval using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. The RCS Director must approve the report no later than 15 working days after the occurrence or discovery of the incident. A copy of the approved investigation report will be provided to the Regional Incident Management Coordinator for further follow-up action and attachment to the GER (for critical incidents not involving suspected abuse, neglect, mistreatment, or exploitation) or the GER Resolution (for incidents involving suspected abuse, neglect, mistreatment, or exploitation).

ix) **GER Resolution Completion –** Upon completion of the follow-up investigation for incidents involving suspected abuse, neglect, mistreatment, or exploitation, the Regional Incident Management Coordinator will ensure that a GER Resolution is initiated in the Therap® system using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. The GER Resolution, or the investigation report attached to the GER or GER Resolution, must fully and completely describe the investigation process, persons interviewed, evidence collected, the findings of the investigation, and a list of any recommendations for follow-up action to be taken by the provider in response to the incident.

x) **Results Follow-up to and From the Provider –** The Regional Incident Management Coordinator will provide relevant information about the investigation findings and recommendations for follow-up action to the provider. The provider must submit documentary evidence of address of each of the recommendations to the Regional Incident Management Coordinator as soon as possible but not more than 30 calendar days after receiving the information from the Regional Incident Management Coordinator. Documentary evidence of address of each of the follow-up actions must be attached electronically to the GER (for incidents not involving suspected abuse, neglect, mistreatment, or exploitation) or the GER Resolution (for incidents involving suspected abuse, neglect, mistreatment, or exploitation) in the Therap® system.

xi) **Final Review, Approval and Closure of the GER** – Upon receiving notification of the address of the questions/recommendations by the provider in the GER or GER Resolution, the Regional Incident Management Coordinator reviews the final GER or GER Resolution and if it is complete and contains all required elements using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. The Regional Incident Management Coordinator is responsible to close the GER in the Therap® system.

(1) If the GER is complete and contains all required elements, the Incident Management Coordinator documents approval and closure of the GER in the Therap® system by checking the box "I have reviewed and approved this report" and adding a comment to indicate that there is no additional follow-up action pending or needed.

(2) If the GER/GER Resolution is complete, the Incident Management Coordinator verifies that the incident required investigation and then selects the type of allegation that was investigated and the findings. Upon completing these steps, the Incident Management Coordinator enters the date that the GER/GER Resolution is to be closed in the "Date Closed" field and selects the "Close" button at the bottom of the GER/GER Resolution screen.

3) **Level of Harm 3 Incidents Investigated by the Provider:**

a) The provider is responsible to initiate and investigate the following types of critical incidents:

i) Peer-to-peer altercation that results in no or minor injury;
ii) Suspected emotional abuse, verbal abuse, neglect, mistreatment, or exploitation;
iii) COVID 19 diagnosis (for waiver participants receiving residential supports);
iv) Emergency room visit;
v) Hospital admission;
vi) Incidents categorized as "Other incident";
vii) Choking incidents resulting in an emergency room visit or hospital admission; or
viii) A behavioral issue that results in major injury or property damage that can be repaired/replaced at a cost more than $250.

b) The Regional Community Services Director reserves the right to initiate an investigation into any incident, regardless of incident type or Level of Harm designation, as he/she deems necessary.

c) The following procedures are to be followed for Level of Harm 3 incidents investigated by the provider:

i) **Provider Assignment of Investigator –** The supervisory/management staff member assigns responsibility to a specific provider staff member to conduct the follow-up investigation and sets the date when that investigation must be completed. The timeframe for completion must allow sufficient time for review and approval of the investigation by the supervisory/management staff within the mandatory 15-day timeframe by which investigations must be completed. The name of the person assigned to conduct the investigation and the date when that investigation is to be completed must be documented in the GER in the "Plan for Future Corrective Actions" field under the "Actions Taken" section. The review, verification, and approval of the information in the initial GER including the assignment of responsibility for completing the follow-up investigation must be documented in the Therap® system as soon as possible but not more than 24 hours after the occurrence or discovery of the incident.

ii) **Regional Office Initial GER Review –** Upon receiving notification of the GER in the Therap® system, the Regional Incident Management Coordinator reviews the GER content to determine if it is complete and accurate using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide, making corrections as deemed appropriate. If there are concerns about the GER content, the Regional Incident Manager contacts the provider via phone with a follow-up email describing what needs to be completed/revised in the GER and informing the provider that those revisions must be completed in the Therap® system as soon as possible but not more than three working days after the notice. The Regional Community Services Director reserves the right to initiate an investigation into any incident as they deem necessary.

iii) **Initial Incident Review in Weekly RCS Incident Review Committee –** The Regional Incident Management Coordinator will review the content of the GER in the next weekly Regional Incident Review Committee Meeting and, if there are any questions/recommendations from the Incident Review Committee, contact the provider to address those questions/recommendations and note responses in the GER in the Therap® system. The provider is responsible to complete and document their follow-up to the questions/recommendations in the GER in the Therap® system as soon as possible but not more than 3 working days after the notice.

iv) **GER Resolution Completion –** Upon completion of the follow-up investigation for incidents involving suspected abuse, neglect, mistreatment, or exploitation, the provider enters information in a GER Resolution in the Therap® system using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. The GER Resolution must fully and completely describe the investigation process, persons interviewed, evidence collected, the findings of the investigation, and a list of all follow-up actions to be taken by the provider in response to the incident. Each follow-up action must include a specific staff member assigned responsibility for assuring the follow-up is successfully completed and the date by which this follow-up must be completed. The GER Resolution including approval by supervisory/management staff must be entered into the Therap® system as soon as possible but not more than 15 working days after the occurrence or discovery of the critical incident.

v) **Final Incident Review in Weekly RCS Incident Review –** Upon receiving notice of the GER Resolution in the Therap® system for incidents involving suspected abuse, neglect, mistreatment, or exploitation, the Regional Incident Management Coordinator reviews the GER Resolution and the information in the related GER in the next weekly Regional Incident Review Committee Meeting. If there are any questions/recommendations from the Incident Review Committee, the Regional Incident Management Coordinator contacts the provider to address those questions/recommendations and note responses in the GER Resolution in the Therap® system. The provider is responsible to complete and document their follow-up to the questions/recommendations in the GER Resolution in the Therap® system as soon as possible but not more than three working days after the notice.

vi) **Results Follow-up to and From the Provider** – The provider must provide documentary evidence of address of each of the recommendations not more than 30 calendar days after the occurrence or discovery of the incident. Documentary evidence of address of each of the follow-up actions must be attached electronically to the GER Resolution in the Therap® system.

vii) **Final Review, Approval and Closure of the GER/GER Resolution** – Upon receiving notification of the address of the questions/recommendations by the provider in the GER Resolution, the Regional Incident Management Coordinator reviews the final GER Resolution and if it is complete and contains all required elements using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. The Regional Incident Management Coordinator is responsible to close the GER/GER Resolution in the Therap® system.

(1) If the GER is complete and contains all required elements, the INCIDENT MANAGEMENT COORDINATOR documents approval and closure of the GER in the Therap® system by checking the box "I have reviewed and

approved this report" and adding a comment to indicate that there is no additional follow-up action pending or needed.

(2) If the GER Resolution is complete, the INCIDENT MANAGEMENT COORDINATOR verifies that the incident required investigation and then selects the type of allegation that was investigated and the findings. Upon completing these steps, the IMC enters the date that the GER Resolution is to be closed in the "Date Closed" field and selects the "Close" button at the bottom of the GER Resolution screen.

5.5 Level of Harm-4 – Therap® Notification Level-High (Deaths)

5.5.1 – For A Natural Death:

1) **Creation of the General Event Report (GER)** Provider staff with direct knowledge of the incident and the individual(s) involved gathers relevant information about the incident and initiates a General Event Report (GER) in the Therap® system. Each field on the GER must be completed and the GER fields must include:
   a) A full and complete description of relevant information about what happened before the death;
   b) A full and complete description of the circumstances of the death;
   c) Documentation of all notifications made regarding the death; and
   d) A description of any immediate follow-up and corrective actions taken related to the death.
   e) The GER must be entered into the Therap® system as soon as possible but allowing sufficient time for supervisory/management staff review and approval of the GER not more than 24 hours after the occurrence or discovery of the incident.
2) **Relative/Guardian/Designated Contact Notification** – If the death occurs while in the care of the provider, the provider must notify the waiver participant's responsible relative/guardian immediately, but not more than 24 hours after the time of death. If the death occurs while away from the care of the provider, e.g., in a hospital or other acute health care location, the first agency to become aware of the death is responsible for the notification. In either circumstance, the provider must verify that the notification occurred and record the notification date and time in the GER in the Therap® system. All fields listed under the contact information (name of person contacted, date and time of notification, who made the notification, and the method of notification) must be completed.
3) **Regional Office Initial Notification –** The provider must notify the Regional Community Services office of a natural death within 24 hours after the occurrence or discovery of the death. If outside regular working hours, the provider will call and leave a message on the regional office on-call phone.
4) **GER Approval –** A supervisory/management staff member (not the person who completed the initial content of the GER) must review the GER and verify that it contains all relevant and required information and that the information included is accurate using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. Upon verifying the accuracy and completeness of the information in the GER, the supervisory/management staff member assigns responsibility to conduct a Comprehensive Mortality Review of the death (see details in §4.5.3 below) and sets the date when the comprehensive mortality review must be completed.
5) **Comprehensive Mortality Review -** A Comprehensive Mortality Review must be conducted for all deaths.
   a) The Comprehensive Mortality Review report must follow the structure and required content of the ADMH Comprehensive Mortality Review Template (see Attachment B) and must include relevant demographic data, health information, information related to hospital admission (if death occurred at a hospital), any emergency medical care/treatment provided, medications prescribed at the time of death, circumstances of the death, autopsy findings if one was conducted, and recommendations for policy, procedure or process changes relevant to the investigation of the death.
   b) Assignment to complete the Comprehensive Mortality Review:
      i) The program provider supervisory/management staff assigns responsibility to complete the Comprehensive Mortality Review to a nurse.
      ii) If the waiver participant is enrolled in self-directed services, the support coordinator will report the death to the Regional Community Services (RCS) office and provide as much information about the death as possible or available respecting the rights and privacy of the immediate family. The support coordinator will request the death certificate from the family/provider. The support coordinator will enter a GER of the event in the Therap® system within 24 hours of learning about the death. The RCS Director will assign responsibility for completion of the Comprehensive Mortality Review to the Regional Nurse.
   c) The review, verification, and approval of the information in the initial GER including the assignment of responsibility for completing the Comprehensive Mortality Review must be documented in the Therap® system as soon as possible but not more than 24 hours after the occurrence or discovery of the incident.

d) The supervisory/management staff member (or RCS Director, if the waiver participant was in self-directed services) must assure documentation of the name of the nurse assigned to conduct the Comprehensive Mortality Review and the date when that review is to be completed in the GER in the "Plan for Future Corrective Actions" field under the "Actions Taken" section.

6) **Regional Office Initial GER Review –** Upon receiving notification of the GER in the Therap® system, the Regional Incident Management Coordinator reviews the GER content to determine if it is complete and accurate using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide, making corrections as deemed appropriate. If there are concerns about the GER content, the Regional Incident Manager contacts the provider via phone with a follow-up email describing what needs to be completed/revised in the GER and informing the provider that those revisions must be completed in the Therap® system as soon as possible but not more than three working days after the notice. The Regional Community Services Director reserves the right to initiate an investigation into any incident as they deem necessary.
7) **Initial Incident Review in Weekly RCS Incident Review Committee –** The Regional Incident Management Coordinator will review the content of the GER in the next weekly Regional Incident Review Committee Meeting and, if there are any questions/recommendations from the Incident Review Committee, contacts the provider to address those questions/recommendations and notes responses in the GER in the Therap® system. The provider is responsible to complete and document their follow-up to the questions/recommendations in the GER in the Therap® system as soon as possible but not more than three working days after the notice.
8) **GER Resolution Completion –** Upon completion of the Comprehensive Mortality Review, the provider attaches the Comprehensive Mortality Review to the GER in the Therap® system. The GER, including the Comprehensive Mortality Review report and approval by supervisory/management staff, must be entered into the Therap® system as soon as possible but not more than 15 working days after the occurrence or discovery of the death.
9) **Final Incident Review in Weekly RCS Incident Review –** Upon receiving notice of the GER including the Comprehensive Mortality Review report in the Therap® system, the Regional Incident Management Coordinator reviews the GER, provides a copy of the Comprehensive Mortality Review report to the regional nurse to review, and reviews the information in the GER in the next weekly Regional Incident Review Committee Meeting. If there are any questions/recommendations from the Incident Review Committee, the Incident Management Coordinator will contact the provider to address those questions/recommendations and note responses in the GER in the Therap® system. The provider is responsible to complete and document their follow-up to the questions/recommendations in the GER in the Therap® system as soon as possible but not more than three working days after the notice.
10) **Results Follow-up to and From the Provider –** The provider must provide documentary evidence of address of each of the recommendations in the Comprehensive Mortality Review. Documentary evidence of address of each of the follow-up actions must be attached electronically to the GER in the Therap® system.
11) **Final Review, Approval and Closure of the GER** – Upon receiving notification of the address of the recommendations from the Comprehensive Mortality Review by the provider in the GER, the Regional Incident Management Coordinator (IMC) reviews the final GER Resolution with the Regional Nurse using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. The Regional Incident Management Coordinator is responsible to close the GER in the Therap® system.
    a) If the GER is complete and contains all required elements, the IMC documents approval and closure of the GER in the Therap® system by checking the box "I have reviewed and approved this report" and adding a comment to indicate that there is no additional follow-up action pending or needed. Upon completing these steps, the IMC enters the date that the GER is to be closed in the "Date Closed" field and selects the "Close" button at the bottom of the GER screen.

5.5.2 – For an Unexpected Death:

1) **Alabama Department of Human Resources Notification** – If there is a suspicion of abuse, neglect, mistreatment, or exploitation regarding the circumstances of the death, the provider staff will notify the Alabama Department of Human Resources (DHR) immediately but not more than one hour after the occurrence or discovery of the incident and provide DHR with relevant information about the incident and the suspicion of abuse, neglect, mistreatment, or exploitation. If abuse, neglect, mistreatment, or exploitation is substantiated upon completion of the investigation by RCS staff, the RCS Director or designee will notify DHR of the findings.
2) All steps noted above for a Natural Death are followed for an Unexpected Death except Regional Office notification must be done immediately (within one hour) upon the provider's or support coordinator's discovery or notification of the death.
3) **Additional Medication Error Reporting –** If the death is related to a Level 3 medication error, it must also be reported on a Medication Error Report (Form NDP-4 – Appendix G) completed by the MAS RN/LPN. When completed, the Medication Error Report should be emailed or faxed directly to the Alabama Department of Mental Health Nurse Delegation Program (AMH/NDP) Office within 24 hours of notification/discovery of the error. All requested information should be provided

including a description of the error focusing on the outcome to the consumer – signs, symptoms, ER visit, etc. A copy of the completed Medication Error Form must also be attached electronically to the GER.

4) Upon receipt of the Comprehensive Mortality Review report for an unexpected death, the Regional Community Services Director will assign the Regional Nurse to conduct a follow-up onsite investigation to review and verify the process, findings, and recommendations of the Comprehensive Mortality Review and set a deadline for completion and submission of the investigation report.
5) **RCS Investigation Completion and Approval –** The regional nurse will, by the assigned date, complete the follow-up onsite investigation of the death using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. The Regional Nurse will note any concerns with the process, findings, or recommendations made by the provider in the Comprehensive Mortality Review and making recommendations for necessary follow-up by the provider. The Regional Community Services Director must approve the follow-up investigation report no later than two working days after receipt of the report. A copy of the approved follow-up investigation report will be provided to the Regional Incident Management Coordinator for further follow-up action and attachment to the GER.
12) **Final Review, Approval and Closure of the GER** – Upon receiving notification of the address of the recommendations from the Comprehensive Mortality Review by the provider in the GER, the Regional Incident Management Coordinator (IMC) reviews the final GER with the Regional Nurse using the GER/GER Resolution Content Review Protocol (Appendix C) as a guide. The Regional Incident Management Coordinator is responsible to close the GER in the Therap® system.
    a) If the GER is complete and contains all required elements, the IMC documents approval and closure of the GER in the Therap® system by checking the box "I have reviewed and approved this report" and adding a comment to indicate that there is no additional follow-up action pending or needed. Upon completing these steps, the Regional Incident Management Coordinator enters the date that the GER is to be closed in the "Date Closed" field and selects the "Close" button at the bottom of the GER screen.

5.6 – Required Procedures Related to Restraint Usage

5.6.1 General Principles

Restraint is a type of restrictive procedure that can only be used as a method of last resort and only when necessary to protect the waiver participant or others from injury. There are three types of restraint procedures that may be used in the HCBS waiver programs operated by ADMH-DDD – manual restraint, mechanical restraint, and chemical restraint. Each of these restraint types is further sub-divided into "programmatic" meaning the application of this type of restraint is prescribed in a behavior support plan (BSP), and "emergency" meaning the application of this type of restraint is being used as an emergency procedure and its use is not prescribed in a behavior support plan. Each of these restraint types are defined and described in detail in Section 4 above.

5.6.2 Prohibited Procedures

The use of any of the following types of procedures is prohibited:

1) Any maneuver or technique that does not give adequate attention and care to protection of the head.
2) Any maneuver or technique that places pressure or weight on the chest, lungs, sternum, diaphragm, back, or abdomen.
3) Any maneuver or technique that places pressure, weight, or leverage on the neck or throat, on any artery, or on the back of the head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway, such as straddling or sitting on the torso, or any type of choke hold.
4) Any maneuver or technique that involves pushing into a person's mouth, nose, or eyes.
5) Any maneuver or technique that utilizes pain to obtain compliance or control, including punching, hitting, hyperextension of joints, or extended use of pressure points.
6) Any maneuver or technique that forces a person to remain in a prone (face down) position.
7) Any maneuver or technique that forcibly takes a person from a standing position to the floor or ground. This includes taking a person from a standing position to a horizontal (prone or supine) position or to a seated position on the floor.
8) Any maneuver or technique that creates a motion causing forcible impact on the person's head or body, or forcibly pushes a person against a hard surface.
9) Any maneuver or technique used as punishment, retaliation, or for the convenience of staff.

5.6.3 Restraint-Related Staff Training Requirements

As a certified provider of services contracted with ADMH-DDD providing services and supports to waiver participants, Section 6-Quality Management in the ADMH-DDD Provider Operational Guideline Manual defines specific responsibilities that you must follow in your training program for staff providing direct services. Training requirements that relate to behavioral services and supports include crisis prevention and management as well as training on correct implementation of the waiver

participants' behavior support plans. You must comply with each of these certification requirements and your compliance is measured during your annual certification review.

Training requirements that the program provider must follow related to restraint usage are listed below:

1) All direct service staff must receive training in management of aggressive behavior prior to working alone with any waiver participants and within 90 days of employment [§6.3.h.D(5)] and annually thereafter [§6.3.h.D(8)]. To comply with this certification principle, the provider must select a proprietary training curriculum to be used in provision of this training. If the provider uses one of the following training curriculums, prior approval from ADMH-DDD is not required, If another curriculum is selected by the provider, that curriculum must be submitted to and approved by ADMH-DDD prior to its use. Approved training curricula include:
   a) CPI – Crisis Prevention Institute Non-Violent Crisis Intervention
   b) The Mandt System
   c) Safety Care – Quality Behavioral Solutions to Complex Behavior Problems
   d) MOAB – MOAB Training International
   e) PMT – Physical and Psychologist Management Training
   f) PCM – Professional Crisis Management Training
2) Within 90 days of employment, all direct services employees must receive training that includes general behavioral principles with emphasis on skill acquisition and behavior reduction techniques [§6.3.h.D(6)].
3) Behavior support plans must describe specific behavioral supports that may and may not be used [6.3.i.G(7)].
4) All direct support staff must receive training in behavioral techniques and plans included in a waiver participant's behavior support plan prior to providing services and supports for that waiver participant [§6.3.i.G(9)].
5) The organization must provide training on specific supports, services, policies and procedures, or other corrective action deemed appropriate, immediately when support staff competency is identified as a (potential) causal factor for substantiated incidents of abuse, neglect, mistreatment, or exploitation including the unauthorized use of restraints [§6.3.e.F(4)].

5.6.4 Required Follow-up Procedures for Frequent Restraint Usage

1) The use of a chemical restraint as an emergency procedure three or more times in a six-month period requires the waiver participant's interdisciplinary team (IDT) to meet, within five working days of the third use, to determine if a BSP that includes the use of chemical restraint is needed. The IDT's determination must be documented. Documentary evidence of the IDT meeting and determination must be attached to the GER for the third restraint in a six-month period that triggered this required additional review and action.
2) The use of a manual restraint as an emergency procedure three or more times in a six-month period requires the waiver participant's interdisciplinary team (IDT) to meet, within five working days of the third use, to determine if a BSP that includes use of manual restraint is needed. The IDT's determination must be documented. Documentary evidence of the IDT meeting and determination must be attached to the GER for the third restraint in a six-month period that triggered this required additional review and action.
3) The use of a mechanical restraint as an emergency procedure three or more times in a six-month period requires the waiver participant's interdisciplinary team (IDT) to meet, within five working days of the third use, to determine if a BSP that includes use of mechanical restraint is needed. The IDT's determination must be documented. Documentary evidence of the IDT meeting and determination must be attached to the GER for the third restraint in a six-month period that triggered this required additional review and action.

SECTION 6 – INCIDENT MANAGEMENT REVIEW AND OVERSIGHT PROCEDURES

6.1 Provider Quality Assurance/Improvement Activities

The Code of Alabama, §580-5-30-.10 establishes several requirements that relate to a certified provider who is contracted with ADMH-DDD to deliver intellectual disabilities services. Those areas that relate specifically to the provider's incident prevention and management system (Local IPMS) include:

6.1.1 Provider IPMS Policy and Procedure Requirements

§580-5-30-.10(5), Protection from Abuse, Neglect, Mistreatment and Exploitation, requires that all providers of services contracted with the ADMH-DDD implement a critical incident prevention and management (local IPMS) policy to protect waiver participants, to improve the organization's responsiveness to incidents, and to manage risk efficiently and effectively. The purpose of the provider's local IPMS policy is to prevent harm and provide a framework for an effective approach to risk

and incident management that takes appropriate account of dignity of risk. The provider's local IPMS policy, and practices associated with its implementation, must identify, define, prohibit, and prevent abuse, neglect, mistreatment, unauthorized or inappropriate use restraints, exploitation and other critical incidents defined in this IPMS Manual. The definitions in the provider's local IPMS policy must be comprehensive, specific, and consistent with the definitions of critical incidents and other terms in this IPMS Manual.

Where preventable incidents occur, the provider's local IPMS policy and associated practices must focus on learning and action to reduce the likelihood that preventable incidents will occur again. The importance of learning, rather than simply assigning blame, is essential for any effective incident prevention system. An approach accounting for dignity of risk acknowledges that a reasonable amount of planned risk is essential for human growth and development. Dignity of risk recognizes there are justifiable risks associated with living life, pursuing goals, and exploring opportunities. Justifiable risks are those a reasonable person would otherwise expect are necessary for a person pursuing specific goals and interests.

The specific requirements that must be included in the provider's IPMS policy and procedure include:

1) Definitions of terms that are comprehensive, specific, and consistent with the definitions of critical incidents and other terms contained in the ADMH-DDD IPMS Manual.
2) A full and complete description of the processes that the provider will employ to assure accurate and timely information is entered into the Therap® system for all critical incidents consistent with requirements set out in this IPMS Manual. Those required elements include, but are not limited to:
    a) For each critical incident, complete and accurate information in all relevant fields in the GER and GER Resolution (for incidents involving abuse, neglect, mistreatment, or exploitation). This information must be entered and approved by the provider within the timelines specified in this IPMS manual.
    b) For each critical incident, additional information requested from the provider by the Regional Community Services (RCS) office upon their review of the GER or GER Resolution. This information must be entered in the GER or GER Resolution within the timeframes specified by RCS staff.
    c) For each critical incident, complete and accurate follow-up information entered in a GER (for incidents that do not involve suspicion of abuse, neglect, mistreatment, or exploitation) or a GER Resolution (for incidents involving suspicion of abuse, neglect, mistreatment, or exploitation) including a detailed report of the provider's investigation of the critical incident, findings from that investigation, and any follow-up corrective or improvement activities necessary to address the findings of the investigation. All relevant documentary evidence related to the investigation beyond what is entered into the Therap® fields including, but not limited to, an investigation report and documentary evidence of successful completion of all follow-up actions.
3) A full and complete description of the process the provider employs to:
    a) Ensure timely and appropriate review of critical incident reports by an Incident Review Committee (IRC) as an element of the provider's overall quality improvement program. The provider's IRC membership is appointed by the agency's chief executive and includes, at a minimum, the Qualified Developmental Disabilities Professional (QDDP) and representatives from the agency's administrative, clinical, self-advocate, and direct support staff. The frequency of IRC meetings is at the discretion of the agency's chief executive but must be no less frequent than monthly.
    b) Collect and analyze data related to critical incidents and the process used to identify, implement, and track completion of all corrective or improvement activities identified from the analysis of critical incident data.

Review of provider compliance with these policy requirements and their consistent implementation will be evaluated as a part of the provider's certification compliance review. A determination of non-compliance will require formal corrective action and a pattern of non-compliance may result in enforcement action up to and including contract termination or decertification. See Section 7 below for further details on non-compliance and resulting actions.

6.1.2 Provider IPMS Data Collection, Analysis, and Follow-Up Actions:

§580-5-30-.10 (11) requires that the ADMH-DDD ensure the provider has a system of internal compliance and quality monitoring that measures compliance with contractual and certification requirements, as defined by ADMH-DDD, and that measures performance on quality measures defined by ADMH-DDD (see details regarding performance measures relating to critical incident management in §10.3.4 below).

1) Critical incident data analysis and follow-up action is a required element of the provider's overall quality monitoring and quality assurance plan and must be detailed in the provider's quality monitoring/quality assurance policy. That policy content must include, but is not limited to:
2) Regarding the process for incident data analysis, the provider must have:

a) A defined and documented process for review of critical incident reports at least monthly.
b) A defined and documented process to collect and aggregate critical incident data.
c) A defined and documented process to analyze incident data at a set frequency, at least quarterly. The purpose of the data analysis is to proactively identify and develop appropriate responses to identified trends or patterns of incidents prior to them developing into repeated or more serious incidents. The analysis must include, at a minimum, evaluating incidents by type, by waiver participant, and by location/environment where they occurred.
    i) A trend is an increasing or decreasing number of incidents occurring over time.
    ii) A pattern is a recurring number of events of a particular type, occurring at a particular time of day or day of the week, resulting from a similar causative factor.

3) Corrective or improvement activities to address identified trends or patterns of critical incidents.
    a) Resulting from the analysis of critical incident data, the provider must identify specific measurable actions to address identified trends, patterns, or other concerns identified from the analysis process.
    b) The provider must, for each measurable action, identify a person responsible for assuring that the action is implemented and a target date by which the action is to be accomplished.
    c) The provider must have a documented system to track each action to its completion and to evaluate the action to determine its success and whether or not additional action is needed.
4) Review of provider compliance with these quality monitoring/quality assurance processes related to critical incident management will be evaluated as a part of the provider's certification compliance review. Evidence of non-compliance will require formal corrective action and a pattern of non-compliance may result in enforcement action up to and including contract termination or decertification. See Section 7 below for further details on non-compliance and resulting actions.

6.2 Regional Community Services (RCS) Office Incident Management Oversight Activities

6.2.1 Review of GERs and GER Resolutions Upon Receipt

1) All procedures outlined in Section 4 above regarding the steps to report, investigate, and complete necessary follow-up actions for each critical incident must be followed by providers and Regional Community Services Office staff.
2) The Regional Incident Management Coordinator (IMC) will log each critical incident in their Incident Tracking Log (Appendix D) for future reference. The log maintained by the IMC will track:
    a) Date of receipt of the initial GER,
    b) Date and time of notification of any external agency(ies),
    c) Date of requested follow-ups and receipt of requested information related to the GER,
    d) Date(s) of review of the GER in the weekly RCS Incident Review Committee (IRC) meeting,
    e) Date of approvals of the completed GER by the IMC (also entered in the Therap® system),
    f) For incidents involving suspected abuse, neglect, mistreatment, or exploitation:
        i) Date of receipt of the GER Resolution,
        ii) Date of requested follow-up and receipt of requested information related to the GER Resolution,
        iii) Date(s) of review of the GER Resolution in the weekly IRC meeting,
        iv) Date of approval of completed GER Resolution by the IMC (also entered in the Therap® system), and
        v) If notification of any external agency regarding the findings is necessary, date of sending the investigation report to the external agency.
3) The IMC will maintain a Provider Non-Compliance Frequency Log (Appendix E) to track provider non-compliance with incident reporting requirements and responsiveness memos and letters sent to providers in accordance with the requirements found in Section 7 below. Data from this compliance log will be summarized in each monthly critical incident data analysis report presented to the Regional Incident Review Committee.

6.2.2 Weekly Review of GERs and GER Resolutions by the RCS Incident Review Committee

1) Each RCS Director will appoint members to the Regional Incident Review Committee (IRC). Members of this committee must include, but is not limited to, the RCS Director, the IMC, the Regional Nurse, the Regional Quality Enhancement Specialist, a Certification Specialist, a Behavioral Services representative, and a representative from the ADMH Advocacy Program. A representative from the ADMH Bureau of Special Investigations will be invited to participate. The ADMH-DDD Statewide Incident Management Coordinator will participate in these meetings periodically to evaluate consistency of practice across the state's five RCS Offices.
2) The IRC members will review each GER and GER Resolution received since the date of the last weekly IRC meeting, identify any questions or issues, and identify any requested follow-up from the provider.
3) If follow-up is requested from the provider, the IMC will notify the provider of the request via phone with a follow-up email describing what needs to be completed/revised in the GER or GER Resolution and inform the provider that those

revisions must be completed in the Therap® system as soon as possible but not more than three working days after the notice. A comment regarding this follow-up must be added to the GER.

4) The IMC will review the revised GER/GER Resolution in the next weekly IRC meeting for final approval.
5) The IMC will log the final approval of the GER/GER Resolution on their Incident Tracking Log (Appendix D) for future reference and entered the finalization/approval date in the Therap® system.

6.2.3 Monthly Incident Data and Trends Analysis Review

1) Each RCS Director will appoint a standing committee to review incident data and trends information on a monthly basis. The membership of this standing committee must include, but is not limited to, the RCS Director, Regional IMC, Regional Nurse, Regional Quality Enhancement Specialist, a Certification Specialist representative, a Behavioral Services representative, an ADMH Advocacy Program representative, and the Statewide IMC. Other members may be appointed at the discretion of the RCS Director.
2) On the fifth working day of each month, the IMC will query the Therap® system to identify all critical incidents by incident type that occurred during the past month. This information will be cross-referenced with the information in the Incident Tracking Log (Appendix D) that they maintain to verify accurate counts of each incident type.
3) Frequency data for each critical incident type will be entered in the "RCS Incident Management Performance Measure Excel Workbook" (see Appendix F) maintained by the Regional IMC. This workbook is maintained on a "shared platform" that can be accessed by the Regional IMC, RCS Director, and the Statewide IMC. This workbook contains both frequency data tables and trend graphs that show trends in incident frequencies over a 2-year span of time. This Performance Measure Workbook will also contain a statewide compilation and trends graphs that summarize the regional office data for statewide evaluation.
4) The Regional IMC, with assistance from the Statewide IMC, will prepare a data presentation including both frequency tables and graphics for review by the Committee in each monthly meeting. This presentation will also include data related to provider non-compliance with incident reporting requirements and/or non-compliance with timely follow-up on inquiries made regarding content issues with GERs/GER Resolutions by the Regional IMC.
5) The Committee will review the critical incident data and identify, if present, any trends in the data that require further evaluation and/or follow-up.
6) For each trend identified as a concern:
    a) The RCS Director will make assignments for necessary follow-up on each identified trend and establish a response date for each identified action. The response date must allow sufficient time for review of the findings and actions by the RCS Director, Regional IMC, and Statewide IMC prior to the next monthly Committee meeting.
    b) The Regional IMC will be responsible for tracking the completion of these assignments within the assigned timeframes.
    c) A summary of the findings and actions will be discussed and evaluated as to whether they address and are positively impacting the identified data trend.

6.3 Statewide Incident Management Oversight Activities

6.3.1 Quarterly Statewide Incident Data Analysis and Review

1) The ADMH-DDD Associate Commissioner will appoint members to a standing committee to review statewide incident data and trends information on a quarterly basis. Required members of this standing committee must include the ADMH-DDD Associate Commissioner, Statewide IMC, DD Community Program Director, Quality and Planning Director, Psychological & Behavioral Services Director, ADMH Advocacy Program representative, Bureau of Special Investigations representative, ADMH Director of Nurse Delegation, and a representative from the Alabama Medicaid Agency. Other members may be appointed at the discretion of the ADMH-DDD Associate Commissioner. The RCS Directors and IMCs will serve as ad hoc members of this committee and will be asked to participate on an as-needed basis.
2) Frequency data for each critical incident type is entered in the "RCS Incident Management Performance Measure Excel Workbook" (Appendix F) by each Regional IMC. This data is maintained on a "shared platform" that can be accessed by the Regional IMC, RCS Director, and the Statewide IMC. This data will serve as the primary data source for the quarterly analysis. This Performance Measure Workbook will also contain a statewide compilation and trends graphs that summarize the regional office data for statewide evaluation.
3) The Statewide IMC will prepare a data presentation for review by the Committee. This presentation will include:
    a) Statewide frequency data and trend graphics for each type of critical incident.
    b) Frequency data and trend graphs from each region for each type of critical incident.

c) A summary of trends identified by the regional offices over the past quarter and a summary of follow-up actions and current status of each, and a summary of follow-up actions from each monthly regional data analysis review over the quarter.
d) Data regarding provider non-compliance with incident reporting requirements and responsiveness to requests for GER/GER Resolution corrections. This data is maintained by the Regional IMC.

4) The statewide quarterly review will focus on:
a) Review of critical incident frequency data to identify provider- or region-specific trends or patterns in the incident data and the impact of follow-up actions taken by regional office staff.
b) Identification of any statewide trends or patterns that require follow-up beyond follow-up actions taken by the regional office staff.
c) Determination of any statewide remedial actions that are necessary to address statewide or region-specific trends and patterns and take appropriate action to address each.

5) For each trend/pattern or recommended remedial action:
a) The ADMH-DDD Associate Commissioner will make assignments for necessary follow-up and establish a response date for each identified action. The response date must allow sufficient time for review of the findings and actions by the Associate Commissioner and Statewide IMC prior to the next quarterly Committee meeting.
b) The Statewide IMC will be responsible for tracking the completion of these assignments within the assigned timeframes.
c) A summary of the findings and actions will be discussed and evaluated as to whether they address and are positively impacting the identified data trend.

6.3.2 Monitoring and Evaluation of the Statewide IPMS System

1) The Statewide Incident Management Coordinator is responsible for monitoring of regional offices for compliance with the IPMS requirements. These monitoring activities include, but are not limited to:
a) Participation in at least one weekly IRC meeting in each region each month.
b) Review of critical incident monthly data reports prepared by each Regional IMC.
c) Conducting at least monthly meetings with all regional IMCs to discuss IPMS processes and challenges and to identify needed system improvements. Results of these meetings will be discussed in ADMH-DDD Leadership Team meetings conducted by the ADMH-DDD Associate Commissioner.
d) Periodic review of Therap® system reports using the system's Business Intelligence analysis tools to measure regional office adherence to the IPMS requirements.
e) A semi-annual onsite audit of the regional incident management oversight system to verify that the processes, procedures, and related documentation described in the IPMS Manual are being consistently followed.
f) Preparation, with active involvement of each Regional IMC, of all required reports for waiver performance measures, ADMH divisional and agency-wide reports, and any reporting required by the Alabama Medicaid Agency.
g) Active and ongoing collaboration with Therap® representatives to address system concerns, request and obtain assistance to address challenges or issues identified in the system operations by regional or state office IMC staff, and development and refinement of data queries necessary for system analysis and reporting purposes.

6.3.3 Certification Reviews

1) Review of provider compliance with IPMS requirements in their policies and procedures, the consistency and quality of their reporting and investigation processes, and the consistency and quality of their incident follow-up activities is measured through:
a) Certification compliance reviews.
b) Evaluation of critical incident data and trends and data maintained by Regional IMCs regarding provider incident reporting and/or follow-up procedural compliance.

2) Each certification compliance review will include a review of incident data and trends for the provider over the past year as well as data regarding the providers incident reporting and/or follow-up procedural compliance.

3) Evidence of non-compliance will require formal corrective action and a pattern of non-compliance may result in enforcement action up to and including contract termination or decertification. See Section 10 below for further details on non-compliance and resulting actions.

6.3.4 Alabama Medicaid Agency/CMS Performance Measure Reporting

1) The Alabama Department of Mental Health Developmental Disabilities Division (ADMH-DDD) is the Operating Agency (OA) responsible for both operations and oversight of three of the state's Home and Community-based (HCBS) waivers – the

Intellectual Disabilities (ID) waiver, the Living at Home (LAH) waiver, and Community Living Program Waiver (CWP). ADMH-DDD staff work cooperatively with staff at the Alabama Medicaid Agency to carry out these operational and oversight responsibilities. The primary measurement and reporting requirements for each waiver are the performance measures approved by CMS for that waiver.

2) The performance measures that relate specifically to the Incident Prevention and Management System are as follows:
   a) Number and percent of abuse, neglect, exploitation, or unexpected death incidents reviewed/investigated with the required timeframe.
   b) Number and percent of closed cases of abuse, neglect, or exploitation for which the Operating Agency verified that the investigation conducted by the provider was done in accordance with state policy.
   c) Number and percent of suspected abuse, neglect, and exploitation incidents referred to appropriate investigative entities, e.g., Adult Protective Services, Child Protective Services, and/or Law Enforcement.
   d) Number and percent of critical incidents that have been resolved by the Operating Agency within 60 days of the critical incident report date.
   e) Number and percent of critical incident trends where systemic intervention was implemented.
   f) Number and percent of critical incident trends for which systemic intervention was implemented that showed sustained improvement after three months of the state implementing a corresponding revision to the intervention.
   g) Number and percent of participants with restrictive interventions where proper procedures were followed.
   h) Number and percent of restraints approved in a behavior support plan that were applied three (3) times in a six-month period and resulted in a team meeting to consider revision to the behavior plan as required by state policy.
   i) Number and percent of unapproved restrictive interventions that had a prevention plan developed as a result of the incident.

SECTION 7 – PROVIDER COMPLIANCE WITH INCIDENT PREVENTION AND MANAGEMENT SYSTEM (IPMS) PROCEDURES AND REQUIREMENTS

7.1 Provider Compliance Requirements Relating to Critical Incident Reporting, Investigation, and Follow-Up

All providers must, report, investigate, identify corrective or process improvement actions, and implement those actions for each critical incident that occurs in their program. Each of these activities must be completed within timeframes prescribed in this IPMS manual. All providers are required to enter information about each critical incident in the Therap® system. For critical incidents requiring immediate notification of ADMH-DDD staff, providers must report those incidents within timeframes prescribed in this IPMS manual. It is important that providers assure their SCOMM notification is turned on in the Therap® system to ensure receipt of all communications regarding a GER or GER Resolution. Provider compliance with all processes, procedures, and timeframes in this IPMS manual is mandatory. Failure to follow IPMS requirements including, but not limited to, responding to requests from ADMH-DDD for information and/or follow-up action may result in certification and/or contract enforcement action up to and including decertification.

7.2 Process for Provider Noncompliance – 3 Requests in 7 Working Days

1) **INITIAL REQUEST -** The Regional Incident Management Coordinator (IMC) will notify the provider regarding a request for information and/or follow-up action related to a GER and allow **3 working days** from the date of the email notification for the provider to satisfy the request.
2) **SECOND REQUEST -** If the provider fails to comply with the initial request, the IMC will send an email to the person that entered the GER into the Therap® system with a copy to the agency's Executive Director notifying them that this is a second request for information and/or follow-up action. A comment will also be entered in the GER in the Therap® system to reference the emailed request. The IMC will allow the provider **2 working days** from the date of the Second Request email notification to comply.
3) **THIRD REQUEST -** If the provider fails to comply with the second request, a notice will be sent via email to the person that entered the GER and the agency's Executive Director notifying them of the continued non-compliance and that this is the final request that will be sent. A copy of the non-compliance memo will be attached to the GER in the Therap® system along with a note in Therap® that this is the final request to comply. The provider will have **2 working days** from the date of the Third Request email to comply.

7.3 Enforcement Actions for Provider Non-Compliance with IPMS Requirements

The Code of Alabama Chapter 580-3-23-.11 Unannounced Visits states that "DMH/MR or its agents has the authority to periodically monitor entity's' continuing compliance with standards, or contract requirements, as applicable, to conduct reviews and investigations at any time or to investigate a complaint or when other information is received regarding consumer rights, services, and/or program operations. (2) If there are findings of non-compliance, the procedures specified in §580-3-23-.15 will be followed."

If, after receiving the third written request referenced in §7.1.2 above, the provider continues not to comply:

1) ADMH-DDD will send a written notice by certified mail to the agency's Executive Director and, as applicable, the Board of Directors, the executive director of the provider's parent agency, and any other appropriate parties, notifying them that ADMH-DDD is initiating a provider non-compliance agency investigation that is to be completed by a date specified in the written notice. The purpose of the investigation is to determine if there are justifiable reasons why the provider has not complied with the current request for information and/or follow-up, and if the provider has a history or pattern of non-compliance with requests for information and/or follow-up action related to critical incident reporting, investigation and/or follow-up.
2) Consistent with requirements at §580-3-23-.12, if the investigation identifies that there is no justifiable reason(s) for the provider's non-compliance with the current request for information and/or follow-up action or the provider has a history or pattern of non-compliance with requests for information from previous critical incident reports, the provider will be determined out of compliance with relevant certification standards and a Certification Site Visit Report that lists each standard not met and specific findings which constitute the basis for non-compliance will be sent to the Agency's Director via certified mail. The report will specify timeframes for mandatory compliance with specific standards. Consistent failure to meet Department standards, as defined in §580-3-23-.16, may result in provider decertification without further certification site visits being conducted.
3) Consistent with requirements at §580-3-13, the provider is required to submit a plan of action to ADMH-DDD for cited non-compliance within thirty (30) days after the date of receipt of the Certification Site Visit Report. The corrective actions outlined in the plan must project compliance with specified divisional standards within sixty (60) days after completion of the site visit. A shorter timeframe may be required if findings indicate a risk to the health/safety of waiver participants and/or for non-compliance with specified standards. Actions taken by ADMH-DDD when the agency's Plan of Action is received are outlined in §580-3-23-.14. Consistent with the requirements at §580-3-23-.16, continued non-compliance may result in further enforcement action up to and including decertification.

7.4 Periodic Monitoring of Compliance with IPMS Requirements

ADMH-DDD conducts annual and periodic compliance monitoring including assessing compliance with all requirements set out in this ADMH-DDD IPMS Manual. Provider agencies and support coordination agencies must maintain documentary evidence of an effective corrective action tracking system that includes all corrective actions, dates of completion, and documentary evidence of the outcomes of the corrective action. They must, as an element of this corrective action tracking system, ensure that corrective actions to address identified non-compliance with any requirements set out in this IPMS Manual are developed, implemented, and evaluated for ongoing effectiveness within timelines specified by ADMH-DDD.

Provider agencies and support coordination agencies must review their corrective action tracking system's overall performance periodically, but at least annually, to evaluate the timely implementation of corrective action plans and the effectiveness of implemented corrective actions to ensure they achieved intended outcomes on an ongoing basis.

SECTION 8 – RESOURCES FOR PROVIDERS

8.1 ADMH Conducting Serious Incident Investigations Training

Community providers and ADMH staff can register for the "Conducting Serious Incident Investigations" training by visiting the training section of the ADMH Provider Portal page at: (ADMH) Conducting Serious Incident Investigations (reliaslearning.com)

8.2 Therap® System Access

Access to the Therap® system is granted to all agencies that provide services. In the event that an agency is decertified and is deemed ineligible to provide services, access to the Therap® system will be immediately revoked by ADMH.

8.3 Regional Provider Training

New providers will receive Therap® system training during the Regional New Provider Orientation. Please contact the RCS Regional Incident Management Coordinator in your region to obtain more information about accessing the Therap® system. Additionally, the Therap® system staff will be providing quarterly webinars on the Therap® website to assist current providers with incident management system operational questions. For more information, please visit https://help.therapservices.net/app/alabama-idd-providers

8.4 Intake Process

For each waiver participant receiving services funded by the Alabama Department of Mental Health (ADMH), you will need to follow this process for having the waiver participant added to your Therap® account:

1) Contact the ADMH Call Center staff at 800-361-4491 to determine which staff will be notified by SCOMM (secure communication/email in the Therap® system).
2) Include the following information about the waiver participant(s) you are requesting to be added to your Therap® account: First Name, Last Name, ADIDS #, Medicaid #, Date of Birth, and specific waiver program in which the waiver participant is enrolled.
3) In order to send a Multi-Provider's SCOMM, you will need to ensure that you have enabled the Multi-Providers SCOMM privileges. To learn more about this process, visit: SComm Settings (therapservices.net)

8.5 Therap® Training Academy

Community providers may access the Therap® Training Academy to complete self-paced, on-demand training related to the use of the Therap® system to document all steps and information related to critical incident reporting, investigation, required notifications, and follow-up activities. You may access the Therap® Training Academy by visiting https://support.therapservices.net/training-academy/

8.6 Therap® Live Help

Community providers may contact Therap® at any time to receive live help related to Therap® system operations and use. You do this by accessing https://www.therapservices.net/ and selected the "Contact Us" button on the top banner on the screen.

8.7 Therap® User Guides

Therap® provides online training and support materials for incident reporting, investigation, and follow-up.

1) For user guides on General Event Reports (GERs), please visit: https://help.therapservices.net/app/products/detail/p/125/~/general-event-reports-ger-
2) For user guides on General Event Report (GER) Resolutions, please visit: https://help.therapservices.net/app/products/detail/p/53/~/ger-resolution-

8.8 Therap® Password Reset

Community providers may reset passwords in the Therap® system by using the following links: https://secure.therapservices.net/auth/login and in the Login section on the right side of the screen, click "Forgot Password?"

SECTION 9 – APPENDICES

9.1 Appendix A - Critical Incident Crosswalk Table

https://mh.alabama.gov/wp-content/uploads/2022/07/Critical-Incident-Crosswalk-Table-07-01-2022-002.pdf

9.2 Appendix B ADMH Comprehensive Mortality Review Template

https://mh.alabama.gov/wp-content/uploads/2020/12/Comprehensive-Mortality-Report-Final.pdf

9.3 Appendix C GERs/GER Resolutions Content Review Protocol

https://mh.alabama.gov/wp-content/uploads/2022/06/GER-and-GER-Resolution-Content-Review-Protocol.docx

9.4 Appendix D RCS Incident Tracking Log (Excel)

https://mh.alabama.gov/wp-content/uploads/2022/06/RCS-Incident-Tracking-Log.xlsx

9.5 Appendix E RCS Provider Non-Compliance Frequency Tracking Log (Excel)

https://mh.alabama.gov/wp-content/uploads/2022/06/RCS-Provider-Non-Compliance-Frequency-Log.xlsx

9.6 Appendix F RCS Incident Management Performance Measure Workbook (Excel)
Insert Link Here

9.7 Appendix G NDP-4 Form
https://mh.alabama.gov/level-2-or-level-3-medication-error-form/

9.8 Appendix H Report of an Adult Suspected To Be Abused, Neglected, or Exploited
Insert Link Here