Alabama Department of Mental Health

Division of Developmental Disabilities

Incident Prevention and Management System (IPMS) Manual

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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 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 central 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 Assurance and Improvement Program 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 an Incident Prevention and Management System (IPMS) that provides guidance for community providers to implement an incident prevention and management system 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 the ADMH-DDD contract with certified 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 all providers of services contracted with the ADMH-DDD to 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.

1.2.5 §38-9-8 "Shirley's Law" Abuse Registry Requirement.

The Code of Alabama, §38-9 provides for the establishment and maintenance of a registry by Department of Human Resources (DHR), listing the names of certain individuals and caregivers whereby a finding of abuse, neglect, or exploitation has been indicated as defined in 38-9-8, *Code of Alabama 1975*, against certain recipients of the Alabama Department of Mental Health Developmental Disabilities Division's system of care. The registry shall provide for the inclusion of specific documented findings by the Alabama Department of Mental Health Developmental Disabilities Division (ADMH-DDD) of neglect, abuse, or exploitation by any individual or caregiver, as well as a brief statement by any individual disputing the findings. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning an indicated finding shall also include disclosure of any statement in the registry relating to the finding or a clear and accurate summary of such statement. Individuals shall be notified in writing prior to submission of their names and related information to the registry and allowed the opportunity for a hearing in the event the individual disputes the findings.

All providers and support coordination agencies contracted with the ADMH-DDD, including Employees of Record for self-directed services, are responsible for ensuring any new hires or volunteers are not listed on the DHR Abuse Registry before starting employment or volunteer work. If a prospective employee or volunteer is listed on the registry, they are ineligible for hire by the agency or entity. If the agency or entity becomes aware a current employee or volunteer is on the registry, his or her employment should be terminated immediately.

An individual shall be listed on the registry if he or she has:

- Been convicted of one of the following crimes:
    - Elder abuse and neglect (1st, 2nd, or 3rd degree – Ala. Code §§13A-6-192, 193, or 194)
    - Financial exploitation of an elderly person (1st, 2nd, or 3rd degree – Ala. Code §§ 13A-6-195, 196, or 197)
    - Any act of elder abuse under Ala. Code §38-9F-3
    - Any act of abuse, neglect, or exploitation listed in Ala. Code §38-9-7
- Had a protection from abuse order (PFA) entered against him or her for the protection of an elderly person or an adult in need of protective services.
- Been found by ADHR, ADPH, or ADMH to have committed an act of abuse, elder abuse, emotional abuse, exploitation, financial exploitation, intimidation, neglect, sexual abuse, or undue influence against an elderly person or an adult in need of protective services.

To check the ADHR registry the provider and/or support coordination agency should complete the Abuse Registry Clearance Form, which can be found at https://dhr.alabama.gov/wp-content/uploads/2023/04/APS-Registry-Clearance-Form-4-26-23.pdf. Further instructions on completion of this form can be found at https://dhr.alabama.gov/wp-content/uploads/2023/06/Instructions-for-DHR-APS-2270.pdf.

Results of the clearance before hire should be maintained in the provider and/or support coordination agencies' personnel and volunteer records for review by the Alabama Department of Mental Health DD Division.

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) **Approved Restraint 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.
4) **Behavior 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 specific situations in regard to a participant's target behavior(s) for reduction. The BSP is developed and implemented to remove barriers to reaching the goals of the PCP.
5) **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.
6) **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.
7) **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.
8) **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.
9) **General Event Report (GER)** – A web-based incident reporting module in the Therap® system used for the mandatory reporting, investigation, and resolution of critical/reportable incidents involving one or more waiver participants.
10) **General Event Report Resolution (GERR)** – A web-based incident reporting module in the Therap® system used for investigation reports, data, and associated documentation.
11) **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 participant's residence or personal property.
12) **Infestation** - The presence of an unusually large number of insects or animals in a place, typically to cause damage or disease.
13) **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.
14) **Mandatory Reporter** – Under Alabama law (*Adults* in Alabama Code Title 38, §38-9-8 or *Children* in Alabama Code Title 26, §26-14-3), this includes 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 Alabama Department of Human Resources and to the ADMH-DDD Regional Office.
15) **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, for correct reason, and recording the administration appropriately.
16) **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.
17) **Medication Assistance 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 in community residential settings and holds a valid medication assistant certification to work under the direction of a licensed nurse.
18) **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.

19) **Minor Injury** - An injury that does not require treatment by a physician, licensed nurse, or other healthcare professional.
20) **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.
21) **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.
22) **Physical 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. In the Therap® system, two or more GERs will be completed to include the aggressor(s) and victim(s).
23) **Preventable Incident** - An incident in which the provider failed to do everything reasonable to prevent it.
24) **Proper Procedures for Use of Restraint 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 for manual and mechanical restraints, and from a MAS Nurse for chemical restraints; (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.
25) **Property Damage** – The damage or destruction of property, damage of the home, or damage to a vehicle.
26) **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.
27) **Qualified Investigator** – An ADMH-DDD staff member or contracted provider staff 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.
28) **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.
29) **Incident Review Committee (IRC)** – A group of subject matter experts who meet at a designated frequency to review critical incident data (at minimum) and information to identify relevant trends, patterns, or issues that require corrective action. Both the waiver provider and ADMH are required to have an Incident Review Committee.
30) **Regional Incident Review Committee** – A group of regional staff that includes, at a minimum, the Regional Incident Manager, Regional Nurse, Regional Quality Assurance Specialist, Regional Community Services Director, a Community Services Specialist, a Certification Specialist, a Behavioral Services representative, a representative from the ADMH Advocacy Program, and the Statewide Incident Management Coordinator.
31) **Statewide ADMH-DDD Incident Review Committee** – A group of subject matter experts, at a minimum, the ADMH-DDD Associate Commissioner, Statewide Incident Management Coordinator, Quality Assurance Director, DD Community Services Director, Psychological & Behavioral Services Director, Provider Certification Director, Support Coordination Director, ADMH Advocacy Program representative, Bureau of Special Investigations representative, ADMH Director of Nurse Delegation, a representative from the Alabama Medicaid Agency, a representative from ADHR, a representative from ADAP, a direct service provider representative, a support coordination agency representative, a person with lived experience, and a family member stakeholder. Other members may be appointed at the discretion of the ADMH-DDD

Associate Commissioner. The RCS Directors, Regional Incident Managers, and Quality Assurance Specialists will serve as ad hoc members of this committee and will be asked to participate on an as-needed basis.

32) **Provider Incident Review Committee** - An Incident Review Committee (IRC) is 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, a Qualified Developmental Disabilities Professional (QDDP), quality assurance staff, 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.
33) **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 manner.
34) **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.
35) **Treatment** – The use of an agent, procedure, or regimen, other than first aid, that can only be performed by a physician, licensed nurse, or other healthcare professional to cure or mitigate an illness, condition, or injury.
36) **Unapproved Restraint Intervention** – A manual, mechanical, or chemical restraint procedure that has not been incorporated into a Behavior Support Plan (BSP) and/or gone through a proper due process system.
37) **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 and is reportable to ADMH-DDD. 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 formal investigation can be found in Appendix A – Critical Incident Crosswalk Table.

1) **Abuse-Mistreatment (Emotional/Psychological)** - 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. This includes 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. **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.*
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 of necessary services. **Guidance***: Physical abuse may be perpetrated by anyone including, but not limited to, an employee, volunteer, family member, other non-waiver community members, or another waiver participant (note that physical abuse between waiver participants resulting in certain levels of harm are classified in Therap® as assault while also being identified as suspected abuse*). *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.*
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. Sexual abuse may be perpetrated by anyone including but not limited to an employee, volunteer, family member, other non-waiver community members, or another waiver participant (note that sexual abuse between waiver participants is classified in Therap® as assault while also being identified as suspected abuse*). *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) **Arrests -** Any incident that results in a waiver participant and/or employee being arrested, charged, or incarcerated. **Guidance:** *This will be classified in Therap as Misconduct/Possible Criminal Activity.*
6) **Assault-Physical** - Two or more waiver participants engaging in intentional, reckless, or aggressive behavior that results in a moderate or major injury to another waiver participant. **Guidance:** *This is considered physical abuse and should be noted as such under basic information.*
7) **Assault-Sexual** - Two or more waiver participants engaging in unwanted or non-consensual sexual contact or activity. **Guidance:** *This is considered sexual abuse and should be noted as such under basic information.*
8) **Choking (Level of Harm 2 or 3)** - Gagging or choking on food, liquid, foreign object, or material that requires the Heimlich maneuver or other method of dislodging the object. Evaluation and/or assessment by nurse or medical personnel is required for all choking incidents. **Guidance:** *If an individual experiences a choking incident resulting in a Level of Harm 3 or 4 that requires the Heimlich maneuver or other method of dislodging the object, he/she must be sent to the Emergency Room for further evaluation whether assessment was completed by physician, nurse, or other medical personnel at the provider agency. Choking that results in observation only after evaluation is considered a Level of Harm 2. Choking that results in a moderate injury is considered a Level of Harm 3.*
9) **Choking (Level of Harm 4)** - Gagging or choking on food, liquid, foreign object, or material that requires the Heimlich maneuver or other method of dislodging the object. Evaluation and/or assessment by nurse or medical personnel is required for all choking incidents. **Guidance:** *If an individual experiences a choking incident resulting in a Level of Harm 3 or 4 that requires the Heimlich maneuver or other method of dislodging the object, he/she must be sent to the Emergency Room for further evaluation whether assessment was completed by physician, nurse, or other medical personnel at the provider agency. A choking incident resulting in a major injury or death is considered a Level of Harm 4.*
10) **Confidentiality/Privacy Breach** - When private information is disclosed to a third party without the waiver participant's consent.
11) **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. This includes deaths occurring from natural causes such as age, disease, a health condition, or a documented terminal illness or condition. **Guidance:** *Natural deaths, in any setting, are to be reported within 24 hours to the Regional Incident Manager or designee by the provider or person notified of the death. The Regional Incident Manager reports the death to the ADMH-DDD Central Office within 24 hours. 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 but must be completed by the responsible provider.*
12) **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 Incident Manager or designee by the provider or person notified of the death. The Regional Incident Manager reports the death to the ADMH-DDD Central Office immediately. A GER for the death and a Comprehensive Mortality Review are required 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 but must be completed by the responsible provider.*
13) **Emergency Room Visit** - Any Hospital Emergency Room visit for a waiver participant but not including visits to community urgent care centers.
14) **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.*

15) **Fall-Major Injury** - A sudden and involuntary drop from an upright position to a lower surface or the ground resulting in a major injury. **Guidance:** *All falls, regardless of whether an injury results, must be reported as a critical incident in the Therap® system. This includes falls witnessed or discovered by a direct service professional, falls reported by a person to a direct support professional, 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 person who has limited support or who lives alone. A fall resulting in a major injury or death is classified as a Level of Harm 4.*

16) **Fall-Moderate Injury** - A sudden and involuntary drop from an upright position to a lower surface or the ground resulting in a moderate injury. **Guidance:** *All falls, regardless of whether an injury results, must be reported as a critical incident in the Therap® system. This includes falls witnessed or discovered by a direct service professional, falls reported by a person to a direct support professional, 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 person who has limited support or who lives alone. A fall resulting in a moderate injury is classified as a Level of Harm 3.*

17) **Fall-Minor Injury** - A sudden and involuntary drop from an upright position to a lower surface or the ground resulting in a minor injury. **Guidance:** *All falls, regardless of whether an injury results, must be reported as a critical incident in the Therap® system. This includes falls witnessed or discovered by a direct service professional, falls reported by a person to a direct support professional, 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 person who has limited support or who lives alone. A fall resulting in a minor injury that does not require the assistance of qualified medical personnel is classified as a Level of Harm 2.*

18) **Fall without Injury** - A sudden and involuntary drop from an upright position to a lower surface or the ground not resulting in injury. **Guidance:** *All falls, regardless of whether an injury results, must be reported as a critical incident in the Therap® system. This includes falls witnessed or discovered by a direct service professional, falls reported by a person to a direct support professional, 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 person who has limited support or who lives alone. A fall without injury is classified as a Level of Harm 1.*

19) **Fire** - A situation in which a person is injured, and/or object, building, or area of land is destroyed by burning. **Guidance:** *A fire resulting in injury to a waiver participant or destruction of property is considered a Level of Harm 3. A fire resulting in a major injury or death is a Level of Harm 4.*

20) **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.

21) **Infestation** - The presence of an unusually large number of insects or animals in a place, typically to cause damage or disease, where the waiver participant had exposure.

22) **Injury-Major** - Any observable and substantial injury that is not considered moderate injury and that results in permanent or protracted impairment, such as a serious fracture, a major 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. A protracted impairment refers to serious bodily harm that results in a diminished quality of life.

23) **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. This includes, but is not limited to, superficial fractures and wounds requiring sutures that does not result in permanent disfigurement. **Guidance:** *Medical treatment includes treatment that can only be done by a physician, licensed nurse, or other healthcare professional outside of the provider agency. Consulting with a licensed nurse or other medical professional without the need for treatment that can only be conducted by a licensed professional does not constitute treatment per this definition.*

24) **Law Enforcement Involvement** – Any call to law enforcement to request assistance for a waiver participant who is exhibiting extreme behavior, notification of an accident, or to report a crime, and no one is arrested, charged, or incarcerated will be classified as "Law Enforcement Involvement" in the Therap system. **Guidance:** *Only the waiver participant(s) involved in the law enforcement involvement will require a GER to be entered.*

25) **Medication Error-Level 1-Charting -** A documentation error that occurs when the staff member who administered the medication does not initial the MAR to verify that it was given. **Guidance:** *The MAS Nurse must be notified immediately upon discovery of any medication error, including but not limited to a documentation error. 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, but not limited to, Type, Cause, Medical Attention Required, Severity, Person*

Responsible, Person Responsible Classification, Prescriber Notified, and Errors. Simply contacting a nurse or physician to report the error with no treatment intervention, would be considered "Observe and Report Only" under the "Medical Attention Required" section. The severity level should be identified as 1.

26) **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 there is no MAS nurse required for services, the participant's community provider must be notified of all level one medication errors at their next doctor's visit. 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, but not limited to, Type, Cause, Medical Attention Required, Severity, Person Responsible, Person Responsible Classification, Prescriber Notified, and Errors. Simply contacting a nurse or physician to report the error with no treatment intervention, would be considered "Observe and Report Only" under the "Medical Attention Required" section. The severity level should be identified as 1.*

27) **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 there is no MAS nurse required for services, the participant's community provider is notified of the level two medication error at the time of intervention. 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, but not limited to, Type, Cause, Medical Attention Required, Severity, Person Responsible, Person Responsible Classification, Prescriber Notified, and Errors. 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 directly to the Alabama Department of Mental Health Nurse Delegation Program (ADMH/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. The severity level should be identified as 2.*

28) **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 there is no MAS nurse required for services, the participant's community provider is notified of the level three medication error at the time of intervention. 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, but not limited to, Type, Cause, Medical Attention Required, Severity, Person Responsible, Person Responsible Classification, Prescriber Notified, and Errors. 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 directly to the Alabama Department of Mental Health Nurse Delegation Program (ADMH/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. The severity level should be identified as 3. A medication error resulting in death would be considered a Level of Harm 4.*

29) **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, 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 RCS after evacuation is completed and safety of person(s) is ensured. A natural disaster resulting in a moderate injury, or evacuation/relocation from the waiver participant's home is considered a Level of Harm 3. A natural disaster resulting in a major injury or death is a Level of Harm 4.*

30) **Neglect** – The intentional or unintentional failure of a caregiver to provide food, shelter, clothing, medical services, supervision, or basic needs for safety for a person who is unable to care for himself or herself; or failure of a person to

provide for their own basic needs. ADMH-DDD recognizes five types of neglect incidents based on level of harm and/or responsible caregiver as outlined below. **Guidance:** *Neglect includes but is not limited to (a) not providing the level of supervision and support required in a Person-Centered 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.*

a) **Neglect of Person Not Resulting in Significant Harm (LOH 1 or 2)** – When the neglect of the responsible provider does not result in any harm or minor injury to the waiver participant, this will be identified in the GER as *Neglect by Responsible Provider* and distinguished as a level of harm 1 where there is no injury and level of harm 2 where there is minor injury.

b) **Neglect of Person Resulting in Significant Harm (LOH 3 or 4)** – When the neglect of the responsible provider results in moderate or major harm to the waiver participant, this will be identified in the GER as *Neglect by Responsible Provider* and distinguished as a level of harm 3 if resulting in moderate injury, or level of harm 4 if resulting in major injury or death.

c) **Neglect by Family/Guardian (LOH 1, 2, 3, or 4)** – When the neglect of the waiver participant's family/guardian does not result in any harm or minor injury to the waiver participant, this will be identified in the GER as *Neglect by Family/Guardian* and distinguished as a level of harm 1 where there is no injury and level of harm 2 where there is minor injury. When the neglect of the waiver participant's family/guardian results in moderate or major harm to the waiver participant, this will be identified in the GER as *Neglect by Family/Guardian* and distinguished as a level of harm 3 if resulting in moderate injury, or level of harm 4 if resulting in major injury or death.

d) **Neglect-AWOL/Missing Person -** A person who cannot be located and there is reason to believe the person may be lost or in danger. **Guidance:** *An incident involving a waiver participant who is missing or has eloped* ***and is considered lost or in danger*** *must be reported even if this behavior is addressed in the waiver participant's Behavior Support Plan. The provider staff must immediately report to police and the Regional Incident Manager or on call phone (outside of office hours). The notification must include justification of* ***why the person is considered lost or in danger,*** *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.* ***A determination on whether a person is lost or in danger is individualized based on the identified capabilities of the waiver participant, emphasizing encouraging independence and dignity of risk offered to all persons.*** *When reporting in the GER the reporter should distinguish the responsible caregiver by choosing "Neglect by Responsible Provider" or "Neglect by Family/Guardian." These incidents are identified as a level of harm 3.*

e) **Self-Neglect -** 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.

31) **Property Damage** – Exhibiting behaviors, such as physical aggression resulting in property damage or destruction over $250 shall be reported to the Regional Incident Manager or designee by the provider with information on how the situation was/is being addressed. A General Event Report is required for property damage even if those behaviors are addressed in an approved behavioral support plan.

32) **Relocation** – Any time the waiver participant is moved from their home overnight or longer for health/safety concerns, with the exception of natural disasters and fire (*see* Natural Disaster definition).

33) **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 (PMP), 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 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 MAS Nurse 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. The start and end time should be included in the relevant fields of the GER. The start time refers to when the medication is administered, and the end time is when determination of effectiveness is noted by the responsible caretaker.

34) **Restraint-Chemical-Programmatic** – Administration of a medication, specifically authorized and described in a waiver participant's Behavior Support Plan (BSP) or Psychotropic Medication Plan (PMP), 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 prescribed by a physician, and identified and authorized in the waiver participant's BSP or psychotropic medication plan. Any prn administration of a psychotropic medication by a MAC worker must be approved by the MAS Nurse. 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. The start and end time should be included in the relevant fields of the GER. The start time refers to when the medication is administered, and the end time is when determination of effectiveness is noted by the responsible caretaker.*

35) **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:

i) Any maneuver or technique that does not give adequate attention and care to protection of the head.
ii) Any maneuver or technique that places pressure or weight on the chest, lungs, sternum, diaphragm, back, or abdomen.
iii) 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.
iv) Any maneuver or technique that involves constraints to a person's mouth, nose, or eyes.
v) Any maneuver or technique that utilizes pain to obtain compliance or control, including punching, hitting, hyperextension of joints, or extended use of pressure points.
vi) Any maneuver or technique that forces a person to remain in a prone (face down) position.
vii) 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.
viii) 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.
ix) 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. The person(s) applying, in charge during, and removing the restraint must be identified. Refer to additional requirements for use of an emergency manual restraint three or more times in a six-month period.

36) **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:

i) Any maneuver or technique that does not give adequate attention and care to protection of the head.
ii) Any maneuver or technique that places pressure or weight on the chest, lungs, sternum, diaphragm, back, or abdomen.
iii) 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.
iv) Any maneuver or technique that involves constraints to a person's mouth, nose, or eyes.
v) Any maneuver or technique that utilizes pain to obtain compliance or control, including punching, hitting, hyperextension of joints, or extended use of pressure points.
vi) Any maneuver or technique that forces a person to remain in a prone (face down) position.
vii) 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.
viii) 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.
ix) 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. The person(s) applying, in charge during, and removing the restraint must be identified.*

37) **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.

38) **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.*

39) **Seizure (Level of Harm 2 or 3)** - An unexpected or uncharacteristic seizure of any duration, regardless of whether an injury occurs. **Guidance:** *A seizure meeting this definition with no injury is considered a Level of Harm 2, and those resulting in moderate injury a Level of Harm 3.*

40) **Seizure (Level of Harm 4)** - An unexpected or uncharacteristic seizure of any duration, regardless of whether an injury occurs. **Guidance:** *A seizure meeting this definition resulting in major injury or death a Level of Harm 4.*

41) **Suicide Attempt** - Suicide attempts shall be reported to the Regional Incident Manager or designee by the provider with information on how the situation was/is being addressed. A General Event Report is required for suicide attempts even if those behaviors are addressed in an approved behavioral support plan. **Guidance:** *Suicide attempts resulting in moderate injury are considered a Level of Harm 3. Attempts resulting in a major injury or death are considered a Level of Harm 4.*

42) **Suicide Threat** - Suicide threats shall be reported to the Regional Incident Manager or designee by the provider with information on how the situation was/is being addressed. A General Event Report is required for suicide threats even if those behaviors are addressed in an approved behavioral support plan.

43) **Vehicular Safety:** This category of incident includes, but is not limited to, being stopped and/or ticketed for moving violations and vehicular accidents where waiver participants are present. Based on the harm caused to the waiver participant, these incidents will be identified as a level of harm 1 when there is no injury, a level of harm 2 when there is minor injury, a level of harm 3 when there is moderate injury, and a level of harm 4 when there is major injury or death. **Guidance:** *This will be classified in Therap as Vehicular Accident.*

3.2 Level of Harm

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	Definitions

1	• 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. • Death of a person that is due to natural causes and/or is expected and explained.
2	• An incident that results in a minor injury requiring minimal (first aid) treatment. • Law enforcement involvement not resulting in arrests, charges, or incarceration.
3	• Any observable and substantial impairment of a person's physical or mental health requiring medical treatment beyond first aid that results in temporary disfigurement, or impairment of the function of a bodily member or organ, such as a serious fracture, a severe wound requiring sutures, injury to an internal organ(s), a severe burn, or any unscheduled acute medical or psychiatric hospital admission. • Any incident for which there is suspicion of sexual, verbal, or abuse, mistreatment (emotional/psychological abuse), neglect with physical or mental health injury, physical abuse with observed physical injuries, or exploitation. • Any incident in which a waiver participant cannot be located and there is reason to believe the person may be lost or in danger. • Any incident resulting in significant damage to a waiver participant's personal property or home.
4	• Any observable and substantial impairment of a person's physical health requiring treatment beyond first aid that results in permanent disfigurement or impairment of the function of a bodily member or organ. • Death of an individual 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 complication(s), undiagnosed conditions, accidents, or a death resulting from suspected abuse or neglect.

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 any kind;
2) An incident involving two or more waiver participants that does not result in physical or emotional injury;
3) An unexpected or uncharacteristic seizure that results in no injury;
4) Incidents involving vehicles that do not result in injury;
5) A fall resulting in no injury;
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; or
7) Death of a person that is due to natural causes and/or is expected and explained.

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 does not require treatment of by a physician, licensed nurse, or other healthcare professional;
2) An incident that results in minor injury;
3) Law enforcement involvement where no one is arrested, charged, or incarcerated;
4) 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;
5) A choking incident that requires the Heimlich maneuver or other similar intervention but does not require hospitalization or result in death; or
6) Use of any type of restraint that does not result in a moderate or 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 that results in temporary disfigurement, or impairment of the function of a bodily member or organ, such as a fracture, a wound requiring sutures, injury to an internal organ(s), a severe burn, or any unscheduled acute medical or psychiatric hospital admission. This also includes non-injury critical incident types as Level of Harm 3 due to the serious nature of the incident regardless of the circumstances or level of injury/harm.

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 (emotional/psychological abuse), neglect with physical or mental health injury, or exploitation;
2) A moderate injury. This is defined as any observable and substantial impairment of a person's physical or mental health requiring medical treatment beyond first aid that results in temporary disfigurement, or impairment of the function of a bodily member or organ, such as a serious fracture, a severe wound requiring sutures, injury to an internal organ(s), a severe burn, or any unscheduled acute medical or psychiatric hospital admission;
3) An emergency room visit;
4) An unscheduled hospital admission (that does not rise to the level of a major injury or unexpected death);
5) An incident involving a waiver participant who cannot be located and there is reason to believe he/she may be lost or in danger;
6) A natural disaster resulting in a moderate injury, or evacuation/relocation from the waiver participant's home;
7) A fire resulting in injury to a waiver participant or property destroyed;
8) A fall resulting in a moderate injury to a waiver participant;
9) A seizure resulting in a moderate injury;
10) A Level 3 medication error in which a waiver participant experienced life threatening and/or permanent adverse consequence(s);
11) A choking incident requiring hospitalization;
12) Any incident involving law enforcement that results in a waiver participant and/or staff member being arrested, charged, or incarcerated;
13) Incidents involving vehicles that result in moderate injury;
14) A behavioral incident resulting in moderate injury, or property damage that can be repaired/replaced at a cost $250 or above;
15) Use of any type of restraint that results in a moderate injury.

3.2.1.4 Description and Examples of Level of Harm 4 Incidents

1) A major injury. This is defined as any observable and substantial impairment of a person's physical health requiring treatment beyond first aid that results in permanent disfigurement or impairment of the function of a bodily member or organ;
2) A fall resulting in a major injury to a waiver participant;
3) A seizure resulting in a major injury;
4) A behavioral incident resulting in major injury;
5) Incidents involving vehicles that result in major injury;
6) Use of any type of restraint that results in a major injury; or
7) Death of an individual 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 complication(s), medication error, undiagnosed conditions, accidents, or a death resulting from suspected abuse or neglect.

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, their staff members, and self-directed workers are mandatory reporters of all critical incidents involving a waiver participant receiving services 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 Alabama 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 (emotional/psychological abuse), neglect, or exploitation must make an immediate report via phone, followed by a written report using the "Report of an Adult Suspected to Be Abused, Neglected, or Exploited" form (Appendix D), to the County Department of Human Resources. Further information and instructions on how to make these reports to ADHR can be found at https://dhr.alabama.gov/adult-protective-services/. To make the report you must:

1) Call the Alabama Adult Abuse Hotline at 1-800-458-7214 or contact the County Department of Human Resources (DHR).
2) Provide name, date of birth, and address of the waiver participant(s) who was the alleged victim of the abuse, neglect, mistreatment, or exploitation.
3) Provide name of involved service provider(s) (residential, day program, other).
4) Provide a detailed description of the details of alleged abuse, neglect, mistreatment, 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 (GERRs). All contracted direct service providers and support coordination agencies are required to set up user accounts for all staff members providing services to waiver participants in the Therap® system to ensure verifiable data is collected for provision of services.

4.2.1 General Event Reports (GERs).

A General Event Report (GER) contains five basic steps:

1. Initial Event Entry – Creating a new GER as soon as possible after occurrence to document relevant information about the circumstances leading up to 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. The original reporter should complete this information in Therap®. It should also be noted all relevant fields in the GER should be completed, even when a red asterisk is not present.

2. Event Review - Documentation of the initial review 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 analysis of the incident. The review should be completed by the original reporter's supervisor or designee.

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 an individual in the provider organization or support coordination agency designated as responsible for the final review, accuracy/completeness verification, and approval process. Upon verifying the accuracy and completeness of the information in the GER, the supervisory/management staff member approves the GER in the Therap® system. General Event Reports (GERs) for Level of Harm 1 and 2 incidents must be submitted and approved in the Therap® system within 48 hours of initial observation or discovery of the incident. General Event Reports (GERs) for Level of Harm 3 and 4 incidents must be submitted and approved in the Therap® system within 24 hours of initial observation or discovery of the incident. The GER approval cannot be completed by the same person who initiated the GER.

4. ADMH-DDD Review – Upon receiving the notification of the GER in Therap®, the Regional Incident Manager reviews the GER content to determine if it is complete and accurate, requesting corrections by the provider or support coordination agency as deemed appropriate. If there are immediate concerns with a GER's content, the Regional Incident Manager will call the provider, then follow-up with an email. For basic concerns, the Regional Incident Manager will request corrections and/or additions via the Follow-Up Comments section on the GER as soon as possible, but no longer than three working days after the

notice. The Regional Incident Manager will always "unapprove" the GER so corrections can be made by the provider or support coordinator, apart from incorrect event date, report date, agency or program site, and/or individual. In only these four cases would a GER be deleted and re-entered by the provider or support coordinator.

5. Final Review, Approval, and Closure of the GER – Upon receiving notification of the corrections and/or additional information by the provider, the Regional Incident Manger will conduct a final review of the information and if everything is addressed will document approval and closure of the GER by checking the box "I have reviewed this approved report" and adding a comment to indicate that there is no additional follow-up action pending or needed. They will indicate the closure date of the GER in the "provider form" section of the GER.

4.2.2 General Event Report Resolutions (GERRs).

A General Event Report Resolution (GERR) is the documentation of the formal investigation process, findings, and recommendations for an incident involving suspected abuse, neglect, mistreatment, and/or exploitation. The GER Resolution contains the name of the person who completed the investigation, the details of the investigation, the person(s) involved in the investigation, the findings of the investigation, whether the suspected abuse, neglect, mistreatment, or exploitation was substantiated, the recommendations identified from the investigation, the supporting documents related to the investigation, and any general comments about the investigation process, findings, or recommendations. The Regional Incident Manager is responsible for completion of the GERR questionnaire for provider and ADMH-DDD investigations.

4.2.3 One Event Type per GER.

When entering a critical incident into the Therap® system that involves multiple related events, the provider will identify the primary event type and enter the GER as one event (creating one GER Form ID per type). In the case there are multiple primary event types that must be recorded per IPMS definitions that cannot be identified in the primary GER, two or more separate GERs would be entered.

There is one exception to this rule. When there is a Restraint Related to Behavior and an associated injury, the reporter will be required to report both the restraint and injury in one GER (creating one GER Form ID for both the restraint and the injury). Other than this one exception, the reporter should only choose one event type per GER.

1) **Example 1:**
   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 reporter should enter two GERs. The first GER would be identified as the event type "Injury" with an injury type of laceration and the cause as fall. A second GER would be completed for the Hospital Admission.

2) **Example 2:**
   a) **Scenario:** A waiver participant chokes on food at breakfast resulting in aspiration, 911 is called, while in route to the Emergency Room he dies in the ambulance.
   b) **Process for Entry into Therap®:** In this scenario, you would complete one GER for the choking incident and another for the person's death.

3) **Example 3:**
   a) **Scenario:** A waiver recipient had to be manually restrained. After the release of the restraint, an assessment was done, and a laceration was noted to the arm that required three sutures at a local Urgent Care.
   b) **Process for Entry into Therap®:** This is an example of the one exception to the rule, and the reporter would enter one GER. A GER would be entered for Restraint Related to Behavior, and in completion when you choose "yes" for the question, "Injury caused by restraint," before you can submit the GER, the Therap system will prompt you to also include a second event type in the same GER for an injury. A second GER **would not** be needed for the visit to Urgent Care. If the waiver participant had gone to the Emergency Room, a second GER would be required.

4.2.4 Required Notifications and Therap® Data Entry Instruction Table.

The first table provides guidance that identifies the correct Therap® designations for persons/entities that are required to be notified for critical incidents in the notification section of the GER. The second table provides notification timelines for each of the designated persons/entities based on Level of Harm and/or incident types. The third table outlines notifications for serious incident reporting to ADMH Officials by the DDD Associate Commissioner. **Providers must ensure their SComm and email notifications are turned on in the Therap® system to ensure receipt of all communications regarding a GER or GER Resolution**.

Required Notification Types	Enter into Therap® in "Person/Entity" with the Listed Drop-Down Choice(s)
Supervisor/Manager/Administrator	Manager Day Program Manager Residential Manager Administrator Supervisor
Behavior Specialist (BCBA, RBT, etc.)	Behavior Specialist
Family/Guardian/Designated Contact	Family/Guardian
Support Coordinator	Case Manager
Medication Assistance Supervising (MAS) Nurse or Community Medical Provider if MAS Nurse not required for services	Nurse/Medical Personnel
Alabama Adult Abuse Hotline at 1-800-458-7214 or County Department of Human Resources (if self-neglect is alleged)	Adult/Child protective services
Family/Guardian/Designated Contact	Family/Guardian
Regional Incident Manager or designee	Regional Community Services Office
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)	Fire Department
Law Enforcement (if law enforcement is requested to come to the site of the incident)	Law Enforcement
Emergency Medical Services (EMS) if the waiver participant requires ambulance transport to an emergency room or hospital.	Emergency Medical Services
ADMH Bureau of Special Investigations (BSI) (***notification done by Statewide Incident Coordinator***)	ADMH Bureau of Special Investigations
Statewide Incident Management Coordinator (***notification done by Regional Incident Manager***)	ADMH staff enters Administrator (enter "Statewide IMC" in Name of Person Notified field)
Associate Commissioner DDD (***notification done by Statewide Incident Coordinator or Regional Incident Manager***)	ADMH staff enters Administrator (enter "Associate Commissioner DDD" in Name of Person Notified field)
Alabama Medicaid Agency (***notification done by Statewide Incident Coordinator***)	Alabama Medicaid Agency

Required Notifications	All required notifications are to be made as soon as possible but not later than:	Guidance

Supervisor/Manager/Administrator	Level 1: Within 1 hour after the occurrence or discovery of the incident. Level 2: Within 1 hour after the occurrence or discovery of the incident. Level 3: Immediately (within 1 hour). Level 4: Immediately (within 1 hour).	This applies to all reportable incidents.
Family/Guardian/Designated Contact	No later than 24 hours after the occurrence or discovery of the incident.	This applies to all reportable incidents. The provider must notify the waiver participant's responsible relative/guardian. 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. If there is no Family/Guardian to notify, the reporter should type "No Family or Guardian" in the "Name of Person Notified" field and choose "Unable to Notify" in the "Method of Notification" dropdown field.
Support Coordinator	Level 1: Within 48 hours after the occurrence or discovery of the incident. Level 2: Within 48 hours after the occurrence or discovery of the incident. Level 3: Within 24 hours after the occurrence or discovery of the incident. Level 4: Within 24 hours after the occurrence or discovery of the incident.	This applies to all reportable incidents where the Support Coordinator is not the original reporter.
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 (as soon as practical to ensure safety of participant).	For all incident types where there is suspected Abuse/Assault, Neglect, Mistreatment, and Exploitation.
Regional Incident Manager or designee	Level 1: Within 24 hours after the occurrence or discovery of the incident. Level 2: Within 24 hours after the occurrence or discovery of the incident.	This applies to all reportable incidents.

	Level 3: Within 1 hour after the occurrence or discovery of the incident (as soon as practical to ensure safety of participant). Level 4: Within 1 hour after the occurrence or discovery of the incident (as soon as practical to ensure safety of participant).	
Medication Assistance Supervising (MAS) Nurse or Community Medical Provider if MAS Nurse not required for services (if assessment or treatment may be required or if the incident is a Level 2 or 3 medication error)	Immediately.	This applies to any reportable incident where assessment or treatment may be required, or the incident is a Level 2 or 3 Medication Error.
Fire Department	Immediately.	If the fire department is requested to come to the site of the incident related to a fire – does not include EMS/ambulance request.
Law Enforcement	Immediately.	If law enforcement is requested to come to the site of the incident.
Emergency Medical Services (EMS)	Immediately or upon instruction from Nursing/Medical personnel.	If the waiver participant requires ambulance transport to an emergency room or hospital.
Behavior Specialist	Within 24 hours after the occurrence or discovery of the incident.	For incidents of critical/reportable Behavioral-Related Incidents and Restraints.
ADMH DD Division Internal Notifications		
Required Notifications	**All required notifications are to be made <u>as soon as possible but not later than</u>:**	**Guidance**
Regional Community Services Director (***<u>notification done by Regional Incident Manager</u>***)	Within 24 hours after the occurrence or discovery of the incident.	This notification timeframe applies to the following incident types: Physical Abuse/Assault, Sexual Abuse/Assault, Neglect, Mistreatment (Psychological/Emotional Abuse), Verbal Abuse, Exploitation, Level 4 Injuries, Unexpected Death, Missing/Eloped Individual, Level 3 and 4 Fires, "Other Incidents," Level 3 Medication Errors, Level 3 and 4 Natural Disasters, and Emergency Use of Restraints. ***Note exceptions to this in the table for Serious Incident Reporting to ADMH Officials.*
Statewide Incident Management Coordinator (***<u>notification done by Regional Incident Manager</u>***)	Within 24 hours after the occurrence or discovery of the incident.	This notification timeframe applies to the following incident types: Physical Abuse/Assault,

		Sexual Abuse/Assault, Neglect, Mistreatment (Psychological/Emotional Abuse), Verbal Abuse, Exploitation, Level 4 Injuries, Unexpected Death, Missing/Eloped Individual, Level 3 and 4 Fires, "Other Incidents," Level 3 Medication Errors, Level 3 and 4 Natural Disasters, and Emergency Use of Restraints. ***Note exceptions to this in the table for Serious Incident Reporting to ADMH Officials.*
Director of Community Services (***notification done by Statewide Incident Coordinator***)	Within 24 hours after the occurrence or discovery of the incident.	This notification timeframe applies to the following incident types: Physical Abuse/Assault, Sexual Abuse/Assault, Neglect, Mistreatment (Psychological/Emotional Abuse), Verbal Abuse, Exploitation, Level 4 Injuries, Unexpected Death, Missing/Eloped Individual, Level 3 and 4 Fires, "Other Incidents," Level 3 Medication Errors, Level 3 and 4 Natural Disasters, and Emergency Use of Restraints. ***Note exceptions to this in the table for Serious Incident Reporting to ADMH Officials.*
Director of Quality Assurance (***notification done by Regional Incident Manager or Statewide Incident Coordinator***)	Within 24 hours after the occurrence or discovery of the incident.	This notification timeframe applies to the following incident types: Physical Abuse/Assault, Sexual Abuse/Assault, Neglect, Mistreatment (Psychological/Emotional Abuse), Verbal Abuse, Exploitation, Level 4 Injuries, Unexpected Death, Missing/Eloped Individual, Level 3 and 4 Fires, "Other Incidents," Level 3 Medication Errors, Level 3 and 4 Natural Disasters, and Emergency Use of Restraints. ***Note exceptions to this in the table for Serious Incident Reporting to ADMH Officials.*
ADMH Bureau of Special Investigations (BSI) (***notification done by Statewide Incident Coordinator***)	Within 24 hours after receiving the incident notification from the Regional Incident Manager.	This notification timeframe applies to the following incident types: Physical Abuse/Assault, Sexual Abuse/Assault, Neglect, Mistreatment (Psychological/Emotional Abuse), Verbal Abuse, Exploitation, Level

		4 Injuries, Unexpected Death, Missing/Eloped Individual, Level 3 and 4 Fires, "Other Incidents," Level 3 Medication Errors, and Emergency Use of Restraints. ***Note exceptions to this in the table for Serious Incident Reporting to ADMH Officials.*
Alabama Medicaid Agency **(*notification done by Statewide Incident Coordinator*)**	Within 24 hours after receiving the incident notification from the Regional Incident Manager.	This notification timeframe applies to the following incident types: Physical Abuse/Assault, Sexual Abuse/Assault, Level 4 Injuries, Unexpected Death, Level 3 and 4 Natural Disasters, and Level 3 Medication Errors. ***Note exceptions to this in the table for Serious Incident Reporting to ADMH Officials.*
DDD Associate Commissioner **(*notification done by Statewide Incident Coordinator*)**	Within 24 hours after receiving the incident notification from the Regional Incident Manager.	This notification timeframe applies to the following incident types: Physical Abuse/Assault, Sexual Abuse/Assault, Level 4 Injuries, Unexpected Death, Level 3 and 4 Natural Disasters, and Level 3 Medication Errors. ***Note exceptions to this in the table for Serious Incident Reporting to ADMH Officials.*

Serious Incident Reporting ADMH Officials (ADMH DD Internal Notification Policy)	
It is the policy of ADMH that serious incidents involving ADMH facilities, and serious incidents involving individuals served in ADMH facilities, community contract settings, and community non-contract settings shall be immediately investigated, and reported to ADMH leadership in accordance with Divisional policies and procedures. Reports of such incidents shall also be made available to other agencies and to the public as required by law and approved by the ADMH Commissioner.	
Incidents subject to this policy:	Death of an individual due to unknown or unexpected causes to include suicide, homicide, other criminal activity, medical errors or complications resulting from medical errors, undiagnosed conditions, accidents, and suspected abuse or neglect.
	Elopement where individual is considered at risk of harm.
	Natural Disasters and Fires resulting in displacement or relocation.
	Serious injury, including but not limited to, a fracture, wound or laceration, head injury, burn, internal organ injury, stroke, disfigurement, paralysis, amputation, loss of vision, or loss of hearing, that results in impairment of an individual's body or organ due to medical error, complications resulting from a medical error, abuse or neglect, assault, or accident.
	Arrest of Employee while on duty.
	Serious Injury or death of staff while on duty.

Required Notifications	All required notifications are to be made as soon as possible but not later than:	Guidance
DDD Associate Commissioner **(notification made by Regional Incident Manager)**	Immediately reported (within 4 hours) upon discovery or notification.	
ADMH Commissioner **(notification made by DDD Associate Commissioner)**	Immediate verbal notification upon discovery or knowledge of the incident.	Within 24 hours of the verbal notification, the DDD Associate Commissioner will provide a written synopsis to the ADMH Commissioner.
ADMH Legal Director, Bureau of Special Investigation Director, Internal Advocacy Director, and Public Information Office **(written synopsis provided by DDD Associate Commissioner)**	Within 24 hours of the verbal notification, the DDD Associate Commissioner will provide a written synopsis.	The investigation will be assigned and initiated within 24 hours of occurrence or the next business day.
DDD Associate Commissioner **(notification made by Assigned Investigator)**	Within 15 business days of initiating the investigation, findings shall be provided to the DDD Associate Commissioner.	

4.2.5 General Event Report Notification Levels. All critical, state-reportable General Event Reports will be identified by indicating a Medium or High notification level. It should be noted, that while some of these incidents may be considered "low" (i.e., falls without injury and medication errors with no adverse consequences) the submitter should indicate either Medium or High as identified in *Appendix A – Critical Incident Crosswalk*. All General Event Reports that are internal to the agency should use a Low notification level. Distinguishing between these Therap® designed notification levels will allow for data stratification to identify reportable incidents.

SECTION 5 – WHO IS RESPONSIBLE FOR SUBMITTING A GER AND CONDUCTING A REVIEW AND/OR FORMAL INVESTIGATION?

1) Submission of the General Event Report (GER).
    a. The entity/individual responsible for services at the time of the incident 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. For example, 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 services with a different agency (such as residential services, supported employment, etc.) the day program provider would also notify the other provider(s) of the incident that was reported. When the incident occurs at a time the person is self-directing their services, the Support Coordinator is responsible for submission of the GER. If a person is receiving only targeted case management services, the Support Coordinator is responsible for submission of the GER. If the person is with family at the time of the incident, the primary provider of services is responsible for reporting the incident.
        i. If an allegation of abuse, neglect, mistreatment (psychological/emotional abuse), or exploitation is reported to a service provider regarding an incident at another provider of the waiver participant, the provider it was reported to is responsible for reporting the incident to the Department of Human Resources, to the Regional Incident Manager or designee, and to the wavier participant's other provider(s). The Regional Incident Manager is responsible for following up with the responsible provider to ensure proper notifications were made and a GER is entered timely.
    b. It should be noted for any critical/reportable incident to ADMH-DDD, the "Provider Form" must be added as part of the GER submission process. For all events other than Medication Errors, the Responsible Provider or Support Coordinator if person is self-directing services or only receives targeted case management, should add the form and indicate the correct Level of Harm in appropriate field. The Regional Incident Manager will complete the remainder of the applicable information in the "Provider Form." For Medication Errors, the Responsible Provider or Support Coordinator if person is self-directing services or only receives targeted case management, is responsible for adding the form, indicating the correct Level of Harm in appropriate field, as well as identifying the

person responsible and their classification (MAC, LPN, RN, or Other). The Regional Incident Manager will complete the remainder of the applicable information in the "Provider Form." Incidents internal to the provider and not critical/reportable to ADMH-DDD should not have a "Provider Form" completed.

2) Review of the General Event Report (GER).
    a. All critical incidents require some level of review by the provider, support coordinator, and/or ADMH-DDD.
    b. The primary focus areas for reviewing an incident include:
        i. 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.
        ii. Determination of whether staff involved in the incident followed relevant policies and procedures prior to and in response to the incident.
        iii. Determination of staff involved in the incident received proper training and instruction.
        iv. Determination if changes in policies, procedures, or protocols are warranted based on the results of the review.
        v. Identification of any follow-up or corrective actions that may be identified as necessary from the findings of the review.
    c. The scope and intensity of the review should be commensurate with the incident's severity.
    d. For Level of Harm 1 and 2 incidents as listed in this manual, the entity who submitted the GER is responsible for reviewing all relevant fields within the GER to ensure the information was reviewed and corrective action and plans for future corrective actions are provided to indicate the agency's response to the incident. A GER Resolution is not automatically required for these incidents nor a formal written investigation report.
        i. In the case an Incident Review Committee notes a pattern or trend of Level of Harm 1 and/or 2 incidents, a formal investigation may be initiated by the provider and/or at the discretion of ADMH-DDD based on the incident type and severity of the pattern or trend.
3) Formal Investigations and General Event Report Resolutions (GERR).
    a. For incidents involving suspected physical abuse (without visible injury), verbal abuse, neglect (LOH 1 and 2), self-neglect, mistreatment (emotional/psychological abuse), emergency restraints, or exploitation under $500, unless instructed by law enforcement, the ADMH Bureau of Special Investigations, the Department of Human Resources, or the ADMH-DDD, the provider (or ADMH-DDD if the individual is enrolled in self-directed services or targeted case management only) is responsible for conducting a formal investigation and submitting a provider-level GERR (with the exception of self-directed services and TCM which would be an oversight-level GERR):
        i. A GER Resolution in the Therap® system,
        ii. A thorough, detailed written investigation report attached to the GER Resolution in the Therap® system by a formally trained investigator who has completed the ADMH required training,
        iii. Evidence and other documentation relevant to the investigation, including authenticated written statements, and
        iv. The agency's plan of action in response to their findings with associated evidence of remediation activities.
    b. For incidents involving suspected physical abuse (with visible injury), suspected sexual abuse/assault, neglect (LOH 3 and 4; including AWOL/Missing Person), major injury, natural disaster (LOH 3 or 4), fire (LOH 3 or 4), exploitation of $500 or more, and medication error (Level 3), ADMH-DDD is responsible for completing a formal investigation and submitting the following into an oversight-level GERR:
        i. A GER Resolution in the Therap® system,
        ii. A *Summary of Findings* (the Summary of Findings document is also provided to the relevant provider by ADMH-DDD) including recommendations of action for the provider. The Summary of Findings is included as an attachment on the GERR, which is accessible to the relevant support coordination agency.

    A thorough, detailed written investigation report, evidence, and other documentation relevant to the investigation, including authenticated written statements, will be housed internally in ADMH-DDD's SharePoint system.
4) All formal investigations must be completed within 15 business days from the initial notification of the incident. The provider will assign an investigator for those incidents as listed in 3.a. above within 24 hours. The ADMH-DDD Statewide Incident Coordinator or designee will assign an investigator for ADMH-DDD investigations listed in 3.b. above within 24 hours. Investigations must be completed by a provider staff member or ADMH-DDD staff member who has completed the *Conducting Serious Incident Investigations* through ADMH-DDD. *See* Section 8 for more information on this training.
    a. Extensions to the 15-business-day timeline can be requested where there are extenuating circumstances that make it unable for the investigator to effectively and thoroughly investigate and provide the report in this time-period. If a provider needs an extension on the deadline, they must reach out to the Regional Incident Manager to formally request an extension. The provider should identify the extenuating circumstances that prevent them

from completing in 15 business days and provide a new date for submission. If the information provided is reasonable, the Regional Incident Manager can grant this extension. However, ADMH-DDD does reserve the right to require submission in the 15 business days if the circumstances do not support the extension or there is a pattern of extension requests by the provider. ADMH-DDD staff investigating incidents may also follow the same process to request an extension from the Statewide Incident Manager or designee. In instances where the extensions are properly requested and granted, if the report is submitted within the new timeframe, the investigation report will not be considered outside of appropriate timelines for the purposes of incident report procedures. Any extensions granted to the provider or ADMH-DDD will be noted in the comment section of the applicable GER by the Regional Incident Manager.

5) Upon receiving the notification of the GERR in Therap®, the Regional Incident Manager reviews the GERR content to determine if it is complete and accurate, requesting corrections by the provider or support coordination agency (for incidents involving participants in self-directed services or TCM-only) as deemed appropriate. If there are immediate concerns with a GERR's content, the Regional Incident Manager will call the provider with a follow-up email. For basic concerns, the Regional Incident Manager will request corrections and/or additions via the Follow-Up Comments section on the GERR as soon as possible, but no longer than three (3) working days after the notice.
6) Upon receiving notification of the corrections and/or additional information by the provider, the Regional Incident Manger will present the GERR information to the Incident Review Committee who will make any final requests and/or recommendations that will be relayed to the provider to respond within three (3) working days.
7) Upon final review of the investigation by the ADMH-DDD IRC for contracted provider investigations, or based on the date requested by ADMH-DDD in ADMH-DDD investigations, the responsible provider who entered the incident report (which includes the support coordination agency for incidents involving participants in self-directed services or TCM-only) must submit evidence of remediation, if applicable, for the investigation recommendations within 30 calendar days.
8) The Regional Incident Manger will conduct a final review of the information and if everything is addressed, including the submission of evidence of remediation activities by the provider, will document approval and closure of the GERR by adding a comment to indicate that there is no additional follow-up action pending or needed and completing the associated GERR questionnaire.
9) The provider is responsible for completing a GER and a Comprehensive Mortality Review for all deaths (or the support coordinator if the participant is enrolled in self-directed services or targeted case management services only). The Regional Community Services Office's Registered Nurse or designee reviews the content provided in the Comprehensive Mortality Review for all deaths. The Regional Community Services Office reserves the right to initiate a formal investigation for any incident involving death.
10) The ADMH Rights Protection and Advocacy Program may also investigate critical incidents. If the Advocacy Program chooses to investigate, they will notify the ADMH-DDD Associate Commissioner. However, this does not negate the requirement of the DD Division to investigate the incident per the processes outlined in this manual.
11) The provider must fully cooperate with the Alabama Department of Mental Health's investigation. If the provider is uncooperative during the investigative process, including but not limited to, access to witnesses, review of relevant documents, and observation of physical locations, the Provider Non-Compliance Letter remediation process will be used, which can potentially result in a for-cause review or a review of the provider's contract which includes this language.
12) The Regional Incident Manager is responsible for ensuring the GERR questionnaire is completed for all investigations, which includes critical information related to the findings, review, recommendations, follow-up, and closure of the report.
13) If the provider disagrees with the findings of the Alabama Department of Mental Health-DDD's investigation or a reversal of the provider's investigation, the following appeal process can be used.
    a. The provider must submit their appeal in writing, if applicable, attached to an email correspondence to the applicable Regional Incident Manager within 10 days of receiving the ADMH Summary of Findings. The provider should include any evidence or relevant information to support their appeal.
    b. The Regional Incident Manager will present the appeal and any associated documentation to the Monthly Incident Review Committee (at the next available meeting date/time from appeal submission).
    c. The Statewide Incident Coordinator will utilize the *Investigation Findings Appeal Form* to document the committee's decision to uphold or reverse the findings of the investigation based on the information presented by the complainant.
    d. This form and all information submitted will then be reviewed by the Director of Quality Assurance, who will provide the findings to the DDD Associate Commissioner.
    e. The DDD Associate Commissioner will make a final determination and inform the provider of the final decision.

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 Reporting Deaths

1) **Creation of the General Event Report (GER) -** Provider staff with direct knowledge of the incident and the people involved gathers relevant information about the incident and initiates a General Event Report (GER) in the Therap® system. For those receiving self-directed services or only targeted case management services, the Support Coordinator will complete and submit the GER within 24 hours of learning of the death. In the case of a discharge during the death event (i.e. hospitalization of the person, transfer process, etc.) the primary provider will still be responsible for the GER and Comprehensive Mortality Report unless the person was fully discharged from the waiver at the time of death. 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 Incident Manager Initial Notification -** If the death is considered expected/natural, the provider (or Support Coordinator in the case of those receiving self-directed services or only targeted case management services) must notify the Regional Incident Manager or designee within 24 hours after the occurrence or discovery of the death. If the death is considered unexpected, the provider (or Support Coordinator in the case of those receiving self-directed services or only targeted case management services) must notify the Regional Incident Manager or designee immediately (within one hour) upon the provider's or Support Coordinator's discovery or notification of the death. If outside regular working hours, the provider will call and leave a message on the regional office on-call phone.
   a) 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.
4) **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 – *see* Appendix) completed by the MAS RN/LPN. When completed, the Medication Error Report should be emailed 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 waiver participant – signs, symptoms, ER visit, etc. A copy of the completed Medication Error Form must also be attached electronically to the GER.
5) **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. Upon verifying the accuracy and completeness of the information in the GER, the supervisory/management staff member assigns responsibility to complete the Comprehensive Mortality Review, which must be completed within 15 business days.

6) **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* Appendix) 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 review of the death.
   b) Assignment to complete the Comprehensive Mortality Review:
      i) The program provider's supervisory/management staff assigns responsibility to an appropriate staff member (nurse, quality, QDDP, etc.) to complete the Comprehensive Mortality Review.
      ii) The Support Coordinator for self-directed services or only targeted case management services will report the death to the Regional IPMS Manager or designee 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 provide as much information as possible on the Comprehensive Mortality Review form and attach to the GER.
   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 completed Comprehensive Mortality Review will be uploaded to the GER (not as a GER Resolution) within 15 business days of the initial event date.
7) **Regional Incident Manager Initial GER Review –** Upon review of the GER in the Therap® system, the Regional Incident Manger reviews the GER content to determine if it is complete and accurate making corrections as deemed appropriate. If there are concerns about the GER content, the Regional Incident Manager describes what needs to be completed/revised in the GER Review/Follow-Up Comments section and informing the provider that those revisions must be completed in Therap® as soon as possible but not more than three (3) working days after the notice. ADMH-DDD reserves the right to initiate an investigation into any incident as they deem necessary.
8) **RCS Nursing Review and Approval** - Upon receipt of the Comprehensive Mortality Review report for an unexpected death, the Regional Incident Manager will inform the Regional Community Services Director who will assign the Regional Nurse to conduct a follow-up onsite review to verify the process, findings, and recommendations of the Comprehensive Mortality Review and, if applicable, set a deadline for completion and submission of any evidence related to identified recommendations. The Regional Nurse will, by the assigned date, complete the follow-up onsite review of the death. The Regional Nurse will note any concerns with the process, findings, or recommendations made by the provider in the Comprehensive Mortality Review and make recommendations for necessary follow-up by the provider.
9) **Initial Incident Review in Weekly Incident Review Committee –** The Regional Incident Manager 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 (3) working days after the notice.
10) **Final Incident Review in Weekly RCS Incident Review –** Upon receiving notice the Comprehensive Mortality Review report is finalized by the Regional Nurse and uploaded into the Therap® system, the Regional Incident Manager reviews the information in the next weekly Regional Incident Review Committee Meeting. If there are any questions/recommendations from the Incident Review Committee, the Incident Manager 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 (3) working days after the notice.
11) **Results Follow-up to and From the Provider –** The provider must provide documentary evidence to address each of the recommendations in the Comprehensive Mortality Review. Documentary evidence addressing each of the follow-up actions must be attached electronically to the GER in the Therap® system.
12) **Final Review, Approval, and Closure of the GER** – Upon receiving provider notification of the actions taken based on the recommendations from the Comprehensive Mortality Review in the GER, the Regional Incident Manager will close the GER in the Therap® system.
   a) If the GER is complete and contains all required elements, the Incident Manager documents approval and closure of the GER in the Therap® system by checking the box "I have reviewed this approved report." Upon completing these steps, the Incident Manager enters the date that the GER is closed in the appropriate field in the "Provider Form."

5.3 – Required Procedures Related to Restraint Usage

5.3.1 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/approved 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 3.

5.3.2 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.

5.3.3 Restraint-Related Staff Training Requirements.

As a certified provider of services contracted with ADMH-DDD providing services and supports to waiver participants, in the ADMH-DDD Provider Operational Guidelines 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 crisis intervention training (also referred to in policy as management of aggressive behavior) prior to working alone with any waiver participants and within 90 days of employment [Operational Guidelines §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:
    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
    g) SAMA – Satori Alternatives to Managing Aggression
    h) Mindset Safety Management
    i) Handle with Care
    j) Aegis Crisis Prevention
    k) Managing Crisis Safely (Glenwood Model)

If another curriculum is selected by the provider, that curriculum must be submitted to and approved by ADMH-DDD (via the Director of Psychological and Behavioral Services) prior to its use, by submitting the following information:

a) Program Manual, along with summary description of program.
b) Program Learning goals and objectives.

c) Format of training and delivery to staff. Identify the trainer(s), their certification/ qualifications, are they in-house/consultant. Is training one-on- one, group format. If delivered in online format, is there an added hands on/ experiential component provided? Describe this component.
d) Time commitment to complete training
e) How staff competency is assessed post training.
f) Plan for annual retraining/refresher.
g) Certification documentation for trainer(s).

2) Within 90 days of employment, all direct services employees must receive training on the Alabama Behavioral Services Procedural Guidelines, which must be adhered to as a minimum set of standards for providing Positive Behavior Supports to individuals enrolled in the HCBS Waiver Programs. [§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)].
6) The curriculum used at the agency, as well as staff training records should be available for review by ADMH-DDD when requested.

5.3.4 Required Follow-up Procedures for Frequent Restraint Usage

1) The use of chemical, manual, and mechanical restraints as an emergency procedure three or more times in a six-month period requires the waiver participant's Team to meet, within five working days of the third use, to determine if a BSP that includes the use of restraint is needed. The Team'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 chemical, manual, and mechanical restraints as an emergency procedure at any time requires the development of a prevention plan as a result of the incident. However, the development of a prevention plan alone does not remove the requirement for a Behavior Support Plan when a more comprehensive plan for intervention is warranted.
3) ADMH-DDD Quality Assurance Specialists review 100% of restraints reported utilizing a Restraint Evaluation Review form to ensure restraints are implemented as outlined in the person's Behavior Support Plan, Psychotropic Medication Plan, and/or Person-Centered Plan. This information is provided weekly to the Regional Incident Managers as a tool to provide feedback and technical assistance to providers in their incident documentation of restraint usage. The information is also provided quarterly to the Office of Psychological and Behavioral Services to note patterns or trends that may warrant additional support to providers in their crisis intervention techniques. Provider should review the form to ensure all pertinent information on restraints are included in the GERs, included but not limited to, a copy of the appropriate plan, identification of approved staff training to implement restraints, de-escalation techniques, etc. See Appendix F.

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/developmental 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 local 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 ADMH-DDD 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 ADMH-DDD 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 review and/or formal investigation of the critical incident, findings from that review and/or investigation, and any follow-up corrective or improvement activities necessary to address the findings of the review and/or investigation. All relevant documentary evidence related to the review and/or investigation beyond what is entered into the Therap® fields including, but not limited to, a formal 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 a provider's 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), quality staff, 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 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 §6.3.4 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.
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 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 ADMH-DDD Incident Management Oversight Activities

6.2.1 Review of GERs and GER Resolutions Upon Receipt

1) All procedures outlined in Sections 4 and 5 above regarding the steps to report, review, investigate, and complete necessary follow-up actions for each critical incident must be followed by providers and ADMH-DDD staff.
2) The Regional Incident Manager will track each critical incident for future reference. The tracker maintained by the Incident Manager will track the following information, including but not limited to:
   a) Date(s) of submission and approval of the initial GER,
   b) Date(s) and time(s) of all required notifications,
   c) Date(s) of requested follow-ups and receipt of requested information related to the GER,
   d) Date(s) of review of the GER in the weekly Regional Incident Review Committee (IRC) meeting,
   e) Close date(s) of the completed GER by the Incident Manager (also entered in the Therap® system),
   f) Information required for all investigations in the GERR questionnaire, and
   g) For incidents involving suspected abuse, neglect, mistreatment, or exploitation:
      i) Date of submission of the GER Resolution,
      ii) Date(s) 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 Regional IRC meeting,
      iv) Close Date of completed GER Resolution by the Incident Manager (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 Regional Incident Manager will also maintain a tracker of 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) The Statewide Incident Management Coordinator will appoint members to the weekly Regional Incident Review Committee (IRC) that will be led by the Regional Incident Manager. Members of this committee must include, but is not limited to, the RCS Director, the Regional Incident Manager, the Regional Nurse, the Regional Quality Assurance Specialist, the Regional Investigator, 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 Regional 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 Regional Incident Manager will notify the provider of the request via follow-up comments in the GER or GERR 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.
4) The Regional Incident Manager will review the revised GER/GER Resolution in the next weekly IRC meeting for final approval.

5) The Regional Incident Manager will log the final approval of the GER/GER Resolution in the Therap® system.

6.2.3 Monthly Incident Data and Trends Analysis Review

1) The Statewide Incident Management Coordinator will appoint a standing committee to review incident data and trends information monthly that will be led by the Regional Incident Manager. The membership of this standing committee must include, but is not limited to, the RCS Director, Regional Incident Manger, Regional Nurse, Regional Quality Assurance Specialist, Regional Investigator, a Certification Specialist representative, a Behavioral Services representative, and an ADMH Advocacy Program representative. Other members may be appointed at the discretion of the Statewide Incident Coordinator or Director of Quality Assurance. In order to move forward conducting the monthly meeting, the Statewide Incident Coordinator will verify a quorum of 2/3rd members are available.
2) On the tenth working day of each month, the Regional Incident Manager will query the Therap® system to identify all critical incidents by incident type that occurred two months in arears.
3) Frequency data for each critical incident type will be entered into an ADMH-DDD workbook to analyze data at the regional and statewide level. This workbook is maintained in SharePoint and can be accessed by the Regional Incident Manager, Statewide IMC, and Director of Quality Assurance. This workbook contains both frequency data tables and trend graphs that show trends in incident frequencies over time. This Performance Measure Workbook will also contain a statewide compilation and trends graphs that summarize the regional incident data for statewide evaluation.
4) The Regional Incident Manager, 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 Incident Manager.
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. This includes the provider non-compliance data, which should be analyzed to determine is systemic remediation needs to occur at the agency-level. For each trend identified as a concern:
    a) The Statewide Incident Management Coordinator will make assignments for necessary follow-up on each identified trend and establish a response date for each identified action in coordination with the committee and relevant office supervisors. The response date must allow sufficient time for review of the findings and actions by the Statewide IMC and Regional Incident Manager prior to the next monthly Committee meeting.
    b) The Statewide IMC and Regional Incident Manger 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. The committee includes the ADMH-DDD Associate Commissioner, Statewide Incident Management Coordinator, Quality Assurance Director, DD Community Services Director, Psychological & Behavioral Services Director, Provider Certification Director, Support Coordination Director, ADMH Advocacy Program representative, Bureau of Special Investigations representative, ADMH Director of Nurse Delegation, a representative from the Alabama Medicaid Agency, a representative from ADHR, a representative from ADAP, a direct service provider representative, a support coordination agency representative, a person with lived experience, and a family member stakeholder. Other members may be appointed at the discretion of the ADMH-DDD Associate Commissioner. The RCS Directors, Regional Incident Managers, Quality Assurance Specialists, and IPMS Investigators 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 will be entered into an ADMH-DDD workbook to analyze data at the regional and statewide level. This workbook is maintained in SharePoint and can be accessed by the Regional Incident Managers, Statewide IMC, and Director of Quality Assurance. This workbook contains both frequency data tables and trend graphs that show trends in incident frequencies over time. This Performance Measure Workbook will also contain a statewide compilation and trends graphs that summarize the regional office data for statewide evaluation. This data will serve as the primary data source for the quarterly analysis.
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 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 Incident Manager.

4) The statewide quarterly review will focus on:
   a) Review of critical incident frequency data to identify provider and/or region-specific trends or patterns in the incident data and the impact of follow-up actions taken by ADMH-DDD.
   b) Identification of any statewide trends or patterns that require follow-up beyond follow-up actions taken by the ADMH-DDD.
   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 Incident Manager.
   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, as needed.
   d) Periodic review of General Event Reports, General Event Report Resolutions, and Therap® systemwide reports using the Report Library and Business Intelligence analysis tools to measure regional office adherence to the IPMS requirements.
   e) Preparation, with active involvement of each Regional Incident Manager, of all required reports for waiver performance measures, ADMH divisional and agency-wide reports, and any reporting required by the Alabama Medicaid Agency.

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 Incident Managers 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 7 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 Waiver Program (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 assurance 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 emergency restraints 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 and email notifications are 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 – Three (3) Requests in Seven (7) Working Days

When a provider fails to comply with any of the IPMS Manual requirements, they may receive a "Provider Non-Compliance Letter." These letters provide an accountability process to ensure providers are adhering to ADMH-DDD regulations regarding incident reporting to protect the health and safety of waiver participants in Alabama. There are two type of letters, which both follow the same process. The first letter type is used for minor issues and results in data to identify patterns and trends at the agency that may lead to required technical assistance and/or Certification review. The second letter type is used for noncompliance with requirements that could immediately impact the health and safety of waiver participants and can result in an agency review, for cause review, contract review, and/or decertification.

1) LETTER PROCESS
   a) INITIAL REQUEST - The Regional Incident Manager will notify the provider with a comment on the GER regarding a request for information and/or follow-up action related to a GER and allow three (3) working days from the date of request from the Incident Manager.
   b) SECOND REQUEST - If the provider fails to comply with the initial request, the Incident Manager will send a letter by email to the agency's Executive Director or designee 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 letter request. The Incident Manager will allow the provider **two (2) working days** from the date of the Second Request email notification to comply.
   c) THIRD REQUEST - If the provider fails to comply with the second request, a final letter will be sent via email to the agency's Executive Director or designee notifying them of the continued non-compliance and that this is the final request that will be sent. A copy of the non-compliance letter will be attached to the GER in the Therap® system along

with a comment in Therap® that this is the final request to comply. The provider will have **two (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 "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 §7.2 above for the second letter type where noncompliance with requirements could immediately impact the health and safety of waiver participants and 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 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 review 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 §580-3-23-.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). A course on how to write an investigative report is also available at: ADMH - Writing an Investigative Report (reliaslearning.com).

8.2 Therap® System Access

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

8.3 Therap® Provider Technical Assistance

New providers will receive initial Therap® system training as part of the creation of a Provider account. Please contact the RCS Regional Incident Management Coordinator in your region to obtain more information about accessing the Therap® system. Also, please visit https://help.Therap®services.net/app/alabama-idd-providers for more information on how to use the Provider account.

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 at 800-361-4491 to determine whom to send the participant's information by Secure Communications (SComm) in the Therap® system.
2. Include the following information in the body of the SComm: **First Name, Last Name, ADIDS #**, **Medicaid #**, **Date of Birth**, and indicate the specific waiver in which the waiver participant participates.
3. Community providers will need to ensure that **Multi-Provider SComm** has been turned on under Agency Wide and Administrative Roles on the User Privilege page **prior to sending SComm**. To learn more about this process, visit: SComm Alabama.

You can locate the most recent Guidance document on the state page under the **Admin - Intake / Referral Process for AL I/DD Providers** section.

8.5 Therap® Training Resources

Community providers may access the Therap® Training suite to find 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 various training resources by accessing The Training Menu on the banner of the Help & Support Page. This can be accessed at the bottom of all screens while logged into an account, or by visiting this link: Therap® Training Courses

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 can access Live Help at the bottom of all screens while logged into Therap®.

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: User Guides - General Event Reports (GER)
2. For user guides on General Event Report (GER) Resolutions, please visit: User Guides - GER Resolution
3. For additional guides on GER review and prior to Approval visit: User Guides - GER Review and Return to Submitter

8.8 Therap® Password Reset

Community providers may enable Self Password Reset to select users in the Provider account by activating this feature administratively for the user. For the user guide on how to set up Self Password Reset, please visit this link: User Guides - Self Password Reset. The user will then perform the initial steps to set up Self Password Reset from within their Login account. Once set up is completed, the user can access this feature from the "**Forgot Password**?" feature on the Therap® login page. See the link here: Therap® Secure Login Page.

APPENDICES

Appendix A - Critical Incident Crosswalk Table

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

Appendix B - ADMH Comprehensive Mortality Review Template

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

Appendix C - NDP-4 Form

https://mh.alabama.gov/level-2-or-level-3-medication-error-form/

Appendix D – ADHR APS, Adult Abuse Reporting Form and Instructions

https://dhr.alabama.gov/wp-content/uploads/2019/07/AdultAbuseReportingForm.pdf
https://dhr.alabama.gov/wp-content/uploads/2019/07/DHRASD798Instructions.pdf

Appendix E - ADHR APS, Abuse Registry Clearance Form and Instructions

https://dhr.alabama.gov/adult-protective-services/alabama-elder-and-adult-in-need-of-protective-services-abuse-registry/

Appendix F – Restraint Evaluation Review (RER) Form