LIBERTY HOUSE FOUNDATION, INC.

PROTECTION OF PEOPLE WITH SPECIAL NEEEDS

Standards for Incident Reporting, Expectations for Prompt and Thorough Investigations and Incident Review Committee Findings and Recommendations

PART 524-OMH – INCIDENT MANAGEMENT REGULATIONS

PART 624-OPWDD – INCIDENT MANAGEMENT REGULATIONS

PART 625-OPWDD – EVENTS AND SITUATIONS THAT ARE NOT UNDER THE AUSPICES OF AGENCY REGULATIONS

LIBERTY HOUSE FOUNDATION, INC. WILL MAKE EVERY CONCERTED EFFORT TO PROTECT THE INDIVIDUALS WE SERVE. ALL STAFF HIRED BY LIBERTY HOUSE WILL COMPLETE THE FOLLOWING PRE-EMPLOYMENT BACKGROUND CHECKS:

JUSTICE CENTER – CHECK OF STAFF EXCLUSION LIST
JUSTICE CENTER – CRIMINAL BACKGROUND CHECK
CENTRAL REGISTER CHECK – CHECK OF STATEWIDE REGISTER OF CHILD ABUSE
OPWDD - MHL 16.34 – CHECK OF SUBSTANTIATED ABUSE IN OPWDD SYSTEM
DEPARTMENT OF MOTOR VEHICLE - DRIVERS LICENSE CHECK
DRUG SCREENING

ALL STAFF WILL READ, REVIEW AND SIGN THE JUSTICE CENTER CODE OF CONDUCT AND MANDATED REPORTING REQUIREMENTS.

INCIDENT REVIEW PLAN

To ensure the health and safety of Liberty House clients, as well as to ensure prompt reporting and investigation, Liberty House adheres to the procedures set forth in this plan as to prompt reporting, investigation, and review of allegations of abuse and neglect, significant incidents and reviewable incidents. All staff will receive training as to the proper procedures set forth in this plan.

REVISED: February 21, 2019
ADOPTED: February 28, 2019

FOR *COMPLETE* DEFINITIONS OF ALLEGATIONS OF ABUSE, NEGLECT, SIGNIFICANT INCIDENTS, SERIOUS NOTABLE OCCURRENCES AND MINOR NOTABLE OCCURRENCES PLEASE REFER TO Part 524 or Part 624 or 625

REPORTABLE INCIDENT - ABUSE AND NEGLECT

Physical abuse: non-accidental contact with a client, which causes or potentially causes physical pain or harm.

Sexual abuse: any sexual contact involving a custodian and a client, or any sexual contact involving a client that is encouraged or allowed by a custodian.

Psychological or emotional abuse: Includes any verbal or nonverbal conduct that is intended to cause a client emotional distress.

Deliberate misuse of restraint or seclusion: Restraint that is done for the purpose of punishment, for the convenience of a custodian, or with deliberate cruelty.

Neglect: any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a client.

Aversive conditioning: Unpleasant physical stimulus used to modify behavior without person-specific legal authorization; or

Obstruction: conduct by a custodian that is intended to impede the discovery, reporting or investigation of a reportable incident.

Unlawful use or administration of a controlled substance: any administration by an employee of a controlled substance as defined by Public Health Law without a lawful prescription, or any unlawful use or distribution by an employee at the workplace or while on duty

REPORTABLE INCIDENTS -SIGNIFICANT INCIDENTS

Conduct between persons receiving services: that would constitute abuse as described in paragraphs (1) through (7) of this subdivision if committed by a custodian, except sexual activity involving adults who are capable of consenting and consent to the activity; or

Conduct on the part of a custodian, that is inconsistent with the individual's plan of services, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, and that impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services, including:

Seclusion: The placement of individual receiving services in a room or area from which he or she cannot, or perceives that he or she cannot, leave at will except when such placement is specifically permitted by section 633.16.

Unauthorized use of time-out: Means the use of a procedure in which a person receiving services is removed from regular programming and isolated in a room or area for the convenience of a custodian, for disciplinary purposes, or as a substitute for programming;

Medication error with adverse effect: The administration of a prescribed or over-the-counter medication that is inconsistent with a prescription or order issued for a service recipient by a licensed qualified health care practitioner, and that has an adverse effect on an individual receiving services. Adverse effect means the unanticipated and undesirable side effect from the administration of a particular medication, which unfavorably affects the wellbeing of a person receiving services.

Inappropriate use of restraints: The use of a restraint when the technique that is used, the amount of force that is used, or the situation in which the restraint is used is inconsistent with an individual's plan of services (including a behavior support plan), generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies. A restraint includes the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

Mistreatment: Other conduct on the part of a custodian, that is inconsistent with the individual's plan of services, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, and that impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services.

Missing Person: The unexpected absence of an individual receiving services, that based on the person's history and current condition, exposes him or her to risk of injury.

Choking, with known risk: The partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food that leads to a partial or complete inability to breathe, involving an individual with a known risk for choking and a written directive addressing that risk.

Self-abusive behavior, with injury: A self-inflicted injury to an individual receiving services that requires medical care beyond first aid.

Choking, with no known risk: Partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food, that leads to a partial or complete inability to breathe, other than choking with known risk.

A person is considered to have no known risk of choking if the person:

 does not have a documented history of choking or aspiration; does not have a modified consistency diet due to a swallowing disorder or other documented risk of choking; does not have a service plan including intervention to address rapid eating or food seeking behavior or other risk of choking.

Unauthorized absence: The unexpected or unauthorized absence of a person after formal search procedures have been initiated by the agency. Reasoned judgments, taking into consideration the person's habits, deficits, capabilities, health problems, etc., determine when formal search procedures need to be implemented. It is required that formal search procedures must be initiated immediately upon discovery of an absence involving a person whose absence constitutes a recognized potential danger to the wellbeing of the person or others.

Injury, with hospital admission: An injury that results in the admission of a service recipient to a hospital for treatment or observation.

Theft and financial exploitation: Any suspected theft of a service recipient's personal property (including personal funds or belongings) or financial exploitation, involving a value of more than $100.00; theft involving a service recipient's credit, debit, or public benefit card (regardless of the amount involved); or a pattern of theft or financial exploitation involving the property of one or more individuals receiving services.

Other significant incident: An incident that occurs under the auspices of an agency, but that does not involve conduct on the part of a custodian, and does not meet the definition of any other incident described in this subdivision, but that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a person receiving services

NOTABLE OCCURRENCES - SERIOUS:

IMMEDIATE NOTIFICATION and entry into IRMA.

Death: The death of any person receiving services, regardless of the cause of death. This includes all deaths of individuals who live in residential facilities operated or certified by OPWDD and other deaths that occur under the auspices of an agency.

Sensitive situation: Those situations involving a person receiving services that do not meet the definitions of other incidents but that may be of a serious delicate nature, and are reported to ensure awareness of the circumstances. Sensitive situations may include but not be limited to, must be defined in agency policies and procedures, and include, but not be limited to, possible criminal acts committed by an individual receiving services.

MINOR NOTABLE OCCURRENCES:

ENTRY INTO IRMA

Injury: Any suspected or confirmed harm, hurt, or damage to an individual receiving services, caused by an act of that individual or another, whether or not by accident, and whether or not the cause can be identified, that results in an individual requiring medical or dental treatment by a physician, dentist, physician's assistant, or nurse practitioner, and such treatment is more than first aid.

Theft or financial exploitation: Any suspected theft of a service recipient's personal property (including personal funds or belongings) or financial exploitation, involving values of more than $15.00 and less than or equal to $100.00, that does not involve a credit, debit, or public benefit card, and that is an isolated event.

AGENCY INTERNAL OCCURRENCES:

Those situations involving a person receiving services that are reported to the Incident Review Committee for awareness, review and recommendations.

REPORTING OF INCIDENTS

ALL ALLEGATONS OF ABUSE AND NEGLECT AND SIGNIFICANT INCIDENTS FOR OMH PROGRAMS MUST BE REPORTED FIRST TO:

THE JUSTICE CENTER @ 1-855-373-2122.

EFFECTIVE JUNE 30, 2013, ALL DEATHS OMH/OPWDD MUST BE REPORTED TO:

THE JUSTICE CENTER @ 1-855-373-2124.

Once the Justice Center receives, a report they will make a determination as to whether or not they will investigate or they will turn it over to the state agency the client is funded by. The state agency will then make a decision as to whether or not they will investigate or turn it over to the provider. The provider will be e-mailed by the Justice Center or the overseeing state agency that a report has been made and there is a pending incident in their Que.

Liberty House shall document all incidents and the results of investigations and report them using current incident management and reporting programs for each state agency.
NIMRS-OMH and IRMA–OPWDD. (Form 158 is used to submit Investigative Record of Abuse/Neglect to OPWDD). Only trained, objective staff that has been given secure access shall investigate and report incidents. The agency will keep record of investigative training by the Justice Center, OMH and OPWDD in personnel file.

IMMEDIATE INTERNAL REPORTING

Immediate Reports - by telephone or in person **first** to Julia Beebe, Executive Director, (518) 240-6022 (home) or (518) 744-5177 (cell) Reportable Incidents and Serious Notable Occurrences. If not available Christina Maresco, Program Coordinator, (518) 260-1042.

Within 48 Hours: of occurrence or discovery: Minor Notable Occurrences

IMMEDIATE EXTERNAL REPORTING

Reports - by telephone, fax, or other appropriate means, of all allegations of abuse and neglect and significant incidents. **The subject of an allegation of abuse/neglect must be notified that an investigation is being conducted unless notifying the subject would impede the investigation. When cases are assigned to the agency the investigator must request that the Justice Center conduct a search in the Statewide Central Register for any known subjects/suspects in the case. Completed SCR check form should be e-mailed to: subjectssearch@justicecenter.ny.gov**

* **The New York State Office of Mental Health** – **518-402-4478** – Clinical Risk Management- Contact: Ellie Hunt. Facility Code # 6475, Day Program Code # 0770, ISES Program Code # 4340, Advocay Program Code # 1760 **ANY QUESTIONS REGARDING REPORTING CALL - 518- 474-3619**

* **The New York State Office for People with Developmental Disabilities – 518-408-2180 – Incident Management Unit –** Contact: Paul Johnston Facility Code # 40100.

* **OPWDD: AFTER HOURS NUMBER: 888-479-6763**

*** Client's next of kin, guardian or qualified person ***

- Of allegations of client or child abuse or neglect, incident resulting in injury, or if the person is missing and his life is in jeopardy, or an accident or injury that affects the health or safety of a consumer. Unless there is written advice from the above that they object to such notification.
  **** As defined in Section 33.16 Mental Hygiene Law, e.g., parents or other legal guardians, parents, spouses, or adult children with decision-making authority for adult consumers.***

  Service Coordinator
  Residential Staff

* **Law enforcement officials within 3 days if:**

- Any intentional hitting, slapping, pinching, kicking, hurling, strangling or shoving of an individual receiving services by a staff member, intern, contractor, consultant or volunteer of a DDSO or provider entity.

- Any intentional hitting, slapping, pinching, kicking, hurling, strangling or shoving of an individual receiving services by another individual receiving services.

- Any unauthorized or unnecessary use of restrictive personal intervention techniques, including the use of more physical force than is necessary for the safety of the individual receiving services, by a staff member, intern, contractor, consultant or volunteer.

- Any unauthorized or inappropriate use of restraint where the staff member, intern, contractor, consultant or volunteer knowingly acts in a manner likely to cause injury to the physical or mental welfare of the person receiving services may be a crime and must be reported to law enforcement.

- Any sexual contact between two persons receiving services in which one person receiving services uses force or coercion may be a crime and must be reported to law enforcement.

- Any sexual contact between two persons receiving services, in which at least one person has not been determined to be capable of consenting to sexual contact may be a crime and must be reported to law enforcement.

- Any sexual contact between a person receiving services and a person not receiving services, who is not an employee, intern, consultant, contractor or volunteer of an agency, where the person receiving services has not been determined to be capable of consenting to sexual contact may be a crime and must be reported to law enforcement.

- If a sexual consent determination has not been completed for an individual, or if an individual's condition has changed such that there is any question as to the individual's ability to consent, clinical staff should be immediately consulted to complete a sexual consent determination. If a sexual consent determination cannot be completed within 24 hours, the agency must report to law enforcement as soon as it is evident that the sexual consent determination cannot be completed within that timeframe.

- Engaging in a pattern of conduct (more than an isolated incident of misconduct) which may include the use of verbal threats, screaming, taunting or shouting at a person receiving services by a staff member, intern, contractor, consultant or volunteer, with the intent of causing ridicule, humiliation, scorn, contempt, pain or dehumanization to an individual or individuals receiving services which causes emotional pain to such individual(s) may be a crime and must be reported to law enforcement.

- Any situation in which a staff member, intern, contractor, consultant or volunteer knowingly acts, or fails to act, in a manner likely to be injurious to the physical or mental welfare of an individual unable to care for himself or herself may be a crime and must be reported to law enforcement.

- Any instance in which an individual dies in a manner in which the cause of death is unknown, or in which the individual is not under the care of a physician and the death is not due to natural causes must be reported to law enforcement.

- Theft, fiscal misappropriation and property crimes against individuals receiving services.

Within 10 days, the agency will provide written report OPWDD 148 to any party who received telephone notification.

Within 10 days, the agency will provide written report OPWDD 147 to eligible requestors.

Liberty House will release records and documents pertaining to reportable incidents to eligible requestors in accordance with Jonathan's Law.

INVESTIGATIONS

All allegations of abuse and neglect, significant incidents and reviewable incidents reportable by Liberty House will be promptly investigated by the Executive Director or designee. The intensity of the investigation will reflect the seriousness of the incident. When an allegation of abuse has been reported, Liberty House will take the following action first:

PROTECTIVE ACTIONS

* Removal, reassignment, relocation or administrative leave of the alleged abuser. If the suspected abuse poses a serious and immediate threat to an individual's health and safety, the staff person may not continue to work until the investigation is completed. If the allegation is substantiated, termination will be immediate.
* Increasing the degree of supervision of the alleged abuser. Immediate supervisor will see that "eyes-on" supervision is implemented.
* Provision of counseling to the alleged abuser.
* Provision of increased training to the alleged abuser and staff pertinent to the prevention and remediation of abuse.
* Increasing supervision and providing additional support to restore a secure environment to the affected staff and persons in the facility.
* Removal or relocation of the person, consistent with his or her developmental needs (or any court order applicable to the person) when it is determined that there is a risk to such individual if he or she continues to remain in the program.
* Provision of counseling to the individual and to other persons in the facility.

THOROUGH INVESTIGATIONS

Once an investigator has been assigned to the agency he/she will begin a systematic collection and examination of the information and circumstances surrounding the incident in order to describe and/or explain an event or series of events. This will include a comprehensive and objective inquiry regarding the factual aspect of an incident with a goal towards understanding the clinical, administrative and human factors involved in the cause of an incident. Investigations shall incorporate the following:

- Appropriate medical examination of the injured party
- Witnesses shall be identified and interviewed
- Interviews will be conducted separately
- All pertinent information shall be reviewed
- Physical evidence shall be identified and preserved
- All investigations shall be documented and include an investigative report

Objective of the investigation:

- To determine facts
- To assist in preventing recurrence of similar situations
- Identify opportunities for system improvements
- To assist in preparing for appropriate disciplinarian action
- To assist in preparing appropriate training

INDEPENDENCE OF INVESTIGATORS OF ALLEGATIONS OF ABUSE AND SERIOUS INCIDENTS

1. Restrictions on situations that may compromise the independence of investigators.

   i. No one may participate in the investigation of any reportable incident, serious reportable incident, or allegation of abuse in which he or she was directly involved, in which his or her testimony is incorporated, or in which a spouse, domestic partner, or immediate family member was directly involved. (When a serious reportable incident or allegation of abuse is to be investigated, every effort is to be made to have someone conduct or review the investigation who is not an immediate supervisor of staff directly involved with the situation or event so as to be as disinterested and objective a party as possible.)

   ii. Those who are members of a standing committee to review and monitor reportable incidents, serious reportable incidents, and allegations of abuse shall not routinely be assigned the responsibility of investigating such events.

   iii. For serious reportable incidents and allegations of abuse that occurred or were discovered on or after the date that this regulation becomes effective:

      a. The agency shall assign an investigator whose work function is at arm's length from staff who are directly involved in the serious reportable incident or allegation of abuse. The requirements identified in clauses (b) and (c) of this subparagraph reflect the minimum expectation regarding independence concerning the investigator's work function.

      b. No party in the line of supervision of staff who are directly involved in the serious reportable incident or allegation of abuse may conduct the investigation of such an incident or allegation, except for the CEO.

      c. The CEO (not a designee) may conduct the investigation of a serious reportable incident or allegation of abuse unless he or she is the immediate supervisor of any staff who are directly involved in the serious reportable incident or allegation of abuse.

1. Restrictions on review of specific incidents or allegations of abuse.

   a. No committee member may participate in the review of any reportable incident, serious reportable incident, or alleged abuse in which he or she was directly involved, in which his or her testimony is incorporated, in which his or her spouse, domestic partner, or other immediate family member was directly involved, or which he or she investigated or participated in the investigation. Such members may, however, participate in committee deliberation regarding appropriate corrective or preventive action.

   b. No committee member may participate in the review of a serious reportable incident or allegation of abuse, if such committee member is the immediate supervisor of staff directly involved in the event or situation. Such member may, however, participate in committee deliberation regarding appropriate corrective or preventive action.

INCIDENT REVIEW COMMITTEE

REVIEW AND MONITORING OF INCIDENTS

The Incident Review Committee is established for the purpose of reviewing and monitoring trends and ongoing practices and procedures in relation to responding to, reporting, investigating and documenting incidents, notable occurrences, minor notable occurrences and sensitive situations. Within two weeks of meeting the committee will provide written recommendations to the Executive Director and Liberty House Board of Directors regarding changes in the policies, practices and procedures, or shall recommend such other action as may be indicated.

The membership of the Incident Review Committee shall include at least one member of the governing body, one member of the clinical staff, one member of the program staff, service recipients and representatives of family, consumer and other advocacy organizations. The Incident Review Committee shall also include a physician by special arrangement. All members of the committee will be trained in confidentiality laws and regulations and comply with section 74 of the Public Officers Law.

The Incident Review Committee shall meet at least quarterly, and within one month of a report of a reportable incident or serious notable occurrence. Written minutes of all meetings shall be maintained and reports shall be submitted to the Executive Director and the Liberty House Board of Directors as necessary. The committee will document their reviews and recommendations by themselves, OMH/OPWDD and/or Justice Center and will track results. Incident Review Committee members who were present when the incident occurred shall be excluded from the Committee's final deliberations.

Process:

1. A complete copy of the investigative report along with all documentary evidence shall be submitted to the Incident Review Committee. The committee shall examine such report. The committee will determine was the investigation thorough, were recommendations appropriate, are there additional recommendations that the committee feels are necessary, and are all the recommendations addressed. The committee shall report their findings to the Liberty House Executive Director and Liberty House Board of Directors.

2. A copy of the written investigative report shall be made available upon request of a qualified person. All reports released to a qualified person must not be further disseminated except to a health care provider, behavioral health care provider, law enforcement if the qualified person believes a crime has been committed, the qualified persons attorney. Clear notice of the prohibition on re-disclosure will be given in writing to said qualified person.

3. Director will offer to hold a meeting with qualified person to further discuss incident.

4. Within three weeks of the IRC meeting, the portion addressing Reportable Incident and Serious Notable occurrences will be entered into NIMRS/IRMA.

5. All information regarding incidents will be maintained in the Incident Review Handbook.

6. Incident Review committee members will follow-up with agency director regarding all recommendations made.

Members of the Incident Review Committee:

Christina Maresco-Chair	Program Coordinator, Liberty House
Jeff Shakow	Clinical Coordinator, Liberty House
Jessica Davis	DSP/Rehabilitation Counselor, Liberty House
Pam Kaiser	Former Liberty House Board Member/Financial Analyst @ Warren/Washington County Community Services Office
Linda Eckstein	Peer Counselor - East Side Center
Roy Schult	Liberty House Board of Directors
Kathaleen Kelley	Liberty House Board of Directors
Marie Edson-Fleming	Liberty House Foundation Member
Carrie Wright	Program Analyst, Warren/Washington County Community Services Office
Dr. Paul R. Filion	Irongate Family Practice Associates

RECORDING, REPORTING, MONITORING OF REVIEWABLE INCIDENTS

In distinguishing reviewable incidents from serious reportable incidents, the reasoned judgment of the Liberty House Executive Director shall prevail. However, the categorization of such events shall be subject to review of regulations promulgated by the Justice Center, the Office of Mental Health and the Office for People with Developmental Disabilities.

All reviewable incidents shall be internally investigated, reviewed and reported to the Incident Review Committee. The committee shall report to the Executive Director and Liberty House Board of Directors their findings.

PART 625-OPWDD – EVENTS AND SITUATIONS THAT ARE NOT UNDER THE AUSPICES OF AN AGENCY REGULATIONS

Events or situations that are not under the auspices of an agency include:

(i) Any event or situation that directly involves or may have involved agency personnel or a family care provider (or respite/substitute provider) during the time he or she was acting under the supervision of a State agency other than OPWDD (e.g. an agency employee has a second job at a hospital and an incident occurred while he or she was providing care to an individual receiving services during the individual's hospitalization).

(ii) Any event or situation that exclusively involves the family, friends, employers, or co-workers of an individual receiving services, whether or not in the presence of agency personnel or a family care provider or at a certified site.

(iii) Any event or situation that occurs in the context of the provision of services that are subject to the oversight of a State agency other than OPWDD (e.g. special education, article 28 clinic, hospital, physician's office), whether or not in the presence of agency personnel or a family care provider.

(iv) Any allegation of neglect that is based on conditions in a private home (excluding a family care home).

(v) The death of an individual who received OPWDD operated, certified, or funded services, except deaths that occurred under the auspices of an agency.

If more than one agency is providing services to the individual, there shall be a responsible agency that is designated to intervene in events or situations that meet the definition of physical, sexual, or emotional abuse; active, passive, or self-neglect; or financial exploitation.

The agency responsible for intervening shall be the provider of the services to the individual (or sponsoring agency) in the order stated:

- residential facility, including a family care home (note: this does not include free-standing respite facilities);
- certified day program (if the individual is receiving services from more than one certified day program, the responsible agency shall be the agency that provides the greater duration of service on a regular basis)
- MSC or PCSS;

If the discovering agency is not the responsible agency, the discovering agency shall notify the responsible agency of the event or situation (unless it is sure that the responsible agency is already aware).