Risk Management Training Manual

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Developed by:

The California Department of Developmental Services
And
The Columbus Organization

Risk Management Training Manual

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Risk Management Training Manual

Use of this Manual

Introduction

The *Risk Management Training Manual* is the outcome of a collaborative effort by California's Department of Developmental Services and The Columbus Organization. It is one of many initiatives undertaken to enhance risk management for consumers with developmental disabilities receiving services and supports in the community. The input and experience contributed by regional centers, medical schools, and many other stakeholders over the years have proven most beneficial to this endeavor.

This manual has been designed as a tool for regional centers to utilize in their staff development and quality assurance efforts. Regional centers can utilize the training modules for their own staff or as training opportunities for their vendors.

Structure

This manual is comprised of the following six training modules, each targeting a key aspect of risk management.

Module	Title
Module I	Principles of Risk Management
Module II	Risk Assessment, Evaluation & Planning
Module III	Risk Assessment, Evaluation & Planning Committee
Module IV	Special Incident Reporting
Module V	Causal Analysis
Module VI	Mortality Review

Each training module is divided into the following sections:

- Cover Sheet
- Instructors Guide
- Learning Objectives
- Script & Suggestions for Instructor
- Power Point Presentation
- Hand-outs

Options for Using the Material in this Manual

The material in this manual can be used in various ways. The manual in its entirety can be used as a comprehensive curriculum in risk management. In addition, each module can be presented as a stand-alone course. The handouts, including sample assessment inventories and checklists, can be shared with staff to enhance their day to day work in planning and coordination of services.

All of the materials in this manual can be tailored to any regional center's particular needs. The instruments, forms, or tools incorporated in the modules are not mandated for use by any regional center. They have, however, proven useful to many people in service coordination, quality assurance, and staff development roles. Feel free to use them and make them your own.

Principles of Risk Management

Module I

Instructor's Guide

Length of Session: 45 minutes to 1 hour

Intended Audience: Regional center staff and vendored service providers

Class Size: Limited only by room capacity

Training Materials: Handouts: Principles of Risk Management
Elements of Effective Risk Management

Power Point presentation (or transparencies):
Principles of Risk Management

LCD projector or Overhead projector

Flipchart and markers (as desired)

Methods: Lecture; instructor guided discussion; interactive

Course Outline

I. Welcome and Introductions

II. Principles of Risk Management

III. Elements of Effective Risk Management

Principles of Risk Management

Module I

Learning Objectives

At the conclusion of this module, participants will:

1. Understand the broad concept of risk.

2. Be familiar with the principles of risk management.

3. Be able to describe elements of effective risk management.

Principles of Risk Management

Script for Instructor	*Suggestions for Instructor*
Risk Management is a term given to a set of practices that lead to minimizing possible harm to individuals. In this instance, individuals are persons with developmental disabilities who receive services through the regional centers. We will first examine risk management principles and discuss why risk management is important. In the second segment of this module, we will look at the specific elements that should be present in an effective risk management system.	*Ask the group what risk means to them. What are some common risks of everyday life for all of us? Use some common examples such as driving in traffic, family history of heart disease, cancer, or high-risk behaviors such as riding a bicycle without a helmet or walking alone in unfamiliar neighborhoods after dark.*
While it may not be possible to totally protect individuals, a risk management system seeks to identify factors that may increase those risks and actively promote practices that will keep risk as low as possible. The purpose of a risk management system is to promote a positive quality of life for all persons with developmental disabilities by ensuring their basic safety and well-being.	*Distribute the Handout: '**Risk Management Principles'** and review each principle.*

Script for Instructor	*Suggestions for Instructor*
Slide 1: **Prevention of Serious Incidents is The Highest Priority** If it is possible, we want to anticipate what risks may exist and prevent them from happening. Can you think of an example? These examples illustrate interventions for risk factors that could be reasonably anticipated or identified and prevented. This is the best possible risk management.	*Start the Power Point or Overhead Projector Presentation.* *Survey the group for examples. The following is one example that you may use to begin the discussion. If you experience a power outage, ensure that the food in the refrigerator is safe before anyone grabs a snack and risks food-borne illness.*
Slide 2: **Safe and Accessible Environments are Everyone's Responsibility** We all are responsible for looking out for risks and for doing what we can to make environments safer. If you visit an individual at their group home and notice a frayed electrical cord, it is your responsibility to bring that to the attention of the home staff and *ensure* that it is removed before there is a problem.	

Script for Instructor	*Suggestions for Instructor*
Slide 2 (continued) Let's talk about some other examples that you have seen.	*It is very effective to have participants use examples from their own environments. Provide guidance but let them think a little and praise their outstanding examples!*
Slide 3: **Continuous Communication, Accurate Reporting, Consistent Analysis of Information, and Development of Sound Person-Centered Strategies are Essential to Prevent Serious Incidents** We need all four elements: communication, reporting, analysis, and strategy development to address individual situations. Continuous communication and sharing of information among all involved in supporting an individual is critical to identifying risk and ensuring safety. Individuals and their families have critical information about potential risks to share with the planning team.	

Script for Instructor	*Suggestions for Instructor*
Slide 3 (continued) When an incident does occur, accurate and timely reporting is essential. Reports must include who, what, when and where. Accurate analysis of risk based upon complete information enables us to develop sound person-centered strategies to prevent future incidents.	
Slide 4: **Staff are Competent to Respond to, Report and Document Incidents in a Timely and Accurate Manner** All regional center and vendor staff witnessing or learning of an incident must report it in a timely and accurate manner. Training to understand what to do when an incident occurs and how and where to report it is key. Let's review the timelines for reporting. When should vendors report special incidents to regional centers? When should regional centers report special incidents to DDS?	*Remind participants of the Title 17 requirements: Vendors are to report special incidents to the regional center 'immediately, but not more than 24 hours after learning of the occurrence of the special incident'. Regional Centers are to report special incidents to DDS 'within two working days of learning of the occurrence'.* *Depending upon the roles of those in attendance, a brief review of applicable regulations and statutes can be included here. For example, vendors representing residential services licensed by Community Care Licensing, participants who work with children or who work with persons who are elderly, etc.*

Script for Instructor	*Suggestions for Instructor*
Slide 5: **Individuals have the Right to a Quality of Life Free of Abuse, Neglect, and Exploitation** The focus of this training is on the requirements for risk management, including those regarding regional center and vendor special incident reporting. In addition, other reporting requirements may be applicable depending upon the characteristics of the individuals served or the types of setting in which services are provided. Under Child and Adult Protective Services laws, you are considered a mandated reporter. If you genuinely believe that abuse, neglect or exploitation is occurring or has occurred, you are legally obligated to report it.	
Slide 6: **Risk Management Systems Should Emphasize Staff Involvement as Integral to Providing Safe Environments** Risk management is not just the job of management. The staff involved in any situation need to also be involved when it comes time to discuss future preventative actions or to help figure out how an incident could have been avoided. When service providers review incidents, it is invaluable to have input from direct support staff.	*Survey the group on specific types of information that direct support staff may have that others on the individual's team may not. Examples may include such things as sleep and wakefulness cycles, personal grooming habits, particular fears, or behavioral changes during times of stress.*

Script for Instructor	*Suggestions for Instructor*
Slide 7: **Quality of Life Starts with Those who Work Most Closely with Persons Receiving Supports and Services** The people working most closely with consumers have a unique responsibility in supporting quality of life. They see things first, and often sense changes before there is a major problem. Direct support staff should be alert to potential risks and work to prevent incidents from occurring. With the goal of harm prevention, the experts are those closest to the individual.	
Slides 8 & 9: **Effective Risk Management** The protection of rights of individuals and their protection from harm are the highest priorities. The implementation of effective risk management practices should lead to a safer and improved quality of life for consumers.	

Script for Instructor	*Suggestions for Instructor*
Slides 8 & 9 (continued) An effective **system** of Risk Management is based upon the **principles** of risk management we have just reviewed. Additionally, this system would incorporate other elements as listed on the handout being distributed. In summary, the implementation of sound risk management practices is intended as conscious and deliberate efforts to provide a safer and less risky environment for consumers served by regional centers and service providers.	*Distribute the handout: Elements of Effective Risk Management. Review each of the points with the group prior to the summary statement at the end of the script.* *Thank those in attendance for their participation and wish them well in their efforts to improve the quality of life for individuals receiving services and supports.*

Principles of Risk Management

Prevention of Serious Incidents

is

The Highest Priority

Safe and Accessible Environments

are

Everyone's Responsibility

Prevention of Serious Incidents

- Continuous Communication
- Accurate Reporting
- Consistent Analysis of Information
- Development of Sound Person-Centered Strategies

Staff are Competent to:

- Respond to . . .
- Report . . .
- Document . . .

Incidents in a Timely Manner

Individuals have the Right

to

A Quality of Life

Free of Abuse, Neglect, and Exploitation

Risk Management Systems

Should Emphasize Staff Involvement

as **Integral** to

Providing Safe Environments

Quality of Life Starts with:

Those who Work Most Closely

with

Persons Receiving Services and Supports

Effective Risk Management

- Training of all involved in supporting individuals with developmental disabilities in the risk management process
- Individual risk assessment, evaluation, and planning
- A well-defined process for reporting incidents that is timely, complete, and accurate

Effective Risk Management

- **Immediate follow up and intervention to ensure health and safety and to mitigate future risk**
- **Regular review and analysis of incidents by a risk management, assessment and planning committee**
- **Trending of data to detect patterns and facilitate development of risk mitigation strategies**
- **Proactive measures to prevent or minimize the likelihood of further incidents**

RISK MANAGEMENT PRINCIPLES

The following fundamental principles guide Risk Management Systems:

- Prevention of serious incidents is the highest priority.

- Safe and accessible environments are everyone's responsibility.

- Continuous communication, accurate reporting, consistent analysis of information, and development of sound, person-centered strategies are essential to prevent serious incidents.

- Staff are competent to respond to, report and document incidents in a timely and accurate manner.

- Individuals have the right to a quality of life that is free of abuse, neglect, and exploitation.

- Risk management systems should emphasize staff involvement as integral to providing safe environments.

- Quality of life starts with those who work most closely with persons receiving services and supports.

Elements of Effective Risk Management

- Training of all involved in supporting individuals with developmental disabilities in the risk management process

- Individual risk assessment, evaluation, and planning

- A well-defined process for reporting incidents that is timely, complete, and accurate

- Immediate follow up and intervention to ensure health and safety and to mitigate future risk

- Regular review and analysis of incidents by a risk management, assessment and planning committee

- Trending of data to detect patterns and facilitate development of risk mitigation strategies

- Proactive measures to prevent or minimize the likelihood of further incidents

Risk Assessment, Evaluation and Planning

Module II

Instructor's Guide

Length of Session: 1 ½ to 2 hours

Intended Audience: Regional Center service coordinators; Quality Assurance staff; Service Providers

Class Size: Limited only by room capacity

Training Materials: Power Point presentation (or transparencies):
Risk Assessment, Evaluation and Planning

LCD projector or Overhead projector

Flipchart and markers (as desired)

Methods: Lecture; instructor guided discussion; interactive group exercise

Handouts:
IPP Resource Manual excerpt
CDER Sample Summary
Assessment, Evaluation and Planning worksheets (A-B-C)
Consumer Profiles
- A: Annie
- B: Bob
- C: Cecilia
- D: Donald
- E: Ed
- F: Felicia

Risk Assessment Inventories
- Osteoporosis
- Falls
- Depression
- Skin Breakdown
- Substance Abuse
- Physical & Nutritional Management

Additional Considerations: Due to the large number of handouts used in this session, the trainer should count out and sequence them ahead of time to limit interruptions during distribution.

The group exercise using Consumer Profiles can be conducted with the entire group as a whole or with the participants divided into smaller groups. If the number of participants is 12 or fewer, this exercise works very well with participants forming one group.

Allow approximately 20 minutes to complete the exercise.

Any or all of the Consumer Profiles can be used in either format depending upon the size of the group or any preferences articulated in advance by those requesting the training. The instructor should ask about these preferences when preparing the training session.

The handout **'Consumer Profiles: Questions for Group Exercise'** is to be used with each of the profiles. It contains the same questions regarding risk assessment and planning that pertain to all of the situations described in the profiles.

Course Outline

I. Welcome and Introductions

II. Risk Assessment, Evaluation and Planning

- A. Proactive Approach
- B. Mitigation
- C. Who Needs Risk Planning?
- D. Assessment
- E. Evaluation
- F. Planning

III. Implementation of Risk Planning

- A. Risk and Responsibility
- B. Documentation
- C. Communication and Training
- D. Monitoring and Evaluation
- E. Outcomes

Risk Assessment, Evaluation and Planning

Module II

Learning Objectives

At the conclusion of this module, participants will:

1. Know how to complete risk assessments.

2. Know how to evaluate assessment information and identify risks.

3. Be able to utilize a sample of risk assessment tools.

4. Be able to develop individual risk management plans.

Risk Assessment, Evaluation and Planning

Script for Instructor	*Suggestions for Instructor*
Slide 1: **Risk Assessment, Evaluation and Planning** Welcome to Risk Assessment, Planning and Evaluation. By the end of this session, you will know how to complete risk assessments for individuals, evaluate that information and develop risk plans. We will cover some different methods for documenting risk planning and have an opportunity to practice these skills. Some tools to make risk assessment and planning easier will be introduced.	*Start Power Point (or Overhead) Presentation and have Slide 1 running as you begin.*
Slide 2: **Proactive Approach** This approach to risk management is considered proactive because the intention is to address risk issues before they become problematic. For example, diabetes can be life threatening but careful planning and adherence to a health risk plan may help keep the individual healthier and not as likely to go into crisis. A proactive approach means that the team is involved in developing, implementing, and monitoring assessment based plans.	

Script for Instructor	*Suggestions for Instructor*
Slide 3: **Mitigation** Mitigation is an important word in risk management. It simply means reducing the likelihood of occurrence or recurrence of situations or events. Mitigation strategies are essential components of the risk plan. These strategies may not totally prevent an occurrence but proactive interventions may diminish the consequences.	*Using the diabetes example, regular blood sugar checks will mean that appropriate interventions are taken to manage the disease before a person reaches a crisis point.*
Slide 4: **Who Needs Risk Planning?** Everyone needs to be assessed for risk. The process of risk assessment, evaluation and planning is intended to be an ongoing, routine part of the work of staff supporting the individual. Some who are in a state of crisis will need immediate risk planning. Those with frequent special incident reports, serious health or behavior challenges may need more extensive assessment and planning.	

Script for Instructor	*Suggestions for Instructor*
***Slide 5**:* **Assessment** • **Begin by reviewing the Individual Program Plan.** Look for wants, needs, and preferences of the individual that may involve risk. Note any indicators on the IPP that signify a risk may be present. These may include special diet, Behavior Support Plan, desire to move, communication needs, health conditions, diagnoses, history. • **Review the Record for the following:** Physical examination, psychological evaluation, social evaluations, therapy evaluations or progress reports, reports from school, work or day program, and, any information to indicate possible risk factors. Any Special Incident Reports for the past year and note any patterns. The CDER, noting conditions, status or diagnoses that indicate risk factors.	

Script for Instructor	*Suggestions for Instructor*
Slide 5 (continued) • **Interview the Consumer** Interview the consumer and any other interested parties such as family, friends, advocates, and staff in home or day programs. • **Observe** What is the individual's behavior telling you? Do you see things that cause you concern and may indicate that the individual is at risk, such as withdrawal, tactile defensiveness, avoidance of assistance with personal hygiene? • **Sample Risk Assessment Inventories** Here are some examples of risk assessment inventories. Use of these simple assessments may alert you to a potential risk. • **Make Referrals as Determined** When a potential risk is identified, the consumer may need further assessment or referral to a specialist, the regional center's clinical team, or to some other resource for evaluation. Falls are a good example. Why do people fall? It may be that a vision screening or environmental modification will be needed	*Distribute the 6 sample **Risk Assessment Inventory Handouts** that are included with this training module (e.g. falls, substance abuse, skin breakdown, etc.).* *Review some or all of the **Risk Assessment Inventories** and discuss how participants could use these to identify risk factors with individuals.*

Script for Instructor	*Suggestions for Instructor*
Slide 5 (continued) to reduce the number and/or the severity of falls. For some people, exploration of changes in mobility status may be critical in learning the reason why they fall. The preventative action or mitigation strategy will vary based on your assessment of the reason for the falls.	

Script for Instructor	*Suggestions for Instructor*
Slide 6: **Evaluation** Once you have completed this risk assessment process, it is time to take the information and *evaluate* it to determine if significant risks are present and, if so, that effective risk mitigation strategies are in place. **Convene the Team** Discuss with the consumer and team members what may constitute a risk for the individual. Base decisions on actual as well as perceived risk. For example, living in a high crime neighborhood does not mean that you will become the victim of a crime. If you do not have good personal safety skills, however, you may be at a greater risk than others in the same neighborhood. **CDER Summary Exercise** The purpose of this exercise is to enhance your awareness and understanding of *significant risk*.	***CDER Summary Exercise:*** *1. Distribute the **CDER Summary** handout. Discuss the CDER as a tool that is available, contains a wealth of information, and is already in the person's record.* *2. Give the group a few minutes to review the document and then ask participants to identify risks.* *3. Responses should note such things as poor self-care skills, incontinence, aggression, running away behavior, and poor communication.* *4. Now tell the group that this is a three-year-old child. What seems like a significant risk with this new information?* *5. In summary, tell the participants that this exercise has gone from assessment to evaluation.*

Script for Instructor	*Suggestions for Instructor*
***Slide 7**:* **Planning** Once you have completed the evaluation, determine if there is a strategy, or multiple strategies, in place to address the individual's most significant risk. If there are no plans, the team needs to determine how these risks will be addressed. There may be multiple interventions for a single risk factor. The consumer must participate in the planning process and agree to the plan.	
Slide 8: **Risk and Responsibility** Balancing individual's rights, including the right to make choices, with the potential risks that may be involved in the exercise of these rights, can be a very difficult task. **Choice:** Individual choice should be respected but it may be necessary to probe to determine underlying causes for an individual making choices that are not in his or her best interest. **Rights:** Keep the consumer's rights in mind and remember your responsibilities to consumers. Some things may not be easy	*1. Encourage participants to describe specific situations where they supported individuals in choices related to high-risk behaviors.* *2. If the group needs prompting, ask participants: Have they ever worked with individuals who engaged in high-risk behaviors?* *3. Prompt with examples such as: a person who engages in unprotected sex; an individual who has a respiratory condition and smokes; a person who has a gall bladder condition and frequently eats greasy*

Script for Instructor	*Suggestions for Instructor*
Slide 8 (continued) to mediate and may require repeated attempts and different interventions before any success is found.	*fast food, etc.* *4. The conclusion of the discussion: we keep trying to ensure individual health and safety with creativity, sensitivity, and commitment condition and eats a lot of fast food, etc.*
Slide 9: **Documentation of the Assessment and Planning Process** If the risk planning process has not been formally incorporated into the person's IPP, there are other ways to ensure that these proactive measures in risk management are captured in a documented manner. The regional center's Risk Assessment, Evaluation, and Planning form(s) should be used to document the risk planning process. If this regional center does not use its own form, the following slides present samples that you may consider using.	

Script for Instructor	*Suggestions for Instructor*
Slide 10: **Risk Assessment, Evaluation, and Planning** **Worksheet Sample A** This form provides for documentation of the review of an individual's significant risk factors as well as the interventions needed to mitigate risk.	
Slide 11: **Risk Assessment, Evaluation, and Planning** **Worksheet Sample B** This sample is similar to Sample A, but the categories are keyed to the sections of the CDER. Your regional center may find other ways to adapt this form to effectively document risk-planning efforts.	

Script for Instructor	*Suggestions for Instructor*
Slide 12: **Risk Assessment, Evaluation, and Planning** **Worksheet Sample C** This is an example of a record entry documenting the risk assessment, evaluation, and planning process. Any of these sample worksheets can be used to document a person's risk mitigation plan. Now let's practice the process with an exercise using a selection of different **Consumer Profiles** and the sample **Risk Assessment, Evaluation, and Planning Worksheets** we have reviewed.	***Consumer Profile Exercise:*** *The next exercise can be conducted with the group as a whole or with the participants divided into small groups.* *1. Hand out a* ***Consumer Profile*** *and* ***Questions for Group Exercise*** *to each group.* *2. Ask the group(s) to designate a recorder/reporter to summarize their discussions at the end of the exercise.* *3. Instruct the participants to review the* ***Consumer Profile*** *and answer the* ***Questions for Group Exercise****.* *4. To assist in their discussion encourage the group to refer to the* ***Risk Assessment, Evaluation, and Planning Worksheets*** *and* ***Risk Assessment Inventories****.* *5. If conducting this exercise with one group, record responses on a flip chart, dry erase board, or blank transparency. If arranged in small groups, ask each recorder or reporter to present the group's findings. Clarify responses as needed.*

Script for Instructor	*Suggestions for Instructor*
Slide 13: **Communication and Training** Risk planning will only be effective if all people who need to know about the Risk Plan follow it. For instance, if the risk assessment identifies that the individual has difficulty swallowing, the team might decide that mealtime safety requires a staff member close by to respond if the person experiences problems while eating. Anyone who assists with the individual when he eats must know this and be prepared to intervene appropriately. It must be clear what the staff is to do and when. If the person attends a dance on Saturday night and refreshments are to be served, what should the staff do? Use systems already in place to document training or communication of risk planning. Verify that the plan will actually affect the identified risk. Solicit input from team members who may not have participated in developing the plan.	*Ask participants to suggest how to communicate the Risk Plan among all those involved with individuals, e.g., day program staff, respite providers, family members who take individuals home for visits, etc.* *Participants may suggest communication logs that accompany the consumer between home and other service sites, telephone contact systems set up by providers, regional center distribution of IPP sections providing information on precautions, or individualized approaches and interventions.*
Slide 14: **Monitoring and Evaluation of the Plan** Once risk management plans are in place for an individual consumer, they must be tracked for effectiveness. If the plans are identified on the IPP, then they will fit into the tracking processes	

Script for Instructor	*Suggestions for Instructor*
Slide 14 (continued) already in place. This would mean review of the Plan at the time of quarterly or annual reviews. If Risk Plans are not part of the IPP process, the team should establish a schedule for review.	
Slide 15: **Outcome** The purpose of risk planning is to be proactive and improve the quality of life for the individual. This desired outcome should guide all efforts in helping consumers reduce and/or eliminate the significant risks in their lives.	

Risk Assessment, Evaluation and Planning

Proactive Approach

- Risk Assessment and Evaluation
- Team Planning
- Risk Plans in Place
- Monitoring of Plans

Mitigation

- Reducing the Likelihood of Occurrence or Recurrence
- Proactive
- Results in Increased Safety

Who Needs Risk Planning ?

Anyone with an assessed risk, such as:

- Frequent SIRs
- Crises
- Serious Health or Behavior Challenges

Assessment

- Reviews –IPP – Records
- Interviews
- Observations

Evaluation

- Who is at Risk?
- Risk vs. Significant Risk
- Team Decisions

Planning

- Is there a Plan in place?
- Should there be a Plan in place?
- Make needed referrals

Risk and Responsibility

- Choice
- Rights

Documentation

- IPP Process
- Informal
- Formal

Risk Assessment Evaluation & Planning Worksheet (Sample A)

Individuals Name:			Date of Discussion:	Date of Note:
Participants:				
Significant Risk Factors in the Person's Life - List	**Are risks present?**		**Description of the risk, circumstances, frequency**	**Interventions required to eliminate or minimize risk**
	YES	**NO**		
1. Functional Status				
a. Eating	**?**	**?**		
b. Ambulation	**?**	**?**		
c. Transfers	**?**	**?**		
d. Toileting	**?**	**?**		
2. Behavioral				
a. Self-abuse	**?**	**?**		
b. Aggression towards others or property	**?**	**?**		
c. Use of physical or mechanical restraint	**?**	**?**		
d. Emergency drug use	**?**	**?**		
e. Psychotropic meds	**?**	**?**		
3. Physiological				
a. Gastrointestinal conditions	**?**	**?**		
b. Seizures	**?**	**?**		
c. Anticonvulsant meds	**?**	**?**		
d. Skin breakdown	**?**	**?**		
e. Bowel function	**?**	**?**		
f. Nutrition	**?**	**?**		
g. Treatments	**?**	**?**		
4. Safety				
a. Injuries	**?**	**?**		
b. Falls	**?**	**?**		
c. Community Mobility	**?**	**?**		
5. Other	**?**	**?**		

Instructions for completing the risk assessment worksheet: Under each specific area, list the Significant Risks identified. Indicate "yes" or "no" as to whether a significant risk has been identified in the listed category. Indicate "yes" or "no" as to whether training/service plans are present for the specific risk. If training/service plans have been developed, indicate the training/area. Briefly, indicate a summary of the intervention required to eliminate or minimize the risk.

Risk Assessment Evaluation & Planning Worksheet (Sample B)

Individuals Name:	Date of Discussion:	Date of Note:

Participants:	1.	2.	3.	4.	5.

Significant Risk Factors in the Person's Life - List	Are risks present? YES	Are risks present? NO	Description of the risk, circumstances, frequency	Interventions required to eliminate or minimize risk
1. Qualifying Developmental Disability				
2. Other Disabilities / Health Conditions				
3. Special Conditions / Behaviors				
4. Skill Development				
5. Other				

Risk Assessment Evaluation & Planning (Sample C)	
Name:	**Date:**
Participants:	
Tasks Completed for Assessment:	
Documents Reviewed:	
People Interviewed:	
Assessments Completed or Referral Made:	
Significant Risks Identified:	
Plan:	
Location of Plan Information:	
Other Information:	

Communication and Training

- Who needs to know
- Location
- Verification

Monitoring and Evaluation

- IPP Process

- Periodic Revisiting of the Plan

Outcome

- Improved Quality of Life for the Individual

DEPARTMENT OF DEVELOPMENTAL SERVICES RUN DATE: _____
CLIENT DEVELOPMENT EVALUATION REPORT RUN TIME: _____
CLIENT PROFILE
BASED ON CDER EVALUATION OF: _____

* * CONFIDENTIAL CLIENT INFORMATION W & I CODE SEC. 4514* *

NAME: _____ _____ UCI: _____

COUNSELOR: _____
DOB: _____ AGE: _____ SEX: _____ PROG: _____ SECT:_____ UNIT:_____
LGL STAT: _____ S PARENT OR RELAT RESIDENCE: PARENT / REL
ETHNICITY: _____ LANGUAGE: _____
HEIGHT: _____ WEIGHT:_____

-QUALIFYING DEVELOPMENTAL DISABILITIES-

MENTAL RETARDATION: NONE
CEREBRAL PALSY: NONE
AUTISM: FULL SYNDROME
FACTOR: OTHER UNKNOWN AND UNSPECIFIED CAUSE OF MORBIDITY OR MORTALITY
IMPACT: MODERATE DATE: 1 / 02
EPILEPSY: NONE
OTHER TYPE OF DEVELOPMENTAL DISABILITY: NONE

-OTHER DISABILITIES / HEALTH CONDITIONS-

CHRONIC MAJOR MEDICAL CONDITIONS
CONDITION: HEPATITIS B IMMUNE STATUS UNKNOWN
IMPACT: NONE
HEARING UNCORRECTED: HEARING WITHIN NORM LIMITS
VISION UNCORRECTED: VISION WITHIN NORM LIMITS
MOTOR IMPAIRMENTS –
HAND USE: NO LIMITATION AMBULATION: WALKS WELL

SPECIAL CONDITIONS/BEHAVIORS
-EVALUATION-

AGGRESSION: VERBAL ABUSE, THREATS
RUNNING AWAY: SERIOUS PROBLEM
HYPERACTIVITY: NEEDS INDIVI. ATTN:
RESISTIVENESS: OFTEN RESISTIVE
SFTY AWARE: SUPRVSD AT ALL TIMES
SLF INJ: FREQUENCY – AT LEAST 1/WK
FRUSTRATION: MAY BE AGGRESSIVE
TANTRUMS: AT LEAST 1 PER WEEK
ATTN SPAN: FOCUS FOR LESS THAN 1 MIN.

ASSESSMENT OF BEHAVIORS: (FF=34)

SKILL DEVELOPMENT

EATING: FINGER FEEDS SELF
BLADDER CONT: INADEQUATE
HYGIENE: UNALBE TO PERFORM
DRESSING: COOPERATES IN DRESSING
WRITING SKILL: DOES NOT COPY OR TRACE
EXPRESSIVE LANG: SIMPLE WORDS
TOILETING: NOT TOILET TRAINED
BOWEL CONT.: INADEQUATE
BATHING: UNABLE TO BATHE SELF
READ SKL: DOES NOT READ
RECEPT. LANG: SIMPLE WORDS ONLY
CLAR. SPEECH: UNDERSTOOD BY PEERS

DEVELOPMENTAL LEVEL-05%

Risk Assessment Worksheet: Sample A

Individual's Name:			**Date of Discussion:**	**Date of Note:**
Participants:				
Significant Risk Factors (List)	**Present**		**Description of risk, circumstances, frequency**	**Interventions required to eliminate or minimize risk**
	Yes	**No**		
1. Functional Status				
a. Eating	**?**	**?**		
b. Ambulation	**?**	**?**		
c. Transfers	**?**	**?**		
d. Toileting	**?**	**?**		
2. Behavioral				
a. Self-abuse	**?**	**?**		
b. Aggression toward others or property	**?**	**?**		
c. Use of physical or mechanical restraint	**?**	**?**		
d. Emergency drug use	**?**	**?**		
e. Psychotropic meds	**?**	**?**		
3. Physiological				
a. Gastrointestinal conditions	**?**	**?**		
b. Seizures	**?**	**?**		
c. Anticonvulsant meds	**?**	**?**		
d. Skin breakdown	**?**	**?**		
e. Bowel function	**?**	**?**		
f. Nutrition	**?**	**?**		
g. Treatments	**?**	**?**		
4. Safety				
a. Injuries	**?**	**?**		
b. Falls	**?**	**?**		
c. Community Mobility	**?**	**?**		

5. Other	**?**	**?**		

Instructions for Completing Risk Assessment Worksheet

- Under each specific area, list the Significant Risks identified.
- Indicate “yes” or “no” as to whether a significant risk has been identified in the listed category.
- Indicate “yes” or “no” whether training/service plans are present for the specific risk.
- If training/service plans have been developed, indicate the training/area.
- Briefly, indicate a summary of the intervention required to eliminate or minimize the risk.

Risk Assessment, Evaluation and Planning Worksheet: Sample B

Individual's Name: Stephen Anderson	**Date of Discussion:** January 22, 2003	**Date of Note:** January 23, 2003
Participants: Steve Anderson, Brenda Smith (SC), Mary Anderson (Mother), Rhonda Johnson (Provider XYZ), Frances Mathers (Administrator)		

Significant Risk Factors (List)	Present		Description of the risk, circumstances, frequency	Interventions required to eliminate or minimize risk
	Yes	No		
1. Qualifying Developmental Disability				
Seizure Disorder	X☐	☐	Average of six seizures per year for the last four years; takes medication. Four of the last six occurred at night.	Plan developed (see IPP and quarterly notes). Interventions: supervision, medication monitoring, special diet, consumer education, bed rails, Medic-Alert bracelet. IPP modified to include plans.
	☐	☐		
2. Other Disabilities / Health Conditions				
	☐	☐		
	☐	☐		
	☐	☐		
3. Special Conditions / Behaviors				
	☐	☐		
	☐	☐		
	☐	☐		
4. Skill Development				
	☐	☐		
	☐	☐		
	☐	☐		
5. Other				
	☐	☐		
	☐	☐		

Instructions for Completing Risk Assessment Worksheet

- Under each specific area, list the Significant Risks identified.
- Indicate “yes” or “no” as to whether a significant risk has been identified in the listed category.
- Indicate “yes” or “no” whether training/service plans are present for the specific risk.
- If training/service plans have been developed, indicate the training/area.
- Briefly, indicate a summary of the intervention required to eliminate or minimize the risk.

Risk Assessment, Evaluation and Planning Worksheet: Sample C

Name: Stephan Anderson | **Date:** January 22, 2003

Participants:
Stephan Anderson**,** Brenda Smith, Service Coordinator; Mary Anderson, Mother; Rhonda Johnson, XYZ Day Services; Frances Mathers, Administrator

Tasks Completed for Assessment:

Documents Reviewed: Complete case record; medication history ; history and physical; CDER (11/27/02); Physical Therapy Evaluation (10/11/02); Clinical Team Report (12/16/02)

People Interviewed: All above participants and Dr. Michael Holmes, Neurologist

Assessments Completed or Referral Made: Seen by Clinical Team 12/16/02

Significant Risks Identified:
Uncontrolled seizures, defined as averaging six per year for the past four years.

Plan:
1. Stephen must never be alone in a situation where a seizure could risk his life (bathing); he must be accompanied when traveling; (residence, day program, family).
2. Modify environment for safety: bed rails because 4/6 seizures occurred at night (residence).
3. Quarterly monitoring of blood levels of medications (Dr. Holmes-residence will document).
4. High protein diet as recommended by neurologist (home).
5. Consumer education – to help Stephen make informed decisions about risks (day program).

Location of Plan Information:
IPP of January 21, 2003; monitored quarterly by Service Coordinator

Other Information:
Although Dr. Holmes strongly recommends the use of a helmet, Steve stated on January 21, 2003, that he would "…never get a girlfriend wearing one of those things". XYZ will provide education about safety and helmets and will reevaluate Steve's preferences in April, 2003.

Steve did agree to this education, to bed rails and to receiving the special diet. He takes his medication independently and appears to understand the danger of being hurt if he is alone. He said that he doesn't want to drown in the tub like his friend, and it is okay for staff to be near as long as they don't watch him bathe.

Risk Assessment Inventory: Depression

The following risk factors may be indicators of existing or developing problems. These should be considered by the service coordinator, service provider, and other Team members when assessing and planning for risk mitigation. Referrals for further evaluation by clinicians or the regional center's Clinical Team may be needed to diagnose a specific condition or otherwise address consumer risk. ***This inventory is not intended to take the place of a professional diagnosis conducted according to accepted standards of clinical practice.***

Personal Risk Factors

v if Present	Risk Factor
	Loss of interest in things you used to enjoy, including sex
	Feeling sad, blue, or "down in the dumps"
	Feeling slowed down or restless and unable to sit down
	Feeling worthless or guilty
	Changes in appetite or weight (loss or gain)
	Thoughts of death or suicide; suicide attempts
	Problems concentrating, thinking, remembering, or making decisions
	Trouble sleeping or sleeping too much
	Loss of energy or feeling tired all of the time
	Headaches
	Other aches and pains
	Sexual problems
	Digestive problems (upset stomach, etc.)
	Feeling pessimistic or hopeless
	Being anxious or worried

Consumer: _____**Date**_____

Risk Assessment Inventory: Falls

The following risk factors may be indicators of existing or developing problems. These should be considered by the service coordinator, service provider, and other Team members when assessing and planning for risk mitigation. Referrals for further evaluation by clinicians or the regional center's Clinical Team may be needed to diagnose a specific condition or otherwise address consumer risk.

Personal Risk Factors

v if Present	Risk Factor
	History of falls
	Previous falls resulting in a fracture or laceration
	Frequent falls (two or more per month)
	Impaired vision
	Muscle or strength weakness
	Gait or balance disorders
	Dizziness or vertigo
	Incontinence or frequent toileting
	Agitation
	Sleep Disturbance
	Medications with known side effects that may affect balance or ability to ambulate
	Orthostatic hypotension (dizziness upon standing)
	Impaired mobility
	• Requires assistance with ambulation
	• Uses mobility equipment (wheelchair, walker, cane)
	Foot or leg deformity
	Seizures

Environmental Risk Factors

v if Present	Risk Factor
	Poor lighting
	Wet or slippery floors
	Loose electrical cords
	Inappropriate footwear
	Loose rugs
	Other: specify _____

Consumer: _____ **Date:** _____

Risk Assessment Inventory: Osteoporosis

The following risk factors may be indicators of existing or developing problems. These should be considered by the service coordinator, service provider, and other Team members when assessing and planning for risk mitigation. Referrals for further evaluation by clinicians or the regional center's Clinical Team may be needed to diagnose a specific condition or otherwise address consumer risk. ***This inventory is not intended to take the place of a professional diagnosis conducted according to accepted standards of clinical practice.***

Personal Risk Factors

v if Present	Risk Factor	
	Long term use of high dose corticosteroids	
	Heavy smoking (or passive smoking)	
	Heavy drinking	
	Immobility	
	Lack of sunshine	
	Low calcium intake	
	Other diseases	
	Family history of osteoporosis or fractures	
	Fracture after a minor bump or fall	
	Loss of height	
	Back pain	
	In women:	Early menopause (before 45 years old)
		Early hysterectomy (before normal menopause age of 50)
		Irregular or infrequent periods during your lifetime

Consumer:_____**Date**_____

Risk Assessment Inventory: Physical & Nutritional Management

The following risk factors may be indicators of existing or developing problems. These should be considered by the service coordinator, service provider, and other Team members when assessing and planning for risk mitigation. Referrals for further evaluation by clinicians or the regional center's Clinical Team may be needed to diagnose a specific condition or otherwise address consumer risk. ***This inventory is not intended to take the place of a professional diagnosis conducted according to accepted standards of clinical practice.***

Physical Management

v if Present	Risk Factor
	Does the consumer have difficulty with gross motor skills such as walking or sitting?
	Does the consumer have:
	• Contractures (severe joint tightness)?
	• Severe scoliosis and/or kyphosis (curvature of the spine)?
	• Windswept deformity of the legs (both legs fixed or pointed to one side)?
	• Severe muscle tightness (spasticity) or muscle weakness (floppy)?
	Does the consumer maintain his/her head in a tipped back (hyperextended) position?
	Has the consumer had problems with skin breakdown, redness that does not disappear after 20 minutes, or skin breakdown that doesn't heal?
	Does the individual have poor bladder or bowel control?

Nutritional Management

v if Present	Risk Factor
	Are there special dietary needs (i.e., caloric, consistency, texture)?
	Has the consumer received modified food textures in the past (i.e., blended, chopped)?
	Does the consumer need assistance to eat?
	Does the consumer cough during meals?
	Does the consumer have a history of choking?
	Does the consumer frequently refuse certain types of foods or liquids?
	Does the consumer eat in other than an upright position?
	Does the consumer exhibit poor head control?
	Does the consumer have a problem with:
	• poor lip closure and/or tongue thrust
	• bite reflex
	• gagging during meals and/or tooth brushing
	• rumination
	• excessive belching
	• frequent vomiting
	• persistent drooling
	Has the consumer experienced dehydration in the past 12 months?
	Does the consumer have history of nasogastric (NG) and/or gastrostomy (G) tube use?
	Does the consumer tip his/her head back to swallow?
	Does it take more than 30 minutes for the consumer to eat a meal?
	Does the consumer have to swallow repeatedly to clear the mouth?
	Has the consumer had any episodes of not breathing, turning blue, severe wheezing, or pneumonia during the past year?
	Is the consumer agitated during or after meals?
	Does the consumer have reddened or whitened gums, visible film or plaque on the teeth, or other significant dental problems?
	Does the consumer not tolerate tooth brushing or being touched around the mouth?
	Does the consumer eat rapidly; take large mouthfuls or too large bites?

Consumer: _____ **Date:** _____

Risk Assessment Inventory: Skin Breakdown

The following risk factors may be indicators of existing or developing problems. These should be considered by the service coordinator, service provider, and other Team members when assessing and planning for risk mitigation. Referrals for further evaluation by clinicians or the regional center's Clinical Team may be needed to diagnose a specific condition or otherwise address consumer risk. ***This inventory is not intended to take the place of a professional diagnosis conducted according to accepted standards of clinical practice.***

Personal Risk Factors

v if Present	Risk Factor
	Inability to Move
	Bed or Chair Confinement
	A person in a chair who is able to shift his or her own weight
	Loss of Bowel or Bladder Control
	Poor Nutrition
	Lowered Mental Awareness

Consumer: _____**Date:** _____

Risk Assessment Inventory: Substance Abuse

The following risk factors may be indicators of existing or developing problems. These should be considered by the service coordinator, service provider, and other Team members when assessing and planning for risk mitigation. Referrals for further evaluation by clinicians or the regional center's Clinical Team may be needed to diagnose a specific condition or otherwise address consumer risk. ***This inventory is not intended to take the place of a professional diagnosis conducted according to accepted standards of clinical practice.***

v if yes	Risk Factors
Frequent Intoxication	
	Does the consumer report or appear to be frequently high or intoxicated?
	Do the consumer's social activities focus on drinking or other drug use, including obtaining, using and recovering from use?
	Has the consumer ever expressed his/her concerns about needing to cut down on use of drugs or alcohol?
Atypical Social Settings	
	Does the consumer's immediate peer group encourage substance abuse?
	Is the consumer socially isolated from others and is substance abuse occurring alone?
	Is the consumer reluctant to attend social events where chemicals won't be available?
Intentional Heavy Use	
	Does the consumer use alcohol with prescribed medications?
	Does the consumer use more alcohol than is safe in light of prescribed medications or compromised tolerance?
	Does the consumer have an elevated tolerance, evidenced by use of large quantities of alcohol or other drugs without appearing intoxicated?
Symptomatic Drinking	
	Are there predictable patterns of use which are well known to others?
	Is there a reliance on drugs or alcohol to cope with stress?
Psychological Dependence	
	Does the consumer rely on drugs or alcohol as a means of coping with stress or problems?
Health Problems	
	Are there medical conditions which decrease tolerance or increase the risk of substance abuse problems?
	Are there recurring bladder infections, chronic infections, bed sores, seizures, or other medical conditions which are aggravated by repeated alcohol or other drug use?

v if yes	Risk Factors
Job Problems	
	Has the consumer missed work or gone to work late due to use of alcohol or other drugs?
Problems with Significant Others	
	Has a family member or friend expressed concern about the consumer's use of alcohol or drugs?
	Have important relationships been lost or impaired due to substance abuse?
Problems with Law or Authority	
	Has the consumer been in trouble with authorities or arrested for any alcohol or drug related offenses?
	Have there been instances when the consumer could have been arrested but wasn't?

Consumer: _____ **Date:** _____

Consumer Profiles: Questions for Group Exercise

The following questions are presented for guidance to the group in its review of consumer risk issues.

1. What risks can you identify from the profile?

2. What, if any, **immediate interventions** are needed to ensure safety?

3. What assessment information is needed for risk planning?

4. What resources can you access to obtain the assessment information you need?

5. What are the appropriate next steps?

Consumer Profile A: Annie

Annie is a 20-year old woman who has mild mental retardation. Annie's Aunt Nancy served as her foster care provider from the time she was 12 years old until her 18th birthday. Under the care of her aunt, Annie grew up very isolated with few friends or opportunities to socialize with other children. Annie's aunt was a very private person who preferred time alone. She structured Annie's time and contacts with others accordingly.

When Annie turned 18, her aunt arranged for a residential placement in a licensed community care home. She lives with three housemates. Since coming to the home two years ago, Annie has had difficulties getting along with the other people living there. She argues and starts fights with the other women. She has also become increasingly verbally abusive to staff.

Annie smokes, and consistently breaks house rules about when and where she can smoke. Smoking in her bedroom has created a safety risk for everyone and she has started a fire in the waste can. Annie becomes quite upset when anyone mentions her smoking habits as a problem.

The residential provider is very concerned about being able to meet Annie's needs and is seriously considering termination of her placement. This provider has contacted Annie's service coordinator for help.

Consumer Profile B: Bob

Bob is a 52 year old gentleman with a mild level of mental retardation. He receives independent living services in his efficiency apartment. Bob has lived in a group home, a supported living arrangement, and then on his own since he left a developmental center ten years ago. Bob is passionate about his desire to remain living independently.

Bob's family has long advocated for him to return to the institution because they feared he was not capable of living in the community, much less living in his own place. After Bob had a stroke a few years ago, his family was even more convinced that he should be living back at the center.

Since his stroke, Bob has had trouble negotiating uneven surfaces, navigating around corners, and walking more than a block in his neighborhood. His speech is frequently slurred and drooling has become a difficult problem. Bob becomes frustrated when people can't understand what he is saying and, as a result, has begun to withdraw from others. The drooling has also made him feel very self-conscious and embarrassed.

Bob's family has never stopped trying to convince him that he would be better off living in an institutional setting. Bob is especially worried that they will be even more adamant if they see the progressive problems he is experiencing with his speech and mobility. In fact, he's getting concerned himself that he will not be able to live independently much longer.

Consumer Profile C: Cecilia

Cecilia is a 47 year old woman who has a seizure disorder and severe mental retardation. She lives with Rosa, her elderly mother, who has dedicated her life to caring for her daughter. Rosa has resisted making any concrete plans for Cecilia after her own death.

Cecilia's mother has rarely sought any type of support or assistance. She always tries to do everything herself, stating that she believes no one else can take care of Cecilia as well as she can. Rosa also believes that Cecilia is her responsibility until the day either of them dies.

Cecilia has become so overweight that she uses a wheelchair for mobility. Rosa has injured herself several times lifting Cecilia and helping her with bathing, using the toilet, and many other activities of daily living. Incontinence has also become a problem with Cecilia, as has her recent diagnosis of osteoarthritis.

It has become increasingly difficult to care for Cecilia, yet Rosa has only requested occasional respite services. Rosa herself has had numerous medical problems including severe osteoporosis, diabetes, and rheumatoid arthritis.

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Consumer Profile D: Donald

Donald is an older gentleman, age 62, who has Down Syndrome. He spent most of his younger life in a state developmental center. He first lived in licensed community care homes, and then received supported living services. For the last 15 years he lived with a roommate who passed away a few months ago. That roommate, Philip, was Donald's closest friend and companion. A new roommate moved in three months ago.

Donald is a well-known figure in his small hometown. Donald's service coordinator is beginning to get calls from people who see him often. Donald has limited communication skills but makes his message known to people who know him well. His friends and neighbors are concerned about him and many feel he may need a more protective and supervised living situation.

Donald has evidently fallen and hurt his foot. It has not healed and the wound is filthy and in need of care. Donald's own hygiene also seems to be deteriorating and his whole appearance has become disheveled.

Consumer Profile E: Ed

Ed is a 25 year old man with severe cerebral palsy and a seizure disorder. Ed uses a wheelchair for mobility. He can transfer himself but can not walk independently.

Ed lives in a home with adults who also have physical disabilities. Ed only recently moved to the home after his mother died. Until then, he lived in the same hometown all his life, and had a close-knit group of friends, most of whom do not have disabilities. Ed's current residence is about 30 miles away from his former home.

For the past several summers, Ed and his friends have gone camping at a spot several hours' drive away. Staff are quite concerned that this will be too risky for him. Generally it is hot at these times and Ed's anticonvulsant medicines can sometimes make him very heat sensitive. The staff are also worried about his capacity to move safely to, from, and around the campsite.

Ed is determined to go on this trip. It's a way to feel like he still has some of his old life, but it's also about feeling like he has some control in his new life. He has begun to feel very angry.

Ed is adamant about going on this camping trip and wants his service coordinator to advocate for him in this regard.

Consumer Profile F: Felicia

Felicia is a 58 year old female with moderate mental retardation. She lived in a state ICF/MR for more than 20 years and was placed there by her aging parents. Felicia is currently living in a community care home and has been there approximately six months.

Felicia has developed Type II diabetes shortly after entering the home and is currently 50 pounds overweight. She has problems with poor eating habits. She does not monitor her food intake or the types of food she eats. She has few other activities during her day and equates pleasure with food and mealtimes. Her diabetes is worsening.

Felicia's residential provider is considering the appropriateness of her placement because she will not comply with her diet, and she cannot self medicate or perform her own blood sugar testing.

Felicia has been exhibiting symptoms that her diabetic condition is progressing. She is often fatigued, has dizzy spells and heals slowly when injured.

Risk Management, Assessment and Planning Committee

Module III

Instructor's Guide

Length of Session: 1-1¼ Hours

Intended Audience: Risk Committee members, management staff, others interested in the implementation of risk management

Class Size: Limited only by room capacity

Training Materials: Equipment: LCD projector or overhead projector

Handouts: Title 17 Regulations 54327.2

Methods: Power point or overhead presentation; group discussion; review of regional center Risk Management and Mitigation Plan

Course Outline

I. Welcome and Introductions

II. Risk Management, Assessment and Planning Committee

- **A.** Introduction to Risk Management, Assessment and Planning Committee
- **B.** Committee Composition
- **C.** Committee Responsibilities: Risk Management and Mitigation Plans
- **D.** Special Incident Reporting
- **E.** Training and Technical Assistance
- **F.** Coordination and Communication with Outside Investigative Agencies
- **G.** Review of Special incident Data
- **H.** Medical Records and Coroner Reports
- **I.** Additional Committee Responsibilities
- **J.** Frequency of Meetings
- **K.** Suggestions for Documentation
- **L.** Benefits of Risk Management, Assessment and Planning Committees

Risk Management, Assessment and Planning Committee

Module III

Learning Objectives

At the conclusion of this Module, participants will:

1. Understand regulations for regional center Risk Management, Assessment and Planning Committees.

2. Understand the functioning of the Committee.

3. Become familiar with the elements of a regional center Risk Management and Mitigation Plan.

Risk Management, Assessment and Planning Committee

Script for Instructor	***Suggestions for Instructor***
Slide 1: **Risk Management, Assessment and Planning Committee** The goal of this session is to learn about the function and responsibilities of a regional center's Risk Management, Assessment and Planning Committee. A major role of the committee is to develop and monitor the regional center's Risk Management and Mitigation Plan. Our focus is on the specific requirements for the committee as mandated by **Section 54327.2** of the Lanterman Act. Throughout this session we will refer to the specific language of each requirement. We will also have an opportunity to offer suggestions on enhancing the effectiveness of the committee in supporting the health and safety of consumers.	*Display title overhead or start Power Point presentation with the title slide (Slide 1).* *Distribute copies of the handout: Regional Center Risk Management, Assessment and Planning Committee and Risk Management Plans.*

Script for Instructor	*Suggestions for Instructor*
Slide 1 (continued) Not all regional centers refer to the committee by the name designated in the regulations. What name does your committee go by?	*Use this name as you proceed with the session.*
Slide 2: **Committee Composition** Section 54327.2 (a) requires the following regarding the composition of the committee: *Each regional center shall establish a Risk Management, Assessment and Planning Committee that, at a minimum, includes a representative from the regional center's clinical, quality assurance and training staff.* Who serves on the committee at this regional center? What are their titles or roles?	*List the titles/roles (not names) of committee members on a flip chart. Ask the group about the different perspectives members bring to the committee's work.*

Script for Instructor	*Suggestions for Instructor*
Slide 3*: Committee Responsibilities: Risk Management and Mitigation Plan** Although the regulations mandate the aspects of risk management that must be addressed in the plan, there are no specific requirements for its design. Every regional center may structure their Risk Management and Mitigation Plan to best fit the issues they face in meeting the needs of consumers. The following section identifies 5 areas for committee attention: Section 54327.2 (b) *The Risk Management, Assessment and Planning Committee shall develop the regional center's* ***Risk Management and Mitigation Plan *which shall address, at a minimum:* • Special Incident Reporting • Training and Technical Assistance • Coordination and communication with outside investigative agencies • Review of Special Incident Data	

Script for Instructor	*Suggestions for Instructor*
Slide 3 (continued) • Medical Records and Coroner Reports Let's proceed by discussing each of these components.	
Slide 4: **Special Incident Reporting** *(b) (1): The Risk Management and Mitigation Plan shall address:* ▪ *The process and procedures for ensuring accurate and timely handling and reporting of special incidents by regional center staff, vendors, and long-term health care facilities;* Special Incident reporting is a critical element of risk management. The committee is central to ensuring that the regional center has responsive and effective policies and processes that provide clear guidance on the handling of all reported incidents. To be effective in understanding and addressing problems with	

Script for Instructor	*Suggestions for Instructor*
Slide 4 (continued) special incident reporting, the committee should review and analyze issues related to the following: ▪ Accurate reporting ▪ Thorough documentation ▪ Timely notifications to family/guardian, and other investigative entities ▪ Appropriate routing and review process ▪ Relevant and functional preventative action steps ▪ Competent disposition and follow up	

Script for Instructor	*Suggestions for Instructor*
***Slide 5*: Training and Technical Assistance** *(b) (2): The Risk Management and Mitigation Plan shall address:* ▪ *The provision of training and technical assistance to regional center staff, vendors and long-term health care facility staff and others on the legal obligations of abuse reporting, special incident reporting, risk assessment, developing and implementing an incident prevention plan, and proactive accident/safety planning through the individualized program planning process;* The provision of training and technical assistance is a valuable element of any regional center's initiatives in risk management. Some regional centers may want to review and revise their curriculum or other resources to better reflect the implementation of specific risk management practices.	*Ask the group to describe the training and technical assistance efforts underway regarding risk management.* *Ask for suggestions of additional topics or strategies that could enhance this area for regional center staff, vendors, and long-term health care facility staff.*

Slide 6: **Coordination and Communication with Outside Investigative Entities** *(b) (3): The Risk Management and Mitigation Plan shall address:* ▪ *Coordination and communication with local licensing, protective service and law enforcement agencies relative to investigative actions and findings;* External agencies' investigative actions and findings are integral to the management of special incidents and more importantly, to the protection of consumers from harm. Positive practices include shared training opportunities with these entities, collaborative review of incidents, and information exchange on issues of common concern.	

Slide 7: **Review of Special Incident Data** *(b) (4): The Risk Management and Mitigation Plan shall address:* ▪ *A process for reviewing individual and aggregate special incident report data to identify trends and unusual patterns which may require regional center action;* Perhaps the most detailed and comprehensive work of risk committees is the review of trends in individual and aggregate special incident data. As the data is processed, multiple reports may be generated. The analysis of targeted reports should identify trends and unusual patterns that may require regional center action. Suggested targets for review and analysis include, but are not limited to, the following: ▪ Multiple SIRs for one individual ▪ Multiple SIRs from one location ▪ Multiple SIRs from one vendor operating in multiple locations ▪ Reports of frequency by type of incident, such as falls ▪ Detailed reports of one type of incident, e.g., alleged abuse	*At the discretion of the regional center, you may wish to provide samples of data reports to the participants. If not, ask the participants to identify the types of targeted reports that are managed by the Committee.*

***Slide 8*: Medical Records and Coroner Reports** *(b) (5): The Risk Management and Mitigation Plan shall address:* ▪ *A process for reviewing medical records and coroner reports, as appropriate, associated with special incidents to ensure that appropriate medical attention was sought and/or given.* This element of the Risk Management and Mitigation Plan may be operationalized through the work of a stand-alone mortality and morbidity review committee. This may also be addressed by a sub-committee of the Risk Management, Assessment and Planning Committee. To carry out the functions of these reviews, additional membership from clinical and consultant staff need to be in place.	

Slide 9: **Additional Committee Responsibilities** *54327.2 (c): The Risk Management, Assessment and Planning Committee shall:* *(1) Monitor the regional center's Risk Management and Mitigation Plan to ensure it is being implemented;* *(2) Annually review the regional center's internal special incident reporting and risk management systems; and* *(3) Update the Risk Management and Mitigation Plan as necessary.*	
Slide 10: **Frequency of Meetings** *Section 54327.2 (d) The Risk Management, Assessment and Planning Committee shall meet at least semi-annually.* Most regional centers meet more frequently than required for enhanced stewardship in the implementation of the Risk Management and Mitigation Plan.	

***Slide 11*: Suggestions for Documentation** The Risk Management, Assessment and Planning Committee should document its activities. The agenda for a committee meeting should be structured and focused. Minutes should focus on outcomes and recommendations, and reflect follow up actions from previous meetings. Meeting minutes serve to chronicle the Committee's efforts and the oversight of the regional center's Risk Management and Mitigation Plan.	
***Slide 12*: Benefits of Risk Management, Assessment and Planning Committees** In closing, here are some of the benefits afforded to a regional center from the work of their Committee.	

Slide 12 (continued)	
▪ Provides opportunities to problem solve and implement proactive strategies to keep consumers safe. ▪ Focuses on the preventative aspects of risk management. The emphasis is on reducing the risk of incident recurrence for one or for other consumers. ▪ Provides a central point for system-wide, as well as consumer-specific, improvements in health and safety.	

Risk Management, Assessment and Planning Committee

Committee Composition

Section 54327.2 (a) requires:

- *Each regional center shall establish a Risk Management, Assessment and Planning Committee that, at a minimum, includes a representative from the regional center's clinical, quality assurance and training staff.*

Committee Responsibilities: Risk Management & Mitigation Plan

Section 54327.2 (b) requires:

- ***The Risk Management, Assessment and Planning Committee shall develop the regional center's Risk Management and Mitigation Plan which shall address, at a minimum:***

Special Incident Reporting

Section 54327.2 (b) (1) requires:

- ***The process and procedures for ensuring accurate and timely handling and reporting of special incidents by regional center staff, vendors, and long-term health care facilities;***

Training & Technical Assistance

Section 54327.2 (b) (2) requires:

- *The provision of training and technical assistance to regional center staff, vendors and long-term health care facility staff and others on the legal obligations of abuse reporting, special incident reporting, risk assessment, developing and implementing an incident prevention plan, and proactive accident/safety planning through the individualized program planning process;*

Coordination & Communication with Outside Investigative Agencies

Section 54327.2 (b) (3) requires:

- ***Coordination and communication with local licensing, protective service and law enforcement agencies relative to investigative actions and findings;***

Review of Special Incident Data

Section 54327.2 (b) (4) requires:

- ***A process for reviewing individual and aggregate special incident report data to identify trends and unusual patterns which may require regional center action;***

Medical Records & Coroner Reports

Section 54327.2 (b) (5) requires:

- ***A process for reviewing medical records and coroner reports, as appropriate, associated with special incidents to ensure that appropriate medical attention was sought and/or given.***

Additional Committee Responsibilities

Section 54327.2 (c) requires:

- ***The Risk Management, Assessment and Planning Committee shall:***

(1) Monitor the regional center's Risk Management and Mitigation Plan to ensure it is being implemented;

(2) Annually review the regional center's internal special incident reporting and risk management systems; and

(3) Update the Risk Management and Mitigation Plan as necessary.

Frequency of Meetings

Section 54327.2 (d) requires:

- ***The Risk Management, Assessment and Planning Committee shall meet at least semi-annually.***

Suggestions for Documentation

- ***Agenda***
- ***Minutes or Committee report***

Benefits of Risk Management Committee

- ***Provides opportunities for problem solving & implementing proactive strategies***
- ***Facilitates a preventative model***
- ***Provides a central point for improvement in consumer health and safety***

54327.2. Regional Center Risk Management, Assessment and Planning Committee and Risk Management and Mitigation Plans.

(a) Each regional center shall establish a Risk Management, Assessment and Planning Committee that, at a minimum, includes a representative from the regional center's clinical, quality assurance and training staff.

(b) The Risk Management, Assessment and Planning Committee shall develop the regional center's Risk Management and Mitigation Plan which shall address, at a minimum:

(1) The process and procedures for ensuring accurate and timely handling and reporting of special incidents by regional center staff, vendors, and long-term health care facilities;

(2) The provision of training and technical assistance to regional center staff, vendors and long-term health care facility staff and others on the legal obligations of abuse reporting, special incident reporting, risk assessment, developing and implementing an incident prevention plan and proactive accident/safety planning through the individualized program planning process;

(3) Coordination and communication with local licensing, protective service and law enforcement agencies relative to investigative actions and findings;

(4) A process for reviewing individual and aggregate special incident report data to identify trends and unusual patterns which may require regional center action, and;

(5) A process for reviewing medical records and coroner reports, as appropriate, associated with special incidents to ensure that appropriate medical attention was sought and/or given.

(c) The Risk Management, Assessment and Planning Committee shall:

(1) Monitor the regional center's Risk Management and Mitigation Plan to ensure it is being implemented;

(2) Annually review the regional center's internal special incident reporting and risk management systems; and

(3) Update the Risk Management and Mitigation Plan as necessary.

(d) The Risk Management, Assessment and Planning Committee shall meet at least semi-annually.

Authority: Section 11152, Government Code. Reference: Sections 4434, 4500, 4501, 4502, 4629, 4648, 4648.1 and 4742, Welfare and Institutions Code.

Special Incident Reporting

Module IV

Instructor's Guide

Length of Session: 1 to 1.5 hours

Intended Audience: Regional center staff or vendored service providers

Class Size: Limited only by room capacity

Training Materials: Power Point presentation (or transparencies):
Special Incident Reporting

LCD projector or Overhead projector

Flipchart and markers (as desired)

Handouts: *Incident Response Checklist*

Requirements for Special Incident Reporting by Regional Centers

Requirements for Special Incident Reporting by Vendors and Long-Term Health Care Facilities

Methods: Lecture; instructor guided discussion; interactive

Course Outline

I. Welcome and Introductions

II. Special Incident Reporting

III. Summary and Closing

Special Incident Reporting

Module IV

Learning Objectives

At the conclusion of this module, participants will:

1. Understand special incident reporting as an element of risk management.
2. Understand the significance of special incident reporting.
3. Learn how to obtain and document all relevant information for an incident report.
4. Relate how special incident reporting influences data analysis.

Special Incident Reporting

Script for Instructor	*Suggestions for Instructor*
Slide 1: **Special Incident Reporting: The Process** Special Incident Reporting is generally thought of as simply "how to complete a Special Incident Report". While, of course, it is necessary to understand how to do this, it is not the intent of this session to present detailed information on how to complete each blank on the form. Correctly completing the SIR form is only the beginning. During this session, we will spend time discussing how to write the incident description portion of the SIR, as this forms the basis of everything that follows. Without a good incident description we will have problems later in reviewing the incident and in developing appropriate preventative actions. In addition, a complete incident description will facilitate accurate analysis of the data, on regional and statewide levels, so that the SIR system can promote safe and healthy lives for everyone.	*Start the Power Point Presentation (or display first transparency on overhead projector). Have the "Special Incident Reporting" title page running as you begin.*

Script for Instructor	*Suggestions for Instructor*
Slide 2: **Something Really BAD Happened!** As service providers or regional center staff, it is imperative that everyone understand what must be reported: Any special incident as defined in Title 17 that occurs "during the time the individual was receiving services and supports from any vendor or long-term health care facility" must be reported to the regional center. The handouts now being distributed include all the specific requirements for Special Incident Reporting for both service providers and regional centers. They serve as ready references as you address special incidents in your day to day work with consumers. The regional center may have additional special incident reporting requirements. Deaths and victim of crime incidents for all individuals, regardless of where they live, must be reported to DDS.	*If the regional center conducts specific training on recognizing and reporting SIR's, then refer to it now.* *Differentiate between what is reported to DDS (Title 17) and what else must be reported to the regional center.* *Distribute copies of the following two handouts:* ▪ ***Requirements for Special Incident Reporting by Vendors and Long-Term Health Care Facilities; and*** ▪ ***Requirements for Special Incident Reporting by Regional Centers.***

Slide 3: **Why Report Incidents?** What are some of the reasons why incident reporting is important? Let's review a few of these reasons. Incident reporting systems: ▪ Ensure accurate data is available to the region, the state, and to CMS, the federal agency that monitors Medicaid waiver services ▪ Analyze and trend incident data from both an individual and systems perspective for monitoring and improvement ▪ To satisfy regulations ▪ To meet our personal & professional responsibility ▪ To provide a healthier and safer environment for everyone we serve	*Record these on a blackboard, marker board, flip chart, or blank transparency.* *The reasons may differ from those listed in the script in the left hand column; however, you should ensure that these are included. Add others on your own if not volunteered by the group.*

Slide 4: **The Incident** Service Coordinators are faced with difficult decisions about how much information should be included on the SIR. There is no single, easy answer to this question that fits every situation. To know the correct answer, it is necessary to look at **why** the Description of the Incident is necessary. The purpose of this section is to objectively report the facts of an incident in as much detail as necessary to answer a few simple questions: Who? What? Where? When? In other words, enough information should be provided to give important clues to the actual circumstances of the incident. Some history related to the incident may also be relevant (e.g. this is the third time the consumer has fallen at home in the past six months). Additional information should be added to the report as it is obtained by the regional center. Reopening an SIR and adding new information as it is received will lead to more fact based conclusions.	*Ask participants how they report or receive reports of special incidents and what information is typically included.* *Another strategy is to read or display a description of a special incident, and:* *(a) Have participants state what additional information they would want to know about what happened, OR* *(b) Have participants tell the person sitting next to them what they think happened. Ask a few people to share their ideas as an illustration of how* ***different*** *people interpret the details of the same incident* ***differently****.*

Slide 5: **The Incident Description** As we have seen, the Special Incident Report should contain sufficient information to answer the 4 'W' questions (Who? What? When? Where?), but how much information is enough? When is it too much? Information should be included so the Special Incident Report is thorough, accurate and clear. This means the words should draw a mental picture of the circumstances surrounding the incident. After reading the Report, everyone should have the same understanding of what happened. Grammar and spelling are important if they compromise thorough, accurate and clear interpretation.	*This section can be reinforced by having participants review sample SIRs and critique how well these reports meet the Thorough-Accurate-Clear guidelines.* *Another technique is to have participants tell what information should be included based on an incident you describe.*
Slide 6: **Incident Description TIP** Remembering these "tips" will provide guidance in determining what (and how much) information to include when reporting a special incident. The emphasis is to be factual. Include facts, as you know them, giving the source of your information. Don't "go beyond" the facts to make judgments.	*If staff who have limited experience are in the audience, you can include examples or have an activity requiring participants to re-write inappropriately worded statements. This activity can be done individually or in small groups. Sharing results at the end of the activity will allow opportunity for you to provide guidance and feedback.*

Slide 7: **Incident Response** Now that we have discussed the type of information needed to complete an SIR, let's talk about both the reporting of and responding to special incidents. If you have had previous training on completing the SIR, you know the mechanics already - who reports what type of incident, to whom do you report, what are the required time lines, etc. This Incident Response Checklist gives you a way to help you work through these steps. The Incident Response Checklist is intended for use in almost every situation; hence, many of the entries say "if appropriate". It is intended to be a useful tool to help everyone understand the expectations of reporting and responding to incidents regardless of your job assignment. Although service coordinators have responsibility for ensuring that special incidents are entered into the SIR system, using this checklist will guide conversations regarding incidents among reporters, service providers, regional center staff and members of the Risk Management Committee. Acquiring all relevant information and distilling it into thorough-accurate-clear incident reports requires skills in observing, listening, interviewing, and processing a large amount of information.	*Hand out the Incident Response Checklist.* *Give participants a few minutes to review it.* *Ask participants to apply the checklist to one of the incidents used in a previous example to become more familiar with this tool.* *Discuss any special requirements of this regional center concerning steps on the checklist.* *For example, if the participants' regional center(s) requires a phone or face-to-face contact between regional center staff and the consumer, discuss this when reviewing the "ensure safety" step.*

Slide 8: **<u>Why</u> Report Incidents?** In this session, we have reviewed why special incident reporting is important and some basic information that should be included. Special incident reporting systems are critical to: ▪ Ensure accurate data is available to the region, the state, and to CMS, the federal agency that monitors Medicaid waiver services ▪ Analyze and trend incident data from both an individual and systems perspective for monitoring and improvement ▪ Satisfy regulations ▪ Meet our personal & professional responsibility ▪ Provide a healthier and safer environment for everyone we serve	*<u>This slide reviews previously presented information that can be used as a wrap-up or closure to the training.</u>* *<u>You may also include other information that you feel your audience needs to have reinforced.</u>* *<u>You may want to include a time for questions following your closing.</u>*

Special Incident Reporting

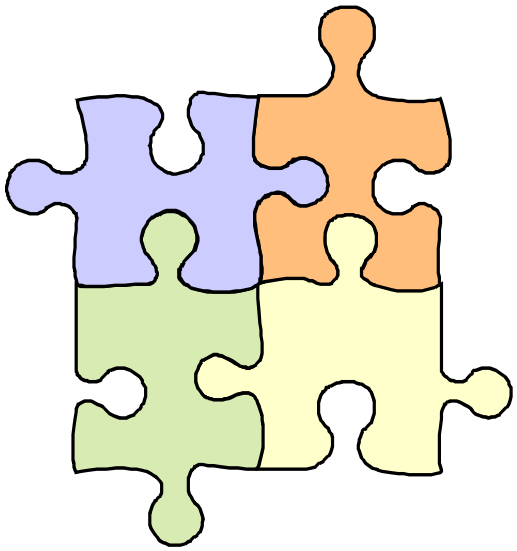
The Process

Something really BAD happened!

WHY Report Incidents?

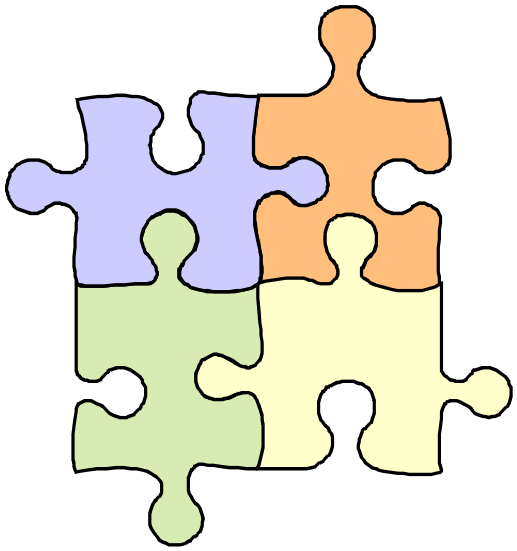
- To ensure accurate data is available
- To analyze and trend incident data
- To satisfy regulations
- To meet personal and professional responsibility
- To provide a healthier and safer environment

The Incident



- **Who**
- **What**
- **Where**
- **When**

The Incident Description



- **Thorough**
- **Accurate**
- **Clear**
- **Grammatical**

Incident Description *Tips*

EXPLAIN HOW INFORMATION WAS ACQUIRED

- Don’t write as if you witnessed an incident (unless you did).
- Document what witnesses reported (occurred/caused).
- Don’t draw conclusions or make judgments.

Incident Response

- **I**nsure safety
- **N**otify entities as required
- **C**heck for completeness
- **I**nquire into inconsistencies
- **D**ocument details
- **E**xplore causes
- **N**ote necessary additions or corrections
- **T**rack follow-up & completion

WHY Report Incidents?

- To ensure accurate data is available
- To analyze and trend incident data
- To satisfy regulations
- To meet personal and professional responsibility
- To provide a healthier and safer environment

54327.1. Requirements for Special Incident Reporting by Regional Centers.

(a) The regional center shall submit an initial report to the Department of any special incident, as defined in Section 54327(b) within two working days following receipt of the report pursuant to Section 54327(b).

(b) When a regional center has knowledge of a special incident for which the vendor or long-term health care facility is responsible for reporting but has not submitted a report to the regional center within the required time period, the regional center shall submit an initial report to the Department within two working days of learning of the occurrence.

(c) The initial report shall include the following information, to the extent the information is available at the time of the initial report:

(1) The consumer(s) name and date of birth;
(2) The vendor or long-term health care facility's name, address and telephone number;
(3) The name and telephone number of the regional center contact person regarding the special incident;
(4) The consumer(s) Unique Consumer Identifier (UCI);
(5) Name of the consumer's conservator or guardian, if applicable;
(6) Date, time and location of the incident;
(7) Date the incident was reported to the regional center;
(8) Name of the person preparing the report;
(9) Date the report was prepared;
(10) Type of incident;
(11) Any medical care or treatment required as a result of the special incident;
(12) Relationship of the alleged perpetrator to the consumer;
(13) Identification of any persons or entities notified about the incident and the date they were notified;
(14) A description of the special incident;
(15) If the special incident was a death, indication if the death was disease related; non-disease related; or, unknown;

(16) A description of any actions/outcomes taken by any of the following persons or entities in response to the special incident:

(A) Regional center(s);
(B) Vendor(s);
(C) Department of Health Services Licensing;
(D) Department of Social Services Community Care Licensing;
(E) Child Protective Services;
(F) Adult Protective Services;
(G) Long Term Care Ombudsman;
(H) Law enforcement; and/or
(I) Coroner.

(17) Any additional information the regional center determines is necessary to explain or describe the special incident.

(c) Any required information that is not submitted with the initial report in (b) shall be submitted within 30 working days following receipt of the report of the special incident pursuant to Section 54327(b).

(d) The regional center shall comply with all Department requests for initial and follow-up information pertaining to a special incident.

(e) The report shall be considered complete when the regional center has submitted all the information required by this section.

(f) Effective January 1, 2002, all reports of special incidents prepared by the regional center shall be transmitted to the Department utilizing the Department's Electronic Data Reporting System.

Authority: Section 11152, Government Code. Reference: Sections 4434, 4500, 4501, 4502, 4629, 4648, 4648.1 and 4742, Welfare and Institutions Code.

ARTICLE 2. VENDORIZATION PROCESS

54327. Requirements for Special Incident Reporting by Vendors and Long-Term Health Care Facilities.

(a) Parent vendors, and consumers vendored to provide services to themselves, are exempt from the special incident reporting requirements set forth in this Article.

(b) All vendors and long-term health care facilities shall report to the regional center:

(1) The following special incidents if they occurred during the time the consumer was receiving services and supports from any vendor or long-term health care facility:

(A) The consumer is missing and the vendor or long-term health care facility has filed a missing persons report with a law enforcement agency;

(B) Reasonably suspected abuse/exploitation including:

1. Physical;
2. Sexual;
3. Fiduciary;
4. Emotional/mental; or
5. Physical and/or chemical restraint.

(C) Reasonably suspected neglect including failure to:

1. Provide medical care for physical and mental health needs;
2. Prevent malnutrition or dehydration;
3. Protect from health and safety hazards;
4. Assist in personal hygiene or the provision of food, clothing or shelter; or
5. Exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or a dependent adult.

(D) A serious injury/accident including:

1. Lacerations requiring sutures or staples;
2. Puncture wounds requiring medical treatment beyond first aid;
3. Fractures;
4. Dislocations;
5. Bites that break the skin and require medical treatment beyond first aid;
6. Internal bleeding requiring medical treatment beyond first aid;
7. Any medication errors;

8. Medication reactions that require medical treatment beyond first aid; or
9. Burns that require medical treatment beyond first aid.

(E) Any unplanned or unscheduled hospitalization due to the following conditions:

1. Respiratory illness, including but not limited, to asthma; tuberculosis; and chronic obstructive pulmonary disease;
2. Seizure-related;
3. Cardiac-related, including but not limited to, congestive heart failure; hypertension; and angina;
4. Internal infections, including but not limited to, ear, nose and throat; gastrointestinal; kidney; dental; pelvic; or urinary tract;
5. Diabetes, including diabetes-related complications
6. Wound/skin care, including but not limited to, cellulitis and decubitus;
7. Nutritional deficiencies, including but not limited to, anemia and dehydration; or
8. Involuntary psychiatric admission;

(2) The following special incidents regardless of when or where they occurred:

(A) The death of any consumer, regardless of cause;
(B) The consumer is the victim of a crime including the following:

1. Robbery, including theft using a firearm, knife, or cutting instrument or other dangerous weapons or methods which force or threaten a victim;
2. Aggravated assault, including a physical attack on a victim using hands, fist, feet or a firearm, knife or cutting instrument or other dangerous weapon;
3. Larceny, including the unlawful taking, carrying, leading, or riding away of property, except for motor vehicles, from the possession or constructive possession of another person;
4. Burglary, including forcible entry; unlawful non-forcible entry; and attempted forcible entry of a structure to commit a felony or theft therein;
5. Rape, including rape and attempts to commit rape.

(c) The report pursuant to subsection (b) shall be submitted to the regional center having case management responsibility for the consumer.

(d) When the regional center with case management responsibility is not the vendoring regional center, the vendor or long-term health care facility shall submit the report

pursuant to subsection (b) to both the regional center having case management responsibility and the vendoring regional center.

(e) The vendor's or long-term health care facility's report to the regional center pursuant to subsection (b) shall include, but not be limited to:

(1) The vendor or long-term health care facility's name, address and telephone number;
(2) The date, time and location of the special incident;
(3) The name(s) and date(s) of birth of the consumer(s) involved in the special incident;
(4) A description of the special incident;
(5) A description (e.g., age, height, weight, occupation, relationship to consumer) of the alleged perpetrator(s) of the special incident, if applicable;
(6) The treatment provided to the consumer(s), if any;
(7) The name(s) and address(es) of any witness(es) to the special incident;
(8) The action(s) taken by the vendor, the consumer or any other agency(ies) or individual(s) in response to the special incident;
(9) The law enforcement, licensing, protective services and/or other agencies or individuals notified of the special incident or involved in the special incident; and
(10) The family member(s), if applicable, and/or the consumer's authorized representative, if applicable, who have been contacted and informed of the special incident.

(f) The report pursuant to subsection (b) shall be submitted to the regional center by telephone, electronic mail or FAX immediately, but not more than 24 hours after learning of the occurrence of the special incident.

(g) The vendor or long-term health care facility shall submit a written report of the special incident to the regional center within 48 hours after the occurrence of the special incident, unless a written report was otherwise provided pursuant to subsection (e). The report pursuant to this subsection may be made by FAX or electronic mail.

(h) When a vendor makes a report of an event to the Department of Social Services' Community Care Licensing Division pursuant to Title 22, California Code of Regulations, Section 80061(b) the vendor shall simultaneously report the event to the regional center by telephone, FAX or electronic mail.

(1) The vendor shall concurrently submit to the regional center a copy of any subsequent written report regarding the event that is submitted to the Department of Social Services' Community Care Licensing Division.

(i) When a long-term health care facility reports an unusual occurrence to the Department of Health Services' Licensing and Certification Division pursuant to Title 22, California

Code of Regulations, Sections 72541, 75339, 76551 or 76923, the long-term health care facility shall simultaneously report the unusual occurrence to the regional center immediately by telephone, FAX or electronic mail.

(1) The long-term health care facility shall concurrently submit to the regional center a copy of any subsequent report, or any written confirmation of the unusual occurrence, that is submitted to the Department of Health Services' Licensing and Certification Division.

(j) The vendor or long-term health care facility may submit to the regional center a copy of the report submitted to a licensing agency when the report to the licensing agency contains all the information specified in subsection (d)(1) through (10).

(k) These regulations shall not remove or change any reporting obligations under the Elder and Dependent Adult Abuse Reporting Act commencing with Welfare and Institutions Code Section 15600 or the Child Abuse and Neglect Reporting Act commencing with Penal Code Section 11164.

Authority: Section 11152, Government Code. Reference: Sections 4500, 4501, 4502, 4648, 4648.1 and 4742, Welfare and Institutions Code.

Incident Response Checklist

The following steps will assist you to respond when a report of a special incident is received. The steps on the left are intended to guide you through the process. The strategies on the right are suggested guidelines for completing each step. Not all strategies will be applicable in every situation. Code Strategies as follows: **Y** = Yes, **N** = No, **NA** = Not Applicable.

Response Steps	Strategies
Insure the safety of the consumer	___ Is the consumer safe now? ___ Is medical treatment being provided? Needed? ___ Are further risks evident (fire or safety hazard, lack of adequate food or shelter, broken equipment, etc.)? ___ What interim measures have been taken to protect the consumer? Other consumers?
Notify legally required entities (as appropriate)	___ CCL ___ CPS ___ Police ___ DHS Licensing ___ Coroner ___ APS ___ Family/Guardian/Conservator ___ LTC Ombudsman
Check for completeness of information	___ Have the "who", "what", "when", and "where" questions been answered? ___ Is the type of incident reported consistent with the information and circumstances reported? ___ What may have contributed to the incident? ___ What aspects of the incident need to be further explored?
Inquire into inconsistencies	___ Are there unanswered questions about this incident? ___ When there are multiple reporters, are conflicts evident among reporters (e.g., family, consumer, direct service provider) from the various incident descriptions? ___ What additional information is needed to clarify these conflicts?
Document details (NOTE: If reportable incident, the SIR must be transmitted to DDS within 48 hours.)	___ Has the SIR been completed? ___ Has a preventative action plan been developed, if needed?
Explore causes of the incident	___ Have all "why" questions been answered? ___ Has the consumer had other incidents? ___ Should others be involved in analyzing this incident (e.g., nurse, PT, Behavior Analyst)? ___ Have significant changes in the person's life been explored? ___ Have some preventative actions already been implemented? ___ What is the status of preventative action? ___ Has long-range planning been conducted to eliminate or minimize risk to this individual or others?
Note necessary additions or corrections to the SIR	___ Are any updates needed to the SIR?
Track SIR for follow-up and completion	___ Do you have a tracking system for ensuring follow-up actions are completed on time? ___ How will effectiveness of preventative actions be determined? When? By Whom? Who will monitor implementation?

Causal Analysis

Module V

Instructor's Guide

Length of Session: 1 to 1.5 hours

Intended Audience: Regional center staff and vendored service providers

Class Size: Limited only by room capacity

Training Materials: Handout: Preventative Action Checklist

Power Point presentation (or transparencies): *Causal Analysis*

LCD projector or Overhead projector

Flipchart and markers (as desired)

Methods: Lecture; instructor guided discussion; interactive

Course Outline

I. Welcome and Introductions

II. Analysis of Contributing Causes

III. Development of Preventative Action

IV. Summary and Closing

Causal Analysis

Module V

Learning Objectives

At the conclusion of this module, participants will:

1. Understand the definition of causal analysis.
2. Understand how incident reporting influences causal analysis and the development of preventative action plans.
3. Complete a sample causal analysis of an incident.
4. Integrate information from the causal analysis into preventative action strategies.
5. Develop effective follow-up plans.

Causal Analysis

Script for Instructor	*Suggestions for Instructor*
Slide 1: **Causal Analysis** The purpose of this training is to learn a new way to determine what preventative actions should be taken after an incident occurs. Causal analysis has become common practice in industries that address major disasters, such as aerospace, nuclear power, and transportation. Causal analysis has been applied to the discovery of why certain catastrophes occurred. These include airplane crashes, nuclear power plant leaks, unplanned power outages, train derailments, and the like. Root Cause Analysis is a standardized way to review and analyze a situation to determine **WHY** an incident occurred. Causal analysis is determining the most **basic** cause or causes of an incident. During this session, we will review causal analysis and apply this method to the development of effective preventative action plans.	*Start the Power Point Presentation (or overhead transparencies and projector). Have the "Causal Analysis" title page running as you open the presentation.* *If participants have not received training in incident reporting, spend a few minutes on the importance of providing thorough and accurate information in reporting the incident.*

Script for Instructor	*Suggestions for Instructor*
Slide 2: **Causal Analysis** We know from our work in services for people with developmental disabilities that rarely, if ever, does any one thing cause an incident to occur. Generally, incidents occur because of a combination of different factors. It is this unique combination of factors that results in an accident, illness, or injury. Think about causal analysis as "peeling an onion" to reveal all contributing causes to an incident. In order to develop appropriate preventative action that will lessen the likelihood of the incident recurring, contributing causes need to be examined. Let's talk about a situation that may appear to be straight forward, but very well could be caused by many different things. This example involves Mary, a woman in her late 60's who fell when she got out of bed this morning. What are some possible causes for Mary's fall?	*In this example, you want to make the point that most incidents have more than one cause, and that at times, those causes are inter-related.* *List on a flip chart all the possible causes volunteered by participants. These may include: Mary was dizzy when she stood up due to blood pressure problems, Mary has an ear infection that affected her balance, Mary's roommate had spilled something on the floor, the overnight staff moved Mary's shoes and she tripped, etc.*

Script for Instructor	***Suggestions for Instructor***
Slide 3: **Purposes of Causal Analysis** The difference between causal analysis and special incident reporting is that, in causal analysis, we want to learn more about an incident than just the facts that surround it. We want to do more than simply *report* an incident. In causal analysis, our goal is to *learn* from the incident. We want to learn why the incident occurred and then ***minimize the possibility of it happening again***. Are any of you aware of an incident that, within a short time, **re**occurred with the person or happened to another person in a similar situation? Causal analysis is a way to be proactive when an incident occurs. When we are reactive, we simply *react* to what has happened: We report the incident to the appropriate people and complete the necessary paper work. When we are proactive, we still report and document, but we also learn from what has occurred. With a proactive approach, we consider how the same incident could happen to this person ***again*** or how the same situation may negatively affect other people.	*List these examples on a flip chart you can refer to during later discussions of preventative action.* *Examples may include falls in the same location of the day program, choking on food that was not prepared according to texture modification requirements, being injured repeatedly by a house mate who has assaultive behavior, etc.*

Script for Instructor	*Suggestions for Instructor*
Slide 4: **Traditional or Cause Analysis** Another way to understand causal analysis is to look at a traditional approach to an incident compared to a causal analysis approach. Typically in the traditional approach, we want to know what happened, who caused it, and what will happen to them. With the causal approach, we may still address those things, but we don't stop there. We ask ***"Why"*** the incident happened, what contributed to the incident happening, and how could it have been prevented. Remember: most incidents do not have only one cause. Usually several things, all working together, contribute to an incident. The traditional approach is concerned with individual blame. The causal approach, on the other hand, is more concerned with problems in the *system*, such as: ▪ Poorly designed policies ▪ Procedures not carried out ▪ Supplies not available ▪ Lack of training or supervision	

Script for Instructor	*Suggestions for Instructor*
Slide 4 (continued) The causal approach admits that sometimes people are put into situations where mistakes are likely to be made. Changing the person will not prevent recurrence without changing the situation or the factors that contributed to a human error occurring in the first place.	
***Slide 5:* A 12 Step Process** This slide outlines causal analysis as a 12-step process. ▪ For Steps 1-3, you need to get the appropriate people together, review the facts, and determine the primary or most obvious cause. The appropriate people would be those who have first hand knowledge of the incident, or who know the consumer well. ▪ Steps 4-6 involve brainstorming possible causes, remembering that with brainstorming, no idea is wrong or too far-fetched. This will lead to identifying barriers and common factors that contributed to the incident. ▪ Steps 7-12 are then used to complete the analysis. Questions regarding all common factors need to be asked and answered. To do this, you will have to ask **WHY** over and over again. Don't settle for a single answer until "the onion is completely peeled" and you have arrived at the most basic, or root cause, of the incident.	*This slide will remain displayed during the review of the process and the application of the example with Maria and Sue that follows.*

Script for Instructor	***Suggestions for Instructor***
Slide 5 (continued) After the causal analysis is complete, preventative actions can be developed, leadership support can be obtained, and the plan can be implemented, and then monitored for effectiveness. Let's apply these steps to a situation involving a consumer named Maria and a staff member named Sue. One evening while Sue was helping Maria take a bath, Sue left the bathroom briefly to get a towel. When she returned, Maria was lying on the floor bleeding from a large cut on her head.	*Lead the group, step by step with questions regarding the scenario of Maria being injured.* *When the primary cause is mentioned, (e.g., Maria was left unsupervised in the bathroom), ask "WHY?" to encourage participants to go deeper into the situation. For example: Maria was unsupervised because Sue did not get the towel first.* ***WHY?*** *Because Sue was distracted and did not prepare completely.* ***WHY?*** *Because there was another emergency going on at the same time.* ***WHY?*** *Because Sue was going to help Maria bathe while another staff person was on break.* ***WHY?*** *Continue until the most basic cause can be determined along with various contributing factors.*

Slide 6: **Possible Common Factors** These **Common** elements are factors that *typically* contribute to special incidents. To complete a causal analysis and determine the contributing factors, each of these should be considered. ▪ **Staff:** *Available staff, tenure, training, competency level, and experience.* ▪ **Consumer:** *Medical status, functional ability, cognitive level, behavior, physical ability, needs, and preferences.* ▪ **Communication:** *Communication systems between consumer, family, providers, staff, shifts, supervisors, disciplines, information, and availability.* ▪ **Equipment**: *Needed, available, working, and in need of adaptation.* ▪ **Policies:** *Policies in place, known, followed, and effective.* ▪ **Environment:** *Life Safety Code violations, cold/hot, noise level, distractions, light/dark, modified, and distractions.* ▪ **Leadership:** *Supervision, training, oversight, and organizational support for a culture that focuses on health and safety.*	*Following the review of this slide, it will be important for participants to practice reviewing an incident to arrive at causal factors.* *A way to do this is to have them review an incident, either individually or in groups. The above incident on Maria can be used, as well as an incident volunteered by one of the participants.* *One way to structure this activity is to have each of the factors listed on a sheet of paper and have the participants list what about that factor "caused" or contributed to this event.* *It is important to point out that discussing common factors may result in the participants realizing that they do not have all the facts and that they have to go back to fact finding.*

Slide 7: **Advantages of Cause Analysis** Causal analysis provides a standard way to review incidents. It is cost effective as it uses information that is already available and helps eliminate difficult or costly reactions to incidents that may not effectively minimize the possibility of the incident recurring. Learning from the incident through causal analysis is a way to prevent partial or incomplete solutions. Now that we have determined the cause(s) of the incident, we can begin to decide what an appropriate follow-up plan would be.	
Slide 8: **Preventative Action** Preventative action is the ability of the system to ensure appropriate actions are taken following an incident. Effective preventative action plans apply corrective actions to the areas of concern found in the causal analysis. Preventative action plans should be developed with a specific goal in mind: what is the intended outcome or result of this preventative action and how will it prevent recurrence? Effective preventative action plans identify responsible parties, timelines, and methods for measuring results. Just as completing a causal analysis takes more than one person, development of preventative actions will take more than one person.	

Slide 8 (continued) All relevant people, including the provider and service coordinator, should collaboratively develop action plans. All parties share responsibility for implementation and oversight so that preventative actions minimize the likelihood of recurrence.	
Slide 9: **Preventative Action Checklist** When developing preventative action plans, there are several things you should ask. The Preventative Action checklist will give you guidance on this task. This checklist is intended to be something you can use for almost every incident; therefore, everything on it will not apply in every situation. A few fundamental questions, however, apply. ▪ Does the action to be taken address the cause of the incident? ▪ Is the action to be taken within the control of the responsible person? ▪ Are the necessary resources available? ▪ If the preventative action is effectively implemented, can it minimize recurrence of the incident?	*Distribute the Preventative Action Checklist. Give participants a few minutes to review it and ask questions on individual steps. Have participants apply the checklist to a recent incident with which they are familiar. You may also use this opportunity to note any special requirements of this regional center regarding preventative action planning.*

Slide 10: **Causal Analysis** Causal analysis is an integral part of the risk management process. It provides direction to planning for preventative actions and focuses on the outcomes that will reduce the likelihood of incidents reoccurring.	

Causal Analysis

Causal Analysis

The most basic reason(s) for an undesirable condition or problem

Purposes of Cause Analysis

Traditional or Cause Analysis

Traditional Approach

- What happened?
- Who was responsible?
- What are we going to do to them?

Cause Analysis

- WHY did it happen?
- What factors contributed?
- Were barriers present?
- How could it have been prevented?

A 12 Step Process

1) Involve appropriate people
2) Review facts
3) Determine primary cause
4) Brainstorm potential contributing factors
5) Identify barriers
6) Check common factors
7) Complete analysis
8) Ask WHY questions
9) Determine contributing causes
10) Develop preventative action
11) Obtain leadership support
12) Monitor results

Possible Common Factors

- Staff
- Consumers
- Communication Systems
- Equipment
- Policies
- Environment
- Leadership

Advantages of Cause Analysis

- **Standardized process**
- **More complete analysis**
- **Increased likelihood of improvement oriented conclusions**
- **Greater buy-in from participants**

Preventative Action

- Identifies situations where corrective actions are needed
- Ensures appropriate actions are taken
- Provides method to evaluate effectiveness

Preventative Action Checklist

- Does the action address the cause of the incident?
- Is the action within the control of the responsible person?
- Are needed resources available?
- If the preventative action is implemented, could it prevent the incident from happening again?

Causal Analysis

- Contributes to the Risk Management Process
- Gives direction to preventative action
- Focuses on outcomes

Causal Analysis

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Preventative Action Checklist

The following steps will assist you to develop preventative actions in response to a report of a special incident. The steps on the left are intended to guide you through the process. The strategies on the right are suggested guidelines for completing each step. Not all steps will apply to every situation. Strategies should be coded as follows:

Y = Yes **N** = No **NA** = Not Applicable

Steps	Strategies
Does the action address the cause of the incident?	___ Have all "who", "what", "when", and "where" questions been answered? ___ Does the incident description adequately depict what happened? ___ Could the incident occur again? ___ Is more than one explanation possible for what happened?
Have prior data and documentation been analyzed to determine any possible contributing factors?	___ Has there been a record review? ___ Have there been documented skills deterioration, sleep disturbances, changes in eating habits, or changes in medication? ___ Have there been changes in events, stressors, and/or noise levels? ___ Has the person been a victim of abuse or neglect? ___ Can you identify any related patterns (employees, place, times of day, setting conditions, other consumers, etc.)? ___ Have environmental issues been identified and corrected?
Does the preventative action plan include specific actions?	___ Is it measurable? ___ Are timelines for preventative action included? ___ Does the preventative action plan include the responsible person(s) and actions needed to be taken?
Are the preventative actions doable?	___ Are noted actions within the control of the service coordinator, regional center, and/or provider? ___ Are necessary resources available? ___ Does the responsible person have the authority to implement prescribed actions?
Can it be monitored?	___ Is there a clear and objective system in place to monitor the implementation and effectiveness of the preventative action plan?
If the preventative actions are implemented, can they prevent the incident recurring?	___ Have past preventative actions been effective in reducing risk? ___ Have all elements of previous preventative action plans been implemented?
If the incident was linked to a medical issue, is medical or clinical assessment or follow-up needed?	___ Was it completed? ___ Was it documented?
If the incident involves a behavioral issue, does the person(s) involved have a behavior plan?	___ If no, is one needed? ___ If yes, has it been reviewed to determine its continued effectiveness? ___ Was it implemented effectively?
If the incident involved an environmental factor, was it rectified?	___ Was the action implemented and documented?
If the incident was linked to a programmatic issue, has the person responsible for the training program been notified and involved?	___ Has the program been reviewed and revised as necessary? ___ Are any revisions documented?

Mortality Review

Module VI

Instructor's Guide

Length of Session: 1 to 1.5 hours

Intended Audience: Regional center staff; Mortality Review Committee Members; Members of the regional center's Risk Management, Assessment, and Planning committee; health care providers

Class Size: Limited only by room capacity

Training Materials: Power Point presentation (or transparencies): *Mortality Review*

LCD projector or Overhead projector

Flipchart and markers (as desired)

Methods: Lecture; instructor guided discussion; interactive

Course Outline

I. Welcome and Introductions

II. Introduction to Mortality Review

III. Designing Mortality Review Systems

IV. Potential Pitfalls

V. Summary and Closing

Mortality Review

Module VI

Learning Objectives

At the conclusion of this module, participants will:

1. Describe the Mortality Review process.
2. Identify reasons for completing mortality reviews.
3. Describe the basic elements of a mortality review system.
4. Identify potential limitations of mortality review systems.

Mortality Review

Script for Instructor	*Suggestions for Instructor*
Slide 1: **Mortality Review** The goal of mortality review is to learn from a person's death, to discover if the same or similar situations may affect others in the future, and to improve overall quality of care. Assessing incompetence, intentional injury or violation of rights, rules, or regulations **is not** the intended goal of mortality review. These issues, if present, are generally addressed through other administrative means. Deaths, regardless of where or when they occur, must be reported as Special Incidents. In addition, regional centers have an obligation to develop and implement 'a process for reviewing medical records and coroner reports, as appropriate, associated with special incidents to ensure that appropriate medical attention was sought and/or given" (Title 17, Article 2, 54327.2, (b) (5). This must be covered in the regional center's Risk Management and Mitigation Plan.	*Start the Power Point presentation or display the title overhead transparency.* *Ask participants to identify actions typically taken at this regional center following a death.* *Ask participants to identify how their regional center could benefit from looking at deaths as an opportunity to improve services.*

Script for Instructor	*Suggestions for Instructor*
Slide 2: **Benefits of Mortality Review** In a mortality review system, factual information is reviewed to determine ways to improve the quality of future services. Benefits of mortality review systems include: • Improved monitoring of quality of care • Development of a mortality database • Improved timeliness of documentation and reporting • Increased attention to quality across all service areas • Enhanced ability to respond to external inquiry/scrutiny (licensing, media, etc.)	
Slide 3: **Organizational Support** There are specific organizational factors that support the mortality review process. Foremost is an organizational culture supportive of risk reduction and safety. When this culture is present, the organization utilizes mortality review as a preventative process. Additionally, a cross-disciplinary, collaborative team approach is necessary to integrate knowledge, experience with the person's circumstances, and different areas of expertise.	*Ask participants how their organization is (or could be) supportive of the mortality review process (for example, policies in place, an active mortality review committee, training for committee members, documentation requirements, etc.)*

Script for Instructor	*Suggestions for Instructor*
Slide 4: **Purposes of Mortality Review** Mortality Reviews should be conducted to: ▪ Determine if there are any **red flag** areas that need immediate resolution. ▪ Determine contributing factors of the circumstances surrounding the individual's death. ▪ Identify patterns or trends of concern (areas needing system support). ▪ Determine whether changes are needed to prevent similar circumstances affecting other consumers. ▪ Propose care and treatment recommendations, if appropriate.	
Slide 5: **Designing the Mortality Review System** When designing a mortality review system, some fundamental questions need to be asked: • Why conduct mortality reviews? • How are mortality reviews conducted? • When are mortality reviews conducted? • Who will be involved?	

Script for Instructor	*Suggestions for Instructor*
Slide 6: **Why Conduct a Mortality Review?** The outcome of the review should be a determination of areas where, in retrospect, support for the consumer could have been improved. The committee should pool ideas of recommendations for future changes in the service system. Changes may include such activities as follow-up training for provider and/or regional center staff; training and information dissemination to hospitals, physicians, other care providers; and organizational changes within the provider or regional center. Recommended organizational changes might vary from revising communication systems among providers to establishing a task force charged with increasing the availability of specific services. If the committee identifies a significant issue that requires immediate attention for the health and safety of other consumers, a committee member should be charged with ensuring that the situation is rectified as soon as possible.	*If participants are involved in the mortality review process currently, have them discuss this intended outcome and why or why not their process is successful in meeting it.*

Slide 7: **How are Mortality Reviews Conducted?** Several methods may be used to complete the review process. It is suggested that, prior to the meeting, each committee member reviews the facts surrounding the events to be reviewed. A thorough review should be made of the case history, medical records, and facts surrounding the incident/illness leading to the death, treatment plans, and other relevant records. In addition to medical and nursing issues, residential supports, day services, healthcare utilization, special incidents, and individual planning efforts during the life of the consumer should be reviewed to identify instances where supports might have been better provided. The review should consider information available throughout the life of the consumer but should focus on the previous twelve months to identify: • trends in planning; • use of resources; • deviations from normal health status; and, • limitations or failures of support.	*Ask participants currently involved in mortality reviews to discuss their procedures. You might ask for strategies they think work well in their system or for areas they think could be enhanced.*

Slide 7 (continued)	
All aspects of the review should be discussed during the committee meeting. If the committee determines that further information is needed, a request should be made to obtain these records and a subsequent review is scheduled. The objective is to examine the impact of all supports on the person's life, not to second-guess the provision of medical and nursing care or to provide a second-opinion of the cause of death. The committee should summarize its findings by identifying areas of concern and making recommendations for any needed follow-up.	

Slide 8: **When are Mortality Reviews Conducted?** Regional centers review all deaths. Consideration should be given to the information on the special incident report (SIR) that would prompt a mortality review. Suggested "triggers" include the following: • High percentage of deaths of unknown origin • Lack of preventative health care • Lack of emergency health care services • Lack of availability of routine health services • Unexpected deaths with one or more of the following conditions: gastrointestinal bleeding, intestinal obstruction, aspiration pneumonitis, malnutrition, decubitus ulcers, cervical cancer, melanoma, diabetic ketoacidosis, tardive akathisia, tardive dyskinesia, or neuroleptic malignant syndrome • All injury-related deaths	

Slide 9: **Who Will Be Involved?** When designing a mortality review process, it is important to determine who should be involved in the review process. Generally, a committee composed of a clinical staff person such as a physician or nurse, or both, completes a mortality review. Some committees include other members who are specifically charged with addressing program planning issues, social issues and relationships, environmental issues, etc. It is also recommended that representatives of the regional center management team such as a service coordination supervisor and quality assurance supervisor be included. A regional center may choose to form a mortality review committee as a sub-committee of the Risk Management, Assessment and Planning Committee. The mortality review committee should meet on a routine basis (e.g., once monthly, twice monthly) depending on the number of cases to be reviewed.	*Ask participants who serves on their committee, if committees are currently being used in their organization.*

Slide 10: **Information Dissemination** Following the review process, recommendations for improvement should be compiled and shared across the entire system. Regional centers will need to consider methods of information dissemination, paying particular attention to confidentiality issues related to the decedents and their families, vendors, and others involved in the person's care and treatment.	*Ask participants what happens to the findings from these reviews. If mortality reviews are not used, have participants list those who should receive, or could benefit, from this information. Lead a discussion on how sharing could be done without compromising confidentiality. Possible solutions could be to: share aggregate results to supervisors such as the number of reviews completed, number and type of recommendations, information available for review, etc.; making aggregate data (altered for confidentiality) available for review by appropriate parties; composing fictitious accounts based on actual reviews that could be used for training.*
Slide 11: **Potential Challenges** What are some problems typically found when completing mortality reviews? • There may not be sufficient information available to conduct a satisfactory review or arrive at definitive conclusions. • Regional centers may not be notified of a death in a timely manner.	

Slide 11 (continued) • Autopsies may not be conducted or reports may not be available, even in situations where the cause of death is unclear. • Death certificates, if available, may list a cause of death that is not included as a diagnosis in pre-mortem records. Despite these possible variables, the process of mortality review can still serve as an enhancement to the delivery of services and supports.	
Slide 12: **Mortality Review** A structured mortality review process is a way to analyze mortality statistics, monitor sentinel health events, and provide qualitative review of individual events. A structured mortality review process results in system-wide quality enhancement.	

Mortality Review

Benefits of Mortality Review

- improved monitoring of quality of care
- development of a mortality database
- improved timeliness of documentation and reporting
- increased attention to quality across all services
- enhanced ability to respond to outside inquiry (licensing, media, etc.)

Organizational Support

- Culture
- Cross-disciplinary team approach

Purposes of Mortality Review

- To determine "red flags"
- To determine contributing factors of the circumstances surrounding the individual's death
- To identify patterns or trends
- To prevent similar occurrences
- To determine whether changes are needed
- To make care and treatment recommendations

Designing the Mortality Review System

- Why Conduct Mortality Reviews?
- How Are Mortality Reviews Conducted?
- When Are Mortality Reviews Conducted?
- Who Will Be Involved?

Why Conduct a Mortality Review?

- Outcomes
- Recommendations

How?

- Collect Information
- Review Life of Consumer
- Identify Issues and Concerns
- Propose Recommendations

When are Mortality Reviews Conducted?

Triggers from Special Incident Reports

Unexpected Deaths

Who?

- Clinical Staff
- Members of Management Team
- Sub-Committee of Risk Management, Assessment and Planning Committee

Information Dissemination

- Recommendations Shared
- Confidentiality Ensured

Potential Challenges

- Sufficient information available
- Timely notification
- Autopsies not conducted
- Death certification information

Mortality Review

System-Wide Quality Enhancement