

**Commonwealth of Massachusetts
Department of Developmental Services**

RISK MANAGEMENT POLICY AND PROCEDURES MANUAL



**Prepared by the DDS
Office of Quality Management**

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FOREWORD

Exposure to risk is a part of life and it is only through making choices and developing good judgment that we all learn and mature. People with intellectual disabilities, however, may be vulnerable to neglect, abuse and a variety of other dangerous situations if they have not learned how to, or are not able to, keep themselves safe. People with disabilities share the same vulnerabilities as others, but they usually have less power to deal with their vulnerability and to access the support they need.

In December 1998, The Department of Developmental Services implemented the statewide Risk Management system. In the decade since its implementation, the system has improved and evolved into an integral part of the support plan for people with disabilities. The system remains grounded in the principles which built the framework and components of a comprehensive process to review, assess and manage risk for individuals with disabilities

The Department's Risk Management System promotes local autonomy, by supporting the Area Office connections and networks among all stakeholders to keep the individual and the community safe. This manual outlines a standardized system and codifies a set of operational procedures and practices that borrows from best practices around the state. Based on a decade of experience the risk management system is continuously evolving to meet the serious complexities of contemporary society

The third edition of the manual reflects the Department's maturing approach to risk management. It builds upon the strengths and accomplishments of the existing system after ten years of implementation, as well as the recommendations of a workgroup convened to review areas where the risk management system could be strengthened.

The primary modifications reflected in the manual include:

- 1) A more holistic approach to risk management which recognizes that the response to risk in an individual's life may involve a variety of approaches and interventions, in addition to or in place of a formal risk management plan,
- 2) An increasing emphasis on risk prevention and several helpful tools to support this approach, including a list of special considerations when reviewing risk and a set of standardized protocols as guides in mitigating significant common risk factors,
- 3) A renewed emphasis on the regular review of potential risk factors for all individuals receiving service coordination to assure that emerging or increased risks are promptly identified and addressed in order to mitigate more serious consequences later on.

We are grateful to the individuals who worked with us in reviewing the DDS approach to risk management. They include:

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PREFACE

Finding the Balance

The Massachusetts Department of Developmental Services (DDS) Risk Management system balances a responsibility to keep individuals safe, with the Department's vision to promote personal independence and self-determination. Individuals who are at risk are best served by an effective partnership among the DDS, service providers, individuals, guardians and families. Optimally, all involved parties must recognize the reality of risk in peoples' lives and the strengths and limitations of the service system. Working together, an environment is created which provides effective and appropriate safeguards and supports. Distinguishing between reasonable and unreasonable risk is sometimes obvious; however, more often, it is a complex task that requires the exercise of professional judgment and the guidance of practice standards.

Many individuals served by DDS, are making their own choices, experiencing the fullness of community life in their work and home lives, assuming personal responsibility for their choices, and learning to evaluate and grow from the experience of those choices. DDS and its oversight agencies have recognized, however, that there are many challenging aspects to the issue of individual choice, including competency and the capacity to make informed decisions, especially when such decisions may result in an unreasonable risk to the individual. Through the risk management process a direction is offered to staff and providers when the question of supporting an individual's choices appears ambiguous. This direction is especially important in supporting individuals who are competent to make informed decisions, but who may exercise poor judgment, which continually places themselves or others at risk. No one individual with disabilities should be abused or neglected as a matter of "personal choice". Finding the balance between the responsibility to protect people while promoting their personal growth and autonomy must begin with the individual and those who know him/her best. This public responsibility must be approached as a partnership, based on a foundation of trust that does not attempt to limit freedom, but rather, assists the individual, when possible, to look at ways to be safe within the choices he/she makes.

Principles of Risk Management System

The Risk Management system has as its foundation, a set of guiding principles. Below are these principles as outlined in the original 1998 manual. They are as pertinent today as they were when first articulated.

- Risk management emphasizes safeguards and strategies to manage reasonable risk whenever possible.
- Identifying and addressing unreasonable risk should be respectful of an individual's rights while addressing competency and capacity to make informed choices.
- The determination of who is at risk should include those who know the individual best. It should be based on professional/clinical assessments, understanding of any cultural and linguistic issues and should always be integrated with the ISP process.
- A risk management system should be locally based and implemented by individuals trained, supervised and supported in making knowledgeable decisions through a collaborative group process.
- Those making determinations about responsive courses of action must have access to clinical, legal and administrative consultation and to individuals/groups with relevant training/expertise.
- The risk management system must include ongoing oversight and monitoring activities based on accurate data and focused on promoting institutional learning.

Goals of a Risk Management System

The key to a truly effective risk management system rests in a focus on early identification and prevention of factors that place individuals at risk. The goals of the DDS risk management system, therefore, are the following:

- To take a broad pro-active approach in identifying risk
- To identify potential risks in their early stages in order to minimize the impact to the individual rather than a reactive response to crises as they arise
- To provide skilled effective interventions to mitigate risk
- To identify successful interventions which mitigate risk to generalize their use on an individual or community level
- To consider which potential risks factors might be the focus of a broad comprehensive system wide intervention
- To interface with other internal and external safeguard systems to prevent harm and promote health
- To analyze trends within other quality management systems for health and safety
- To integrate the work of risk management into the ongoing clinical and service planning activities of the Department

I OVERVIEW OF THE SYSTEM

1. A holistic approach to risk management

In order to support the goal of taking a broad, pro-active approach to identifying risk, DDS and provider staff recognize that risk identification is an on-going and integral part of their daily work. While some conditions and risky behaviors are easily identified, the ability to discover and address less obvious potential risks is a more subtle and nuanced process. Supporters can utilize the wide array of information that is available that may be early warning signs of potential risk. Incident reports, restraint utilization, and investigation reports are just a few examples of information that can point to issues that may place individuals at risk. When viewed holistically and on a routine basis, most risks to individuals can be routinely addressed through the provider and service coordination oversight and review process. In many situations, with an on-going review of potential risks, simple but potentially dangerous risk factors can be identified and addressed in their very early stages and can be managed through the ISP process, clinical/behavioral consultations, and/or positive behavioral supports. A formal risk management plan then is an important, but clearly not the only tool in the total armament of supports to assist in the mitigation of risk to individuals.

2. Who is at Risk?

Often those most at risk are individuals who are the most capable and who may receive minimal support. DDS provider programs and staff effectively support many individuals with complex needs and there is no single profile of individuals who are at risk. However, our experience has demonstrated that individuals generally fall into one of three categories:

- Individuals, who present significant challenges, require a high level of oversight and attention to a variety of potential risks, even while receiving extensive DDS support. This would include individuals with complex medical diagnoses and/or forensic involvement.
- Individuals who do not wish to be labeled as a person having an intellectual disability and do not perceive themselves as "clients" of the Department. Many of these persons are, or have been, in disadvantaged situations and face significant challenges. These circumstances may include poverty, unemployment, mental illness, domestic violence, substance abuse and/or involvement with the criminal justice system. The risk management process encourages partnerships with other public agencies, creating a comprehensive plan to better support the individual. An example of this partnership is risk planning among primary care providers, probation officers, the local emergency crisis teams, Department of Mental Health Homeless Outreach team, and the DDS Area Office.
- Individuals living with family or independently who suddenly require more support than they are receiving and may accept additional assistance when specific challenges in their lives are identified and critically examined.

3. Who identifies individuals who are at risk?

An effective risk management system identifies warning signs early in the process and introduces strategies to mitigate risk before the occurrence of a sentinel event. Simply put, but potentially life threatening risk factors need to be reviewed on a regular basis as part of a pro-active risk management system. The first two goals of the Massachusetts DDS Risk Management system refer to the identification of risk factors: First, “ *take a broad pro-active approach in identifying risk* and the second goal is :, “ *the early identification of potential risks in order to minimize the impact to the individual rather than a reactive response to crises as they arise.*”

It is important that a risk management system not focus exclusively on those extraordinary and hazardous risk factors which affect a very small percentage of individuals supported by the Department. Those factors often involve independent

individuals whose behaviors, such as substance abuse, are very challenging to manage. Risk Management for these individual often involves outreach and continuous engagement in individual supports to assist the individual in a lifestyle change.

It is the practice of the Department of Developmental Services that any staff person may suggest an Area Office Risk Committee review of an individual's risk related circumstances. The decision on whose situation should be examined by the risk committee is ultimately made by the Area Director (AD), or other designated supervisory and clinical staff within the Area Office. Any unsafe situation, at any time, may be identified by: families/guardians; DDS service providers; other public agencies (courts, family and elder services); and other internal staff (e.g., licensure and certification surveyors, Area Office nurses, DDS investigators); and external stakeholders such as neighbors and police. Occasionally, when an individual is recognized as being at risk, a subset of the Area Office Risk Committee may review and resolve the situation quickly with increased supports or by removing the individual from the situation which places them at risk.

More complicated situations demand the diligence of a full risk management assessment and review. This review should include key contacts, providers and clinicians who will assist in creating a risk plan with strategies to reduce or eliminate the risk for an individual. The Risk Management system also offers Area Directors expedient and organized access to the Region's and/or Central Office's administrative and clinical resources

4. When are individuals identified as being at risk?

An individual's risk factors are routinely identified as part of the on-going service coordination process. A regular review of potential risk factors for each individual occurs during regular meetings between a Service Coordinator and his or her Supervisor. This review includes a wide spectrum of concerns that could potentially pose a risk to an individual. Risk situations once identified can be addressed in several different ways and need not necessarily always result in the development of a formal Risk Management plan. Responses might involve a specific support strategy as part of the Individual Service Plan (ISP), a clinical consultation, a behavior plan or a review by the

Area Office risk committee or Statewide Medication Review Committee The key principle at work is that risks are pro-actively identified and that the appropriate support mechanisms are chosen to address them.

Some individuals have known high risk factors and receive extensive supports to balance these risks, as outlined in the ISP process. These individuals may not need a risk plan. In these cases the Area Office risk management committee may choose to continuously review these risks factors through customary service coordination and supervision and refer to the risk management committee if the risks at any time are not adequately managed.

Immediate and unexpected risk however may be identified through any of the Department's safeguard systems. While nothing can take the place of on-going communication with an individual and his/her involved provider and guardian, there are a variety of mechanisms and reports which serve to alert Service Coordinators and Area Office staff to the presence of risk in an individual's life.

Area Office clinicians during the course of their consultations and evaluations may identify an acute physical or behavioral issue which is putting a person at risk. Occasionally, the Office of Investigations or Human Rights may uncover an emergency situation demanding immediate attention and an Area Office would not wait for a risk review to take urgent action.

Consideration for a risk review may also develop when an individual is identified in difficulty through the monthly "trigger" management reports generated by the Home and Community Services Incident System. (*HCSIS Triggers Reports* see page 27). Trigger reports identify individuals who reach a certain threshold of specifically defined incidents that may indicate a pattern of risk that requires more in-depth review. Individuals recognized at risk in these situations may be quickly reviewed by the Area Office risk management team to provide immediate safety for the individual without a formal risk plan. These situations would require review until risk to the individual is managed or eliminated. An example of this situation occurs when an individual's circumstances are reviewed after repeated unplanned hospital visits.

Individuals who continue to have HCSIS reports of assault, victimization, and/or repeated psychiatric or medical hospitalizations and/or on-going involvement with the criminal justice system despite having supports in place, certainly have significant

dynamic factors which need the comprehensive continuous assessment of the Risk Management system and a formalized risk plan.

5. What is the Composition of the Area Office Risk Committee?

Managing risk in the lives of persons with intellectual disability is a responsibility of every member of the Department of Developmental Services. Within the Risk Management system there are specific defined roles at the Area Office, Regional Office and Central Office level of the Department. The most important work in balancing risk and self determination occurs at the Area Office or local level.

The Massachusetts DDS Risk Management system is organized at the local Area Office level to allow key people in an individual's life to offer their expertise and experience in contending with unsafe situations. The system is designed to be an integral part of the daily work of the Department as an enhancement to regular planning and administrative processes. The risk system offers a closer clinical, programmatic and legal focus through intensive case review of unique and challenging situations.

The Area Director occasionally participates but more often designates an Area Office staff person to facilitate the Risk Committee. This person acts as an organizer of scheduling and agendas and as a point person for the Committee. The Committee is comprised of other Area and Regional administrative, clinical professionals and consultant staff. Regional Risk Managers, DDS attorneys and professional experts in particular areas such as human rights, investigations, forensics, psychology and nursing frequently attend on an as needed basis. Service Coordinators and Service Coordinator Supervisors always participate, as well as contracted providers, who may support an individual and/or have designated responsibility for the implementation of the recommended actions outlined in a risk plan. Although their presence is not required, individuals, guardians or family are often encouraged to attend. No action recommended by the Risk Committee that requires the knowledge and consent of the individual or the guardian can be implemented without their consent.

6. What is the function of the Area Office/Facility Risk Committee?

The Area/Facility Risk Management Review Committee has a responsibility to meet at least monthly. To use the system effectively and intervene quickly in the lives of individuals who are at risk, most Area Offices have found that more frequent meetings are necessary. A subset of the committee is often integrated in to the ongoing clinical and service planning of the Area Offices and the risk management review process should not duplicate but rather enhance these efforts.

Key functions of the Area Office risk management team are as follows:

- To review risk factors related to an individual and make decisions regarding the need for a risk plan
- To recommend specific actions and delegate responsibilities to mitigate the risk factors.
- To regularly review the efficacy of existing risk plans and suggest those that could be designated as inactive.
- To refer uniquely challenging and unresolved risky situations to the Regional Risk Manager for review.
- To review Area Office HCSIS monthly “trigger” reports which may indicate the need for a risk plan for individuals
- The committee also may propose and review individuals with high risk behaviors, who repeatedly refuse Department services to be designated a status other than active, per the DDS Case Status Policy (See appendix F)

7. What is the role of the Regional Risk Manager in Risk Management?

Regional Risk Managers support the Area Office Risk Committees to effectively implement the Department's Risk Management system by offering expertise at Area Office committee meetings and by reviewing particular risk plans. In addition to continually monitoring the risk management system, risk managers participate in two other quality management activities: Regional Mortality reviews, and the Statewide Incident Review Committee (SIRC) (see page 35). Regional Risk Managers provide a

link to other systems at the DDS Regional office level such as Investigations, Human Rights, Eligibility, Legal and Survey and Certification. A fundamental function of the Risk Manager is the ongoing review, communication and monitoring of the incident management system known as HCSIS for Home and Community Service Information System . This is a web based incident reporting system which alerts the Risk managers when any major incident is reported in the Region. As an additional set of eyes and ears, the Regional Risk Managers assure that all appropriate and sufficient actions as a result of an incident have been taken. Regional Risk Managers also conduct a quarterly review of trigger reports (Appendix 2). This additional monitoring acts as a safeguard to assure those incidents have been examined by appropriate Area office staff to understand any pattern or trend of risk.

Regional Risk Managers support Area Office Risk Committees to effectively implement the Department's Risk Management system by performing the following functions:

- Participate at Area Office risk committee meetings
- Review risk plans and incident reports
- Serve as the Regional Director's designee to Central Office Risk Management regarding ongoing communication related to HCSIS Management Reports, Case Status Reviews and individual high risk situations.
- Schedule and facilitate Area and Regional meetings related to high profile risk situations related to the criminal justice system and/or Investigation process
- Participate in the Regional Mortality Review process
- Serve as the Regional Director's designee for Reconsideration Requests and certain administrative reviews pursuant to the DDS Investigations Regulations.
- Provide a regional quarterly report on specific individuals whose incident pattern has been identified in Area Office Trigger reports
- Refer individuals for a Central Office Risk Advisory review as needed

8 What is the role of the Department's Director of Risk Management?

The Director of Risk Management functions as a liaison to the senior staff of the Department and has the following primary responsibilities:

- Oversees the Risk Management and Incident Management Systems including regular reporting of individual major HCSIS events and trends in risk.
- Standardizes policy as related to Risk Management and participates as needed in the HCSIS Standards Team
- Chairs the Statewide Incident Review Committee, which has primary responsibility for the review and analysis of aggregate reports generated from the HCSIS incident management and reporting system
- Facilitates other department review processes, such as Root Cause Analysis and the Statewide Medication Review Committee (page 24)
- Facilitates the Central Office Risk Advisory Committee review of plans related to complex and challenging individuals
- Facilitates monthly strategy meetings with Regional Risk Managers and provides clinical consultation and support to Regional and Area Directors
- Contributes to risk management related trainings offered for Service Coordinators and development of specific protocols and tools to mitigate risk
- Works with DDS staff and the staff of other state, public and private agencies to develop programs to systemically address disabled persons at risk, such as the Department of Mental Health's, work group on Problematic Sexual Behavior
- Serves as liaison to the University of Massachusetts Intellectual Disabilities/Mental Health (ID/MH) and Department of Public Health Hospital system
- Facilitates specialty contracts of clinical professionals who assist the Department in determining risk related issues for individuals

9. What is the Central Office Risk Advisory Committee?

Despite the best efforts and talents of clinical and programmatic staff at both the Area and Regional levels, there are certain individuals whose risk factors continue to challenge and defy effective intervention and support. At such times, it is helpful to have the support and consultation of a neutral, uninvolved group of individuals whose objectivity and distance from the direct situation may facilitate a fresh strategy and untried approach. Such is the unique purpose of the Central Office Risk Advisory Committee. In existence for several years, the Central Office Committee has come to be viewed as a constructive and supportive partner in an Area or Region's efforts to mitigate an individual's risk.

The Director of Risk Management, facilitates this group which includes the Director of the Office for Human Rights, the Director of DDS Investigations, the Director of Licensure and Certification, The Deputy Assistant Commissioner of the Office of Field Operations, the Director of Health Services, the Deputy General Counsel for the DDS Legal Office and occasionally when necessary, the DDS Deputy Commissioner. Regional Risk Managers and Area office risk teams, submit the plans of individuals who present compelling legal, medical, human rights and self-determination challenges. The Committee makes recommendations and offers resources and solutions to mitigate and monitor the risk.

An Area Office Risk Committee should consider a Central Office Risk Advisory Committee review of a risk plan for individuals who have had the benefit of the risk management process but continue to have serious risk issues and continue to put themselves in unsafe situations or are at risk of danger to themselves or in harming others. A Regional Director/designee, Facility Director/designee and/or the Regional Risk Manager may all refer individuals to the Central Office Risk Advisory Committee. Referrals to the Central Office Risk Advisory Committee should be directed through the Regional Risk Manager.

At the time of the Central Office risk review, the Regional Risk Manager or Area Office designee documents the recommended actions and updates the electronic Risk Management Plan and confidential record as needed. A brief written summary of the meeting with action steps and issues is forwarded by the Director of Risk Management

or the Regional Risk Manager to the Area Office Management and to Executive staff as requested.

II. ASSESSING RISK

Improving the lives of individuals with disabilities throughout the Commonwealth is the daily work of Area Offices and Facilities and involves continuous risk management even though it may not be labeled as such. The risk management system is designed to complement regular planning and clinical processes by providing a more focused and intensive review of individuals who are most vulnerable and/or are most at risk.

1. Risk Review

Assessing an individual for risk factors is an ongoing process, and as mentioned previously, is an integral part of the on-going review of a Service Coordinator's or QMRP's caseload conducted as part of the supervisory process. As an aid for this review the Risk Management work group developed: *A Guide For Special Considerations When Contemplating Risk In An Individual's Life* (Appendix A), This guide offers thoughtful questions to explore when considering the changes and challenges in an individual's life that are associated with increased risk during normal daily activities, including but not limited to changes in environment, individual behaviors and health status. Once identified, these situations require some sort of evaluation, intervention or further exploration but rarely require the intensive process of a risk management review.

All supports designated for the individual's health and safety should be documented in the ISP. The electronic ISP includes a designation that documents whether the individual's risk factors have been reviewed and whether the individual needs or has a risk plan.

2. When is a risk plan required?

The Department recognizes the local area as being the most knowledgeable about a person's life situation and having the flexibility for decision-making in most risk situations, based on the balance of competency, and personal choice. However, when

the following criteria are present in the lives of individuals **a risk plan is always required:**

- Individual is listed with the Sex Offender Registry Board (SORB)
- Individual is on probation and /or parole,
- Individual is refusing supports, or has no ISP, while having high risk behaviors, that involve the criminal justice system
- Individual is homeless
- Individual weighs in excess of 300 pounds with chronic medical problems
- Individual is pregnant or is parenting without the complete support of a family/ guardian
- Individual is dually diagnosed (MH/ID), refusing services, and accessing emergency services in order to meet basic needs
- Individual has a substance abuse problem
- Individual has problematic sexual behavior, who is residing either independently or with little supervision and support particularly if they are refusing any evaluation and/or treatment
- Individual who has a documented history of fire setting
- Individual is new to the Department, and presents with complex clinical or forensic issues and may have formerly had other public agency involvement (DSS, DYS, DOC, DMH)
- Individual is living independently, may be victimized by persons other than a caretaker (i.e. boyfriend), may be financially exploited and is resistant to breaking a pattern of abuse
- Individual has frequent but unsubstantiated signs of physical or emotional abuse or caretaker omission.
- Individual may be considered for transfer to the Hogan Development Center for a period of assessment and stabilization

The Regional Risk Manager in consultation with the Regional Director may always review exceptions to a mandated plan and document their exception.

3. Additional Guidelines for Identifying Individual Risk Factors

The following situations are offered as reminders when considering more imminent dangers in an individual's life and when to consider a risk plan. They include, but are not limited to situations that:

- ✓ Are unsanitary or inappropriate as living conditions
- ✓ Create indebtedness/ or financial exploitation by others or engages in excessive gambling
- ✓ Include using illegal substances or abusing alcohol
- ✓ Involve engaging in significant self Injurious behavior
- ✓ Include having issues as a parent
- ✓ Are related to a history of fire setting or fascination with fire
- ✓ Are related to personal safety and is a frequent victim, uses poor judgment in unsafe situations and chooses predatory companions

- ✓ Involve the Criminal Justice system but are not related to sexual activity
- ✓ Include a reported history of Sexual disordered Behaviors (including criminal)
- ✓ Include a history of Aggression and or threats of violence or repeated destruction of personal or private property
- ✓ Include multiple unplanned hospital visits of a non life threatening nature
- ✓ Involve complex post hospital care needs unsupported
- ✓ Produce a significant negative change in medical status: mobility impairment, eating/sleeping
- ✓ Involve refusing medically related supports
- ✓ Include medication related issues such as insulin or anticonvulsive need to sustain life.
- ✓ Include chronic eating disorders including obesity and pica
- ✓ Include severe swallowing /choking and or aspiration disorders
- ✓ Include an infectious disease processes such as STD's, Methicillin Resistant Staphylococcus Aureus (MRSA), Hepatitis, Chronic cellulitis. HIV

In keeping with the Department's commitment to prevent and mitigate risk, protocols for the management of certain risk related situations have been developed. The protocols provide helpful information regarding how to identify the risk, who is at risk and how the risk is managed.

The protocols related to certain risk conditions can be found in Appendix B

4. Choosing Categories of Serious Risk

Types and patterns of risk and the description of risk factors are classified and integrated in the Risk Management database. This classification groups specific risk types into **three categories**. These categories allow DDS to identify the frequency of specific risk factors, enhancing the Department's ability to track patterns and trends. Each risk factor is identified by a mnemonic which is listed below with its definition

a. Environmental factors associated with risk

A caretaker, relative, house mate, friend or any person who has a history of, or is determined to be capable of, physical, sexual, emotional, or financial abuse or exploitation, or regularly neglectful care or supervision; or a situation or environment in which these could occur.

Risk Category I	<u>Caretaker/Environmental Issues</u>
CARE	Caretaker Issues
CRIMINAL	Criminal Act by Caregiver
FIN	Financial Exploitation
HOUSE	Housing Related to a Family Dwelling
PSE	Possible Sexual Exploitation
SOCIAL	Other Social Issues

b. Individual behaviors associated with risk.

Risk factors in this category are directly related to an individual's personal behavior, not exclusively the behavior of others towards the citizen. The individual's behaviors are dangerous to them or threaten public safety. Examples include: financial mismanagement, problematic sexual behavior, frequenting places where there are dangerous people, refusal of critical services or treatment. This includes a lifestyle choice that put them at serious risk or poses a serious risk to others, including substance abuse.

Risk Category II	<u>Individual Issues</u>
AGGRESSION	History of assaultive behavior
CJI	Criminal Justice Involvement not sex related
FIN	Financial/Money Management
FIRE	Fire Setting/Fascination
HOUSE	Housing Issue/Homeless
HXSEXBEH	History of Sexual Misbehaviors
PREG	Pregnancy/Parenting Issues
SAFETY	Personal Safety Issues
SELFJNJ	Significant Self Injurious Behavior
SUB	Substance Abuse

c. Complex medical conditions associated with risk

Plans in this category include individuals who have a medical condition(s) and are in need of significant medical safeguards, but who are unwilling or unable to follow prescribed medical care or treatment options. These include, but are not exclusive to, the following:

Risk Category 3	<u>Medical Complications</u>
COMPLEXPHC	Complex Post-Hospital Care Needs
EATDIS	Chronic Eating Disorder, including Pica
MED	Medication Issues
MULTHOSP	Multiple Unplanned Hospitalizations
NEGCHNG	Significant medical support challenges
SWALLOW	Swallowing/Choking/Aspiration problems

The first category of risk is often posed by a caretaker or the environment and refers to dangers to an individual primarily by those responsible for the persons support and protection. These situations often require the professionalism and expertise of the Regional Risk Managers in collaboration with the Service Coordinator as culture and norms confront human rights, family autonomy, and regulation.

The largest percentage of risk plans for the Department are represented by the second category for individuals whose behaviors and poor judgment often put themselves or others at risk. Determining how to manage risk in individuals who are most often competent involves the delicate and artful balance of personal independence and public responsibility. This maneuvering represents the fundamental struggle of risk management in keeping individuals safe. Often the risk clearly puts the individuals in peril and all elements and action steps of the risk team must be coordinated and skillfully communicated to influence sustainable safety for the individual.

The third category of risk is associated with the chronic health problems of individuals supported by DDS. Many individuals with intellectual disability enjoy stable

health and require only routine and episodic health care interventions. Others have complex life long health care issues or newly diagnosed conditions that require a more sophisticated clinical review and an in depth health care management plan. A core mission of DDS is to establish effective and consistent health, clinical and behavioral supports for individuals.

Many individuals by virtue of their disability may have difficulty communicating symptoms of health change to both direct support professionals and health care providers. This inability to express their needs make individuals more vulnerable to continued unaddressed medical conditions. Over the last decade DDS has introduced a series of measures designed to improve the access and quality of health care for individuals supported by DDS. During the ISP process, needs related to health and safety are addressed. When the needs of individuals change based on risk factors identified through any risk review process, one action step may be a Clinical Consultation by an Area Office Nurse.

5. What is the role of Area Office Clinical Consultations in identifying and addressing health risks?

Clinical consultations provide individuals with physical and behavioral health care issues a more in depth review than is typical in the standard ISP or other planning processes. Its primary purpose is to provide an opportunity for a clinician, in most cases a Psychologist or Psychologist Assistant , Registered Nurse or Nurse Practitioner to offer an assessment and guidance to those supporting an individual regarding the specific issues of a particular condition. It also includes an opinion of the types of resources and supports that will assist the person to manage effectively in the community.

All individuals eligible for DDS services may receive a clinical consultation, if deemed appropriate, regardless of whether they live in DDS funded residential supports, live independently with minimal assistance, or live with their families. Guardians and families interested in having a clinical consultation for an individual should contact the individual's Service Coordinator who will initiate the consultation with the Area Office nurse or psychologist.

For individuals living in DDS funded residential supports, similar consultations may be completed by the provider's staff or consultant clinicians. If a provider does not have access to appropriate clinical support, an Area Office staff may be asked to contribute to a consultation. Most clinical consultations include the following elements:

- A review of specific conditions identified
- A general assessment of the supports needed to effectively assist the individual and/or provider to stabilize and support the individual
- An assessment of the supports in place to meet the individual's needs
- A determination of how often the support plan should be reviewed to determine its efficacy in meeting the individual's health care needs.
- A recommendation regarding staff training needed to support the person

A clinical consultation may result in a determination that certain conditions pose chronic risks to a person's health and well-being. When it is established that significant health risk factors will remain in the person's life, these risks may be addressed through inclusion in the ISP or a risk plan may be indicated. The risk plan is an opportunity for DDS staff to succinctly document health specific interventions and their efficacy, in addition to the Service Coordinator progress notes. Continuous review of these interventions assures that all possible choices have been considered to support optimum health for an individual.

6. Statewide Medication Review Committee

Individuals with an intellectual disability present unique challenges to clinicians when diagnosing and treating co-occurring medical, mental health, and behavioral issues. Individuals with intellectual disability oftentimes have complex clinical needs which require advanced levels of clinical experience, specialized training and significant collaboration for successful outcomes. Many individuals are on multiple psycho-active medications for long periods of time which place them at great risk for life threatening side effects including other chronic illnesses such as diabetes. In March of 2011, DDS assembled a clinical team including a neurologists, a gerontologist, an internist, a primary care physician, who is also a professor of family medicine at the University of Massachusetts Medical School, three psychologists, a clinical pharmacist, psychiatrist , psychiatric nurse clinician, the Medical Director of a public health hospital, a social

worker, three registered nurses and two nurse practitioners to provide support and consultation in a number of ways to assist DDS providers and clinicians in the coordinated care and treatment of individuals with an intellectual disability. The Statewide Medication Review Committee offers a simple mechanism for direct referral to a multidisciplinary clinical team for Service Coordinators and providers in the field. The medical issues of each individual referred for consultation are first reviewed by the regional nurse designee to the Committee. This designee can offer suggestions for immediate intervention or make a direct referral for consultation to the Committee through the Director of Risk Management.

The following indications can be used in considering whether an individual should be referred for assessment by the Medication Review Committee:

- 1) Individual is experiencing frequent drug and/or dose changes with poor results
- 2) Individual is experiencing uncharacteristic changes in behavior and/or declining health status despite changes in medications or treatment regimens
- 3) Individual health, psychiatric or behavioral concerns have not demonstrated any positive changes despite multiple strategies attempted
- 4) Individual is showing indications of tardive dyskinesia, movement disorder or other untoward side effect of prolonged use of certain medications
- 5) Individual is on 2 or more antipsychotic medications and is still symptomatic

The formation of this Committee offers the risk management team of the Department a unique consultation service for the assessment and treatment of individuals whose complex clinical presentations need a holistic and comprehensive approach to mitigating health risks.

IV. INCIDENT REPORTING AND RISK MANAGEMENT

The Home and Community Services Information System (HCSIS) is the DDS' internal web based system for the reporting of critical events in an individual's life including incidents, restraints, investigations and medication occurrences. The Incident reporting component of the system requires providers to promptly report any of a number of specifically designated incidents that present a risk of or actual harm to individuals DDS supports. The primary purpose of the incident reporting system is to identify an event (usually adverse), communicate the issue to relevant stakeholders, provide immediate interventions to protect an individual, as well as, longer term action steps to prevent a recurrence. Areas and/or Regions, depending upon the severity of the incident must approve the action steps taken by the provider before an incident can be closed. As such, incident reporting and management enables providers and DDS staff to identify and respond to risk. A list of incident categories is listed in Appendix H.

a. HCSIS Trigger Reports

In addition to “real time” reporting of incidents, Monthly Risk Management or “Trigger” reports are generated based on an established threshold of accumulated incidents for one individual. By defining a number of specific incidents that have occurred within a certain time period, DDS staff are able to “connect the dots” and discover possible patterns and trends that otherwise might be missed when reviewing individual incidents. The criteria for establishing thresholds which “trigger” a report of risk have been determined based on the serious nature of the incident and the accumulated level of risk for an individual. While in the vast majority of instances, Service Coordinators and providers are aware of an individual's level of risk, the trigger reports serve to highlight individuals most at risk, understand what actions were taken to correct a situation and determine whether these interventions have mitigated the circumstances. The report provides an additional safeguard for Area Office staff to establish whether or not an individual situation was carefully managed and reviewed.

Following are the specific thresholds and criteria that generate a trigger report.

- 3 or more unplanned medical hospitalizations, ER visits or psychiatric hospitalizations within a six month period for any reason
- Multiple (2 or more) unplanned medical hospitalizations or ER visits for the same condition or reason that occur within a brief time period (e.g., 30 days).
- A single unplanned hospital visit for a serious event, including suicide attempts, medication side effects, PICA/choking, bowel obstruction and/or dehydration.
- 2 or more incidents involving law enforcement that occur within a 3-month time period.- to be redefined following changes to the reporting system
- Any incident of arson (fire setting) by the individual.
- Any incident of alleged sexual assault, victim or perpetrator – on hold pending changes to coding
- 3 or more behavioral incidents or physical altercations within a 6 month period either as a victim or perpetrator
- 3 or more incidents of abuse or serious neglect that takes place within 3 months
- Any combination of 5 or more incidents within a year excluding MOR's and restraints
- The use of restraint 2 or more times within a month

b. Suggested follow up for Trigger Reports

Trigger reports are retrospective and therefore interventions to mitigate risk are expected to have already occurred. The reports allow managers and clinicians to better understand possible precursors to a type of risk, determine the efficacy of action steps and assure that the impact of a series of events has not been overlooked. Within 30 days of receiving a trigger report a review of an individual's circumstances and the specific incident or series of incidents should occur and be documented.

The required review may take a variety of forms including informal conversation, a team meeting, a clinical consultation or a risk review and development of a risk management plan. All these activities need to be documented either in the appropriate action step section of the HCSIS report or the Notes section of Meditech. There is also an optional Meditech Trigger Notes page with a variety of "canned text" responses that represent the most common types of follow-up to an initial review. On a quarterly basis the Regional Risk Managers review a representative sample of individual's reports

examining documentation to assure that an initial review has taken place for all persons in the Region who have had a pattern of incidents that resulted in a trigger (see criteria for Trigger report previous page) being met.

VI. INTERFACE OF LEGAL ISSUES AND RISK MANAGEMENT

1. Guardianship

One of the key challenges in addressing potential risk issues is the balance of a person's right to determine his or her own life course and DDS responsibility to keep people safe. A key factor in trying to achieve this balance is considering if the person is under guardianship or is capable of making his or her own decisions. Guardianship involves substantial loss of liberty for an individual. It should only be sought for individuals with intellectual disabilities whose cognitive limitations negatively affect their ability to make informed decisions or persons with mental illness whose symptoms significantly impact their ability to make informed decisions. . A number of less restrictive alternatives to guardianship exist which must first be explored, leaving full guardianship as a last option. Only a court can declare (adjudicate) a person incapable of managing his or her own affairs (incompetent) and appoint a guardian to make decisions in the best interest of that individual. Before a court hearing establishing a need for guardianship, an individual receiving supports from DDS is presumed competent to manage his or her own affairs. This is true regardless of their level of intellectual disability. [115 CMR 5.07]. .

If an individual has a court appointed guardian, the guardian must be involved in making an informed decision relative to the risk issue. For the individual who is at risk and is not under guardianship, mitigating the risk issues may prove complex. If an individual has been adjudicated as incompetent to make an informed decision, the

ability to make a final decision is largely decided; however, his/her preferences and wishes must be taken into consideration. The informed decision will be that of the court appointed decision maker, the guardian. The team must actively work with the guardian to determine the best course of action to take to reduce risk for the safety of all involved.

For those individuals who are presumed competent and the team questions their ability to make informed decisions, a competency assessment may be indicated. This information is often helpful in determining what course of action to pursue.

In many cases, the most challenging situations that are presented before a Risk Committee involve those individuals who are legally competent and capable in fact and are in high risk situations. There are often many complicated reasons which prevent the person from extricating themselves from the risk situation. If a person has been assessed to be competent to make informed decisions, then the Risk Committee may have fewer options at their disposal. The Risk Committee must weigh heavily the dangerousness of the individual's situation and need for intervention. There are legal options afforded to the Department to protect those who pose a significant threat to themselves or others. For example, if a person is a danger to themselves or others by reason of psychiatric decompensation, a person can be involuntarily admitted to a psychiatric facility under MGL Chapter 123, Section 12. However, admission or temporary transfer to a DDS Developmental Center is always voluntary as are all DDS related services.

Equally challenging is assessing risk to personal liberty. This situation may occur when one person is in multiple roles, such as, a provider of supports (paid or unpaid), the guardian and the representative payee for an individual. This one person holds all

the legal, financial and sometimes emotional power over an individual. In this situation the service coordinator and other members of the Risk Committee can examine the best interests of the individual to provide a check and balance of the rights of that individual.

Massachusetts Laws have recently changed the type and scope of guardianship and information related to types of guardianship is included in Appendix E.

2. Risk and Interface with Public Safety Agencies

If an individual is at risk and is also involved with the criminal justice system it is important that the risk management team not interfere with any formal investigation that is being conducted by law enforcement. Additionally, the Department's Investigation unit conducts investigations that may involve an individual who has a risk plan. These investigations are done pursuant to departmental regulations 115 CMR Sec 9:00 et al and/or DPPC chapter 19C investigation regulations. In any case which involves DDS staff consulting with the criminal justice system the DDS Legal Office must be notified before any interaction formal or informal with this system. **All individuals with a history of criminal justice involvement are expected to have a risk management plan.**

Sexual Offending Behavior and the Sex Offender Registry Board

Society has found sexually offending behavior so alarming and abhorrent that in recent years states have sought statutes to permanently restrict individuals who are seen as potential re-offenders of sexually related crimes. These so called "Megan laws" (named for a renowned child victim) are found in Chapter 6 Section 178C-178Q which establishes the Sex Offender Registry Board and related compliance to the law.

The Sex Offender Registry Board [SORB] maintains a central computerized registry of all sex offenders required to register pursuant to the statute. Specific details on the provisions of the law and related information as it pertains to sex offenders is available on the SORB website within the Executive Office of Public Safety. All

individuals who are registered with the SORB should have a risk management plan with a semi-annual review of their circumstances. Individuals registered with the SORB can be made “inactive” only after implementation of the Case Status policy and a Central Office Risk review.

The definitions in this section pertaining to the SORB describe language which first classifies individuals in a prescribed way based on an independent evaluation. Each classification provides for an ever increasing level of information about the offender including a website based picture with name and address for Level III offenders. The following information taken from the SORB website describes categories and the legal distribution of personal information based on a person’s classification level.

Level 1 Sex Offenders

The Sex Offender Registry Board [SORB] determines that the risk of re-offense by an offender is low and the degree of dangerousness posed to the public by that offender is not such that a public safety interest is served by public availability, the Board shall give that offender a Level 1 designation. Information on Level 1 offenders will not be available to the public. Neither the police nor the Board has authority to disseminate information to the general public identifying a Level 1 offender.

Information identifying Level 1 offenders may only be given to the department of correction, any county correctional facility, the department of youth services, the department of social services, the parole Board, the department of probation and the department of mental health, all city and town police departments and the Federal Bureau of Investigation for law enforcement purposes.

Level 2 Sex Offenders

The SORB determines that the risk of re-offense is moderate and the degree of dangerousness posed to the public is such that a public safety interest is served by public availability of registration information, it shall give a level 2 designation to the sex offender. The public shall have access to the information regarding a level 2 offender through the Local Police Department and through the SORB.

Level 3 Sex Offenders

SORB determines that the risk of re-offense is high and the degree of dangerousness posed to the public is such that a substantial public safety interest is served by active dissemination, it shall give a level 3 designation to the sex offender.

The public shall have access to the information regarding a level 3 offender through the Local Police Departments and through the SORB.

Further language within this law describes registration and notification of work site.

Sex Offenders moving into the state and changing from one Address to another in state are governed by these laws. All convicted sex offenders must register with the SORB by mail within 2 days of moving into the Commonwealth from another jurisdiction. All sex offenders must register by notifying the SORB of their current and new address by mail at least 10 days prior to moving to a different city or town in the Commonwealth; or moving within the same city or town in the Commonwealth.

Sex offenders must register by notifying the Board of their current and new work address by mail at least 10 days prior to changing a place of employment.

Sex offenders who committed their sex offenses in Massachusetts, were convicted of sex offenses in Massachusetts courts, and are required to register in Massachusetts, must register as a sex offender in any state the offender takes up residence, works in, or attends school.

All **sex offenders residing at a homeless shelter** must verify registration data every 90 days by mail to the Board. The penalties for failure to register with the SORB now carries serious consequences. For this reason DDS has established a protocol to guide Area Office staff in assisting individuals to better understand the SORB laws and the consequences for a failure to register. Potential consequences for failure to register are as follows:

First conviction: imprisonment for not more than 30 days in a house of correction;

Second conviction: imprisonment for not more than 2 1/2 years in a house of correction nor more than 5 years in a state prison or by a fine of not more than \$1,000, or both;

Third and Subsequent conviction: imprisonment in state prison for not less than 5 years.

Since all convicted sex offenders are required to verify that their registration information is accurate and up-to-date and they must annually verify their registration data, by mail, to the Board, DDS has established a protocol to assist individuals with compliance with the law.

Area Offices should make every effort to identify any individual eligible for services who must registered with the Sex Offender Registry Board [SORB]. This occurs during an on going Area Office review of individuals, who may have been charged and convicted of sex offenses. This can also occur when the Regional Risk Managers review risk plans, incident reports and other sources of information to identify individuals who might meet criteria for registration.

DDS Legal office will assist the Department to maintain current information with regard to Massachusetts General Laws Chapter 6 Section 178 as it pertains to individuals supported by DDS. The DDS risk management system communicates any changes in the criteria for registration to Regional and Area Directors to assure full compliance with the SORB law for DDS eligible individuals who may need to register, including registration in anticipation of address change with corrected or updated information.

If a DDS eligible individual meets criteria for SORB registration *and is competent*, DDS Area Office staff will:

Notify the individual by phone and by letter (a standard letter will be developed), advising the individual of their need to register with the Sex Offender Registry ten days prior to establishing a new residence. Depending on whether the individual has yet to be classified or the individual's classification level, the requirement may be to send a form to the SORB (unclassified or Level I) or register directly with the police department (levels II or III). Individuals also should be notified of their right to appeal their classification.

- If after notifying the individual, the person still does not register, DDS AO staff will visit the individual, and assist them in completing the form or accompany them to the local police station to register (if the person is agreeable). Staff should document this interaction.
- If the person fails to register at this point, AO staff should contact the individual's defense attorney (if there is one), to request that the attorney advise his client of their responsibility to register.
- If the person still fails to register, the Area Director should inform the Deputy General Counsel in Central Office Legal. The Deputy General

- At any point during this process AO staff may consult the Sex Offender Registry Board to see if the individual is registered.

If a DDS eligible individual meets criteria for registration and is thought *not competent*:

Individuals thought not to be competent will be referred for a Clinical Team Report. For individuals who are not competent, DDS Area Office staff will pursue the above process (notification by phone, mail to assist with registration) with guardian and inform the guardian of the individual's right to appeal their classification.

- DDS Legal Office will conduct an analysis regarding Protected Health Information and confidentiality to outline limits on sharing of information between DDS and others.
- DDS will establish communication with the Sex Offender Registry Board for purposes of a Memorandum of Understanding.
- Area Office risk review committees and the Central Office Risk Management Advisory Committee will function as places where problems regarding compliance with the SORB law, and/or ambiguous circumstances, are addressed, including planning for competent individuals who are leveled at 3, who refuse treatment and or supports.

V. Specific DDS Policies often associated with Risk Management

1. Unable to locate or refusing contact

Despite the best efforts of staff and clinicians, an Area office may find that some individuals may put themselves at risk by refusing all supports and even contact by a service coordinator. These individuals are listed as Active in the Department of Developmental Services' database, and are not actual missing persons. These individuals or their guardians will not respond to calls, letters, visits, or other attempts to contact them. Many DDS eligible consumers may be Ricci or Brewster class members, with very specific rights under a settlement agreement, and it is the responsibility of the Department to make every effort to contact and reach them.

If an individual is under guardianship, the Department should be assured that the guardian is acting in the best interest of the individual when choosing not to communicate with the Department. Making this evaluation often involves an Area Office

risk review with the Regional Risk manager. The steps below should be carried out in the event that the Area Office has a current address, but has been unable to contact an individual, a class member or their guardian. Each step must be documented in the Meditech record. Once a person is evaluated as competent to make a decision to refuse contact or services, then an Area office has the option to implement the following steps.

1. The Service Coordinator must attempt to call the individual at his/her home number.
2. If they cannot reach them by phone, a letter should be sent requesting the individual or their guardian contact the Area Office. This letter should include the Service Coordinator name and phone number.
3. If these contacts fail, the Service Coordinator, or other accompanied Area Office staff, must visit the address to see if the individual and/or the guardian can be located. They should verify the address as it is written in the record. If no contact is made, a copy of the letter sent previously should be left. NOTE: If there is a compelling reason why this visit may jeopardize the safety of the Area Office staff, then a written statement by the Area Director must accompany this protocol, including what other steps were taken to contact the Ricci class member in lieu of a home visit.
4. If the visit does not yield a contact, the Service Coordinator should review the list of alternative contacts they may have for the individual or the guardian (i.e., work, extended family, clinical services, Rep Payee, possible contacts from other involved agencies, Social Security Administration, etc.), and attempt to contact the individual or class member through these channels.
5. If these efforts fail to establish a contact with an individual under guardianship or who is a class member, a summary should be forwarded to the Regional Director and regional risk manager for review.

2. Case status policy

The case status policy (see Protocols) is often implemented following a refusal of services. During this time a person maybe placed on a status of INACTIVE but would have three years to consider a request of support from the Department before being determined INELIGIBLE for services.

V. Quality Improvement and the Risk Management System

The foregoing sections describe the Department's system for preventing, identifying and addressing risk for the individuals that it supports. As the Department's approach to risk continues to emphasize preventive strategies as well as positive behavioral supports, it is anticipated that individuals will experience fewer incidents and an improved quality of life.

Despite DDS' best efforts, however, incidents will still occur. What is important, is that DDS and its provider partners learn from these incidents, and not only respond to them on an individual basis, but be poised to review patterns and trends and develop service improvement strategies that positively impact on the system statewide. Towards this end, DDS has developed a number of processes which foster the review of statewide data and the development of strategies that support the goal of prevention. They include, but are not limited to:

1) Statewide Incident Review Committee

The Statewide Incident Review Committee is comprised of a representative group of individuals within the Department that systematically reviews the wealth of information that is generated from the HCSIS incident reporting system. With the assistance of the Center for Developmental Disabilities Evaluation and Research, aggregate information generated from the HCSIS data base is reviewed and analyzed. Specific analytic reports are generated and disseminated to the field to assist providers and DDS to examine their own practices and initiate service improvement efforts. As an example, data relating to the frequency of falls in the ID population led to the development of a falls prevention campaign. The curriculum and tools associated with the campaign were piloted with 5 providers statewide, resulting in a 33% reduction in falls.

2) Root Cause Analysis

Root cause analysis (RCA) is a structured approach to the investigation, review and analysis of significant adverse events that is designed to help service agencies reduce the risk of harm for the people they serve. It is designed to look at the systemic causes for what happened, why something happened, and how it can be prevented. Most importantly, it is intended to create a culture of safety within organizations and foster effective preventive interventions. DDS uses the root cause analysis approach to review cases annually where the review of certain critical sentinel events review offer the opportunity to advance organizational learning and growth.

3) Quarterly review of TRIGGER reports

As previously discussed monthly reports related to a series of events that meet certain predetermined thresholds of risk are distributed to the Area Office Director and designees for further analysis. The TRIGGER reports highlight individuals who have a series of incident reports of a specific type such as unplanned hospital events, physical altercations or incidents of staff omission. The expectation is that the Service Coordinator and the Area Office have already implemented an intervention related to this risk, but the TRIGGER reports can show a pattern of events that need further exploration. In addition to this safeguard on a quarterly basis a random sampling of “triggered” individuals is distributed to Risk Managers to further examine an Area office’s response to specific risk to an individual. Trigger reports are derived from the HCSIS incident reporting system and were previously discussed on page 26. The Director of Risk Management reviews a statewide sample of individuals “triggered “ under the various thresholds as a continuous check and review of the system.

VI THE RISK MANAGEMENT INFORMATION SYSTEM

1. Risk plan documentation

DDS uses an electronic database for documenting and maintaining the risk plan. This database is part of the Meditech Information System of an individual and automatically draws key information into the electronic document. The plan has two parts. The risk plan itself contains narrative responses to key questions related to past and present details that inform the committee in order to make good clinical judgments and recommendations regarding appropriate actions and interventions to reduce risk. The second part of the plan details the recommendations and timelines of the risk committee and the completion date for these actions. The meeting dates are noted and the participants in the ongoing meetings are identified at the end of the document.

Typically, Service Coordinators / QMRP's or their Supervisors are responsible for the initial documentation and for continuous updates within the risk plan. Updates to plans are always written before regularly scheduled individual risk reviews and are highlighted with a date with the most recent information being first. While the risk management system was designed to encourage an individual's Service Coordinator/QMRP to be the primary author and editor of a risk plan, for consistency and clinical accuracy many Area Directors designate one staff person to originate all risk plans. In addition to Service Coordinators or their supervisors, other individuals, such as a Program Monitors, Psychologists, Clinical Directors and Assistant Area Directors, and occasionally Regional Risk Managers may be responsible for updates and new information within the risk plan. All documentation should be respectful, factually based and written in a neutral non-judgmental style.

2. Action Steps

A separate page within the risk plan system labeled "Actions" page is designated to document the intended interventions within the plan. The action steps are the outcome of a risk management meeting and reflect the fundamental elements of a risk

plan to mitigate danger in an individual's life. The steps are documented in the Meditech record by the Area Director designee. In most cases this may be the person's Service Coordinator. Each action step is assigned to an individual for follow through and anticipated date of completion is indicated. Please refer to Appendix C for a list of actions and their MEDITECH Mnemonic

3. Meditech Reports

The management information system (Meditech) allows DDS staff to create reports (or hardcopy lists) related to their work in risk management. For example, a Service Coordinator Supervisor may develop a list of all individuals associated with a particular Service Coordinator whom they supervise and the individuals they support who have a risk plan. The Area Office Risk Committee facilitator may develop a report indicating the outstanding action steps needed to be completed at a point in time. Likewise, Regional Risk Managers may run a report indicating the name and number of plans for each Area Office in their region. An Area Director has access to an electronic list of each individual in the office that has a risk plan. The ability to run specific reports in Meditech is associated with the security access level of the individual staff person. The Service Coordinator may only see plans for the individual he/she supports. The Area Director can see plans for all the individuals in their Area Office; Regional staff can see plans for all individuals in a Region and so forth. Through this electronic system, interested parties with designated access throughout a Region can be updated on the progress of interventions and the status of individuals and their risk plans on a regular basis.

4. Confidentiality and access to risk plans

Access to the plans at the Area Office or Facility, Regional and Central Office levels is restricted to protect the confidentiality of the individuals and to allow key DDS staff to provide oversight and support to the involved DDS and provider staff.

a. HIPAA Compliance and Informed Consent

In 1996 the U.S. Congress passed a law called the Health Insurance Portability and Accountability Act of 1996, or "HIPAA." The original law related to the exchange of information for insurance purposes. In April 14, 2003, the U.S. Department of Health and Human Services issued final regulations implementing the privacy provisions of HIPAA. These regulations are called the "Privacy Rule."

The Privacy Rule was implemented and establishes the first national standard for the protection of individually identifiable health information. The "Rule" attempts to balance the need to allow the flow of health information to insure high quality health care, with the need to protect against misuse of individual health information. The Rule establishes procedural, administrative and record-keeping requirements that covered entities must follow, protecting against the improper use or disclosure of certain health information in any format, including oral, on paper or electronic. In addition, the Rule protects individual rights regarding their health information and the need for informed consent when disclosing information. For example any referral of an individual to a specialty provider for an assessment requires the sharing of private health care information. This historic information given to a clinician to provide an assessment is covered under the privacy rule and is only shared when the individual or their guardian has signed an informed consent. (See Understanding informed Consent Appendix E)

A clinician cannot examine an individual until consent to treatment is obtained with the signature of the competent individual or their guardian. Such signed consents are often called "release of confidential information". In this case a release is obtained at the DDS Area Office or DDS provider office and again in the clinician's office.

The Central Office Management Information System staff manages the Meditech system which stores the Risk Management Information System and is responsible for changing, or deleting any errors. Periodic review and routine updates are regularly documented within this system, usually at the Area Office level. Plans can be developed and edited by Service Coordinators who have access only to the plans of the individuals for whom they have responsibility. Regional Risk Managers can review and edit all plans within their designated Region, as necessary.

5. Storage and distribution of plans

All risk plans are stored in the electronic record of the individual. Keeping hard (paper) copies of plans is discouraged. Copies of an individual's risk plan may be distributed to the administrative or clinical staff of a provider agency that is responsible for implementing components of the plan. During discussions of the risk plan, hard copies are collected and shredded for confidentiality purposes. All readers should be reminded that risk plans contain confidential personal and clinical information and are subject to all the applicable laws and regulations related to confidentiality. Some plans may contain clinical information, which is not always routinely available to all staff in an individual's home. **It is expected that an individual's risk plan be stored with other legal and confidential information usually at the Executive Offices of the DDS provider.** Occasionally guardians, other public agencies, such as the Department of Children and Families or law enforcement agencies such as the Sex Offender Registry Board request paper copies of these plans. In these instances requests should be referred to DDS legal staff associated with the appropriate regional office.

APPENDICES

- A) Special Considerations when reviewing risk
- B) Guidelines and Recommendations to Manage Risk and Health
- C) List of action items for Risk Management Plans
- D) Optional Documentation for Trigger Reports
- E) Overview of Massachusetts Guardianship Laws
- F) Understanding Informed Consent
- G) Common Legal Terms
- H) Business Rules for Risk Plans in Meditech
- I) Categories of Incident events in HCSIS

Appendix A.

Special Considerations When Contemplating Risk in an Individual's Life

The following queries relate to the three categories of risk consideration: environmental, individual behaviors or medical situations

Risk Related To Changes in the Environment (Risk Category I)

In the last or next 6 months does/will the individual have decreased access to the community, to caregivers, or a change in housemates or housing? Suffered the loss of a friend /family/caregiver?

Is the person living in an unfriendly environment? from landlord? family members? companions? guardians?

Is the person's home: fire safe? in good repair? Clean? Have basic utilities (heat, electricity, water) need new accommodation? In a safe neighborhood? community accessible? Accessible to provider or DDS staff ?

Risk Related To Individual Behaviors (Risk Category II)

Is the person participating in activities that put them at risk, such as pica, smoking, substance abuse, gambling? Unsafe sexual activity? Or other personal habits that are hazardous such as traveling alone at night? Frequently eloping or wandering?

Risk Related To Personal Health (Risk Category III)

Has there been a significant change in for this individual health in the last 6 months? Frequent ER visits? Multiple medication changes? ? Is the person on multiple psychotropic medications? Is the person refusing to participate in health care appointments/ take medications? Need a health care proxy? Medical/Rogers guardian? Has the individual had routine medical screening consistent with his/her stage of life and current health concerns? If not, why not?

Seizures/epilepsy

Does the person have a diagnosis of seizures, been hospitalized because of seizures within the past six months; had a change in the frequency, Have seizure medications changed in the past 6 months?

Diabetes

Does the person have a special diet? Has the person been hospitalized for diabetes in the last six months? taking insulin? Is the person's blood sugar checked regularly by whom? Gained significant weight? Diagnosed with pneumonia?

Swallowing /eating issues

Does the person have poor dentations, eat too fast, ingest non-food items, cough after meals or have a history of choking or poor swallowing? Refusing to eat? Lost significant weight or change in digestion or bowel habits?

Bowel and Urinary Tract issues?

Does the individual appear to have abdominal pain, have infrequent or frequent bowel movements? Does the individual have frequent urinary tract infections?

Mobility

Has there been a change in person's ability to move about? to use stairs? to participate in personal hygiene? Is the person frequently falling or having falls resulting in injury or ER visits? Is adaptive equipment in need of repair?

Mood or manner

In the last 6 months has the person had a change in alertness, orientation, ability to communicate or in initiating social activities? unable to follow tasks? More forgetful /confused? sleepy? aggressive? agitated ? unhappy? Had an increase in SIB?

Appendix B.

Protocols for Guidelines and Recommendations to Manage Risk and Health can be found on the Department of Developmental Services website www.mass.gov/dds under the category of Risk Management. The Regional Risk Managers wish to thank the members of the DDS Medical Protocols Committee for their efforts in developing these guidelines for care.

Appendix C. Meditech List of Action Items for Risk Management Plans

The following is a list of possible actions and their MEDITECH Mnemonic
Action Items list:

NAME	CODE	RESPONSE
Actions	CONEXP	CONSIDER - EXERCISE PGM
	CONHRR	CONSIDER - HMN RGHTS REVW
	CONJC	CONSIDER - JOB COACH
	CONMP	CONSIDER - MEAL PLAN
	CONNBP	CONSIDER - NEW BHVL PLAN
	CONNPCP	CONSIDER - NEW PCP
	CONNPSYCH	CONSIDER - NEW PSYCHTRST
	CONWIP	CONSIDER - WRK INCTV PLAN
	COORCJ	COORD W/ CRIMINAL JUST
	COORFG	COORD W/ FAM/GUARDIAN
	COORLEG	COORD W/ LEGAL OFFICE
	COORLHA	COORD W/ LHA/LANDLORD
	COORMED	COORD W/ MED PROFESSIONAL
	COORPA	COORD W/ PUBLIC AGENCY
	EXF1TO1	EX FUND - 1:1 SUPERVISION
	EXF24HRRES	EX FUND - 24 RES SUPPORT
	EXFACTRAN	EX FUND - FACILITY TRNSFR
	EXFFAMR	EX FUND - FAMILY RESPITE
	EXFIIS	EX FUND - INC. IND SUPPRT
	EXFLOS	EX FUND - LOS SUPERVISION
	EXFNHPL	EX FUND - NH PLACEMENT
	EXFSHC	EX FUND - SPEC HOME CARE
	EXHSLA	EX FUND - SHARED LIVING
	MONENV	MONITOR - ENVIRNOMENT
	MONFC	MONITOR - FAMILY CONTACT
	MONFHS	MONITOR - FAM HLTH STATUS
	MONLS	MONITOR - LEGAL STATUS
	MONMHS	MONITOR - MENTAL HLTH ST
	MONMONMAN	MONITOR - MONEY MANAGMENT
	MONMS	MONITOR - MEDICAL STATUS

MONPSSK	MONITOR - PUB SAFETY SKLS
MONSZST	MONITOR - SEIZURE STATUS
NOACTION	NO ACTION NEEDED
REFADDMH	REF ADM - DMH HOSPITAL
REFADFAC	REF ADM - FACILITY
REFADNH	REF ADM - NURSING HOME
REFADUM	REF ADM - UMASS NDU
REFCAM	REF CONSLG - ANGER MANGMT
REFCDIAB	REF CONSLG - DIABETIC ED
REFCDV	REF CONSLG - DOM VIOLENCE
REFCHED	REF CONSLG - HLTH/SEX ED
REFCNUT	REF CONSLG - NUTRITION
REFCPSP	REF CONSLG - PRT SKIL PGM
REFCSEXOF	REF CONSLG - SEX OFFENDER
REFCSUBAB	REF CONSLG - SUB ABUSE
REFCVOC	REF CONSLG - VOCATIONAL
REFEVADAPT	REF EVAL - ADAPT TECH
REFEVCTR	REF EVAL - CLIN TM REV
REFEVEM	REF EVAL - ED MIKKELSEN
REFEVETH	REF EVAL - ETHICS COMM
REFEVFR	REF EVAL - FORENSIC RISK
REFEVNP	REF EVAL - NUERO-PSYCH
REFEVPSYPH	REF EVAL - PSYCHOPHARM

Appendix D: Optional Documentation of follow up for TRIGGER Reports

Within 30 days of receiving a trigger report a review of an individual's circumstances and the specific incident or series of incidents should occur and be documented in Meditech. Area Office Directors assign this task to staff in their respective office. Typically, staff in the roles of Clinical Director, Program Monitor, Area Director, Asst. Area Director, Psychologist, or Area Office Nurse will review trigger reports and investigate the underlying details. Often these situations are being addressed as part of the on going service coordination for an individual and a separate note may not be necessary. An optional Note category called HCSIS Trigger, however, has been created to quickly document any interventions or reviews related to the TRIGGER report. The following examples indicate quick documentation in Meditech for TRIGGER reviews:

Trigger Response - Consult Assistive technology
Trigger Response - Behavioral Health Consultation
Trigger Response - CO Risk Review
Trigger Response - Clinical team consult
Trigger Response - AO Nurse clinical consultation
Trigger Response - Refer to ISP team
Trigger Response - Consult primary Care provider
Trigger Response - Consult OT/PT
Trigger Response - Consult other medical professional
Trigger Response - Regional risk manager review
Trigger Response - AO Risk Review
Trigger Response - See HSC Notes
Trigger Response - Consult with provider
Trigger Response – Consult Area Office Psychologist

When a person who has Enter/Edit access to the new TRIGGER notes category performs a lookup in the "Category" field from Notes screen, he or she will see the note category "TRIGGER".

The following example indicates the special TRIGGER NOTE field in Meditech:

Enter Person Note
Dept of Mental Retardation CM *T

Person
XXXXXXXXXXXX OVERWITH, GLADYS

Date
Time
By
Author's Name

06/20/08
1141
ARM
ARMT INSTRUCTOR

Category
De

Note Text

Lookup

Note Category

Category
Description

ISP
Individual Service Plan Note

MGMT
Management/Designee

TRIGGER
HCSIS Trigger

a. Consider Guardianships To Be Narrowly Tailored

If an individual can make necessary day-to-day decisions with the assistance of available programming and with staff and family support, and if that individual is not faced with any present or foreseeable major decisions, guardianship may be unnecessary or may be postponed. Where guardianship is necessary, it may be narrowly tailored to an individual's present or foreseeable future needs. A guardian's authority should be limited to those types of decisions, which the individual is unable to make. For some individuals, the facts show a pervasive incapacity to understand basic health, safety, and welfare issues ordinarily encountered in daily living. If this is the case, a full guardianship of the person and finances may be necessary. For other individuals, their incapacity may be limited to a specific area, such as the inability to make informed decisions regarding a particular medical procedure.

Guardianship is not appropriate to provide for an unforeseeable or unlikely future occurrence. For example, a petitioner should not ask the court to appoint a medical guardian in the unlikely event that an individual might some day require major surgery. Similarly, guardianship should not be used to protect individuals from the daily risks of living, which we all encounter in the community. A competent person may make harmful, unreasonable or even foolish decisions concerning personal and financial affairs. When a person arrives at a decision that is different from that which most other people would choose is not a sufficient basis for a finding of incompetence. It is important to determine if the person has the ability to weigh the risks and benefits of a decision, even if they may choose a course of action that others may think unwise. The fact that an individual relies heavily on others for advice is also not grounds for guardianship. Instead, incompetence is demonstrated only by facts showing that a person does not have the cognitive or functional capacity to understand a problem and make an informed decision even when the facts and consequences are clearly and simply explained to them.

b. Legal Standard for Guardianship

The Legal Standard for Appointment of a Full Guardian Based on Intellectual Disability pursuant to M.G.L. c. 201, Section 6A is as follows:

- ✓ Person is mentally retarded to the degree that s/he is incapable of making informed decisions with respect to (the conduct of his/her personal and/or financial affairs) - (or something more limited where appropriate),
AND
- ✓ That failure to appoint a guardian would create an unreasonable risk to his/her health, welfare and property,
AND
- ✓ Appointing someone with more limited powers i.e. a conservator, a trustee, or an advocate, would not be adequate.

A probate court may also appoint guardians for minors, mentally ill persons, and persons unable to make or communicate informed decisions based on physical incapacity or illness. M.G.L. c. 201, Section 1. The DDS Legal Office can explain the different documents needed to initiate and complete such guardianships.

c. Alternatives to Guardianship

The following is a partial list of alternatives to guardianship. Other options can be developed to suit an individual's needs and capabilities. Most probate judges are glad to limit the scope of a guardianship to those areas of need allowing individuals to retain a maximum amount of independence in their lives.

1. Joint bank accounts with trusted family member, appointment of representative payee, conservator, health care proxy, or a guardian with limited authority.
2. Decision making with supports of individuals family, friends and staff advice,
3. Identification of Advocate: Pursue the availability of citizen advocacy programs: community support services to address specific need for more assistance with medical appointments, more socialization, etc.
4. Modification of living circumstances to provide more structure or support. This can include but is not limited to more hours of staff supervision, the addition of mental health services, or possibly evaluation for treatment with medication,
5. Education/training specific to the skill area, which needs development.
6. Implementation of a shared or delegated financial management plan. (This option is further detailed in the DDS regulations found in chapter 115 sections 5.10 of the Code of Massachusetts Regulations).

d. Guardianship based on Intellectual disability- The Clinical Team Report (CTR)

Typically, an individual's capacity to make his/her own decisions will be raised during a yearly ISP or Risk Management team meeting. Each Area Office may have a different method for referring an individual for a clinical team evaluation, from which a Clinical Team Report will be

generated. The CTR is a probate court form developed pursuant to the guardianship statute. M.G.L. c. 201, section 6A, and is used to outline facts and the professional opinions of a team of clinicians to recommend that the court find an individual incompetent by reason of mental retardation. ***The CTR is a sworn statement signed under the penalties of perjury.***

A CTR must contain the sworn statements of a registered physician, a licensed psychologist and a social worker, each experienced in evaluation of mentally retarded persons. In some cases a certified psychiatric nurse clinical specialist (CNS) can sign in place of the physician. Specific instructions to the clinicians are designated and each clinician must conduct a personal examination of the individual:

- a. Examinations may be conducted separately or jointly.
- b. If separate examinations are conducted, each exam date must be noted.
- c. The number of examination sessions required for each competency evaluation will vary depending on the ability to access information from the individual, staff, family, etc
- d. The CTR expires if not filed with the court within 180 days after the first exam.

A Clinical Team Report (CTR) must include a coherent recommendation, which is agreed upon by all the clinicians who must all sign it. The original must be filed with the Court.

- e. Guardianship Referral Form - Bond and In-State Agent Form

Once the Service Coordinator has received the completed Clinical Team Report, the SC must fill out a Guardianship Referral Form and forward that with the Report to the Legal Office. The Guardianship Referral Form is an essential document to the Legal Office. The guardianship cannot be filed in court without it. The Referral Form asks the SC to name the proposed guardian(s), explain why they have been chosen as guardians, their relationship to the individual, names of heirs at law (see the referral form for guidelines on who needs to be listed) and whether the proposed guardian lives out of state. If the proposed guardian lives out of state the SC will have to identify an in-state agent. An in-state agent is a person who has only one responsibility with respect to the guardianship, which is to receive official mail in the event there is a lawsuit involving the individual.

The Legal Office will also ask the SC to have the proposed guardian(s) fill out a bond. The bond is the guardian's pledge to the court that they will act in the best interests of the individual. Usually the bond is "without sureties" which means that the proposed ward has no significant assets. If the individual does have significant financial assets, the bond will have to be backed up by signatures of other persons who promise to make good any losses to the individual if the guardian misappropriates the individual's money. In some cases the guardian will actually have to pay some money to a bonding company, which serves as insurance that they will not mishandle the individual's funds. Legal staff is available to explain this process and the requirements in more detail.

- f. Serving The Citation - notice to the parties

When DDS is the Petitioner in a guardianship, the agency is required to serve notice of the proceeding on all interested parties including the proposed ward, his/her heirs at law and

anyone who has lawfully objected to the guardianship. This notice is called a “citation.” The court will respond to DDS’s filing of a guardianship petition by sending the Legal Office a citation. The Legal Office will send a copy of the citation to the parties. The Service Coordinator is among those who will receive a citation which h/she must then hand deliver, or cause to be delivered (e.g. the Service Coordinator can ask the individual’s house or day staff to serve it) to the individual. The reason for the notice (proposed guardianship) should be explained to the individual as clearly as possible. The Service Coordinator then signs the bottom of the citation, attesting that he or she has made service on the proposed ward and sends the signed citation back to the Legal Office. If the individual objects to the guardianship, the Service Coordinator should let the Legal Office know this.

[Text of section effective until July 1, 2009. Repealed by 2008, 521, Sec. 21. See 2008, 521, Sec. 44.]

Section 6B. The court may appoint a guardian for a person who is unable to make or communicate informed decisions due to physical incapacity or illness in a like manner, subject to the same limitations, and filed by such persons who may file a petition under section six. The court shall not appoint as guardian any person petitioning for guardianship who: (i) is currently being investigated or has charges pending for committing an assault and battery that resulted in serious bodily injury to the incapacitated or ill person; or (ii) is currently being investigated or has charges pending for neglect of the incapacitated or ill person. The court shall terminate a guardianship appointed under this section if, upon petition, it is established that the guardian is: (i) currently being investigated or has charges pending for committing an assault and battery that resulted in serious bodily injury to the incapacitated or ill person; or (ii) is currently being investigated or has charges pending for neglect of the incapacitated or ill person.

g. Substituted–Special Authority Judgment

The Massachusetts Supreme Judicial Court (SJC) has determined that decisions involving highly intrusive treatments and medical procedures must be made by a probate court applying the “substituted judgment” doctrine. With respect to these decisions, even a duly appointed guardian must seek the express permission of the court before giving or withholding consent.

A guardian is not authorized to make decisions about the following intrusive treatments and medical procedures without a specific order from the court:

- administration of anti-psychotic medication;
- withdrawal of life-prolonging treatment;
- psychosurgery or electroshock therapy;
- sterilization or abortion;
- extraordinary medical procedures and treatments;
- level III behavior modification plans

In a substituted judgment proceeding the court attempts to “stand in the shoes” of the person under guardianship and determine what s/he would choose if competent. This differs significantly from the typical guardianship standard, which requires that a guardian act in the

“best interests” of the ward. An attorney is appointed by the court to represent the individual’s interest in substituted judgment proceedings and a Guardian Ad Litem (GAL) may also be appointed to investigate the situation and make specific findings and recommendations to the court. The role of the GAL is to represent the best interests of the individual. In addition, a guardian cannot commit an individual to a psychiatric facility for an extended period of time without a hearing. Questions about whether a specific procedure requires a substituted judgment determination should be directed to the Legal Office.

h. Rogers Monitor

Service Coordinators will most often hear about substituted judgment in the context of a guardianship for an individual who requires treatment with antipsychotic medication. Such cases are known as Rogers cases because a substituted judgment for an incompetent individual was first required by the court in the Massachusetts case, *Rogers v. Commissioner of Dept. of Mental Health*, 390 Mass. 489, 458 N.E. 2d 308. As noted above, in such cases the court will appoint an attorney for the individual, and someone to monitor the individual’s treatment (called the Rogers monitor—who may be the same person as the guardian or may be someone different) The Legal Office will ask the Service Coordinator to get a sworn, signed affidavit/treatment plan from the physician who prescribes the anti-psychotics medication. The court typically reviews an individual’s treatment with anti-psychotics annually.

i. Health Care Proxy

In 1990 Massachusetts enacted the Health Care Proxy Law. The law allows you to choose, while competent, a trusted relative or friend to make medical treatment decisions for you if, and when you are no longer competent to do so .The proxy only takes affect after a doctor determines that you lack the capacity to make decisions about your course of treatment. A health care proxy may negate the need for future substituted judgment determinations by the court. A health care proxy allows competent individuals to protect their right to make important choices regarding their health care should they later be unable to do so for some reasons, whether due to dementia, unconsciousness or coma.

A health care proxy or “advance health care directive” is a legal document that allows a competent individual (known as the “Principal”) to designate another individual (known as the “Agent”) to make health care decisions on his or her behalf in the event that the Principal becomes unable to make or communicate such decisions in the future. [M.G.L.c.201D]. The proxy document only goes into effect when the Principal is unable to make informed health care decisions as determined by the Principal’s (individual’s) physician.

A Health Care Proxy does **NOT** require court approval but must be witnessed and signed by the individual, the proposed health care agent and two witnesses.

The Legal Office can provide you with a sample health care proxy form. However, there is no required or standard health care proxy form. For such a document to be legally binding, the following requirements must be met:

The Proxy must be a written document.

Any competent adult of 18 Years of age or older may execute a Health Care Proxy

The Proxy must state that the agent can make health care decisions on behalf of the Principal.

The Principal's written instructions may be general or very specific in defining the types of medical treatment or procedures which the Principal would consent to or refuse if competent, including life sustaining treatment and other end-of-life decisions. The Principal may specify whether the Agent shall have full or limited authority.

The Principal must sign the proxy in the presence of two witnesses who are over the age 18 and are not named as the Agent.

The witnesses must also sign the proxy document.

A health care provider may not serve as an agent unless related by blood, marriage or adoption.

The Agent and health care provider are obligated by law to follow the instructions contained in the written proxy unless a court order has been entered which overrides the proxy. The proxy document should be placed in the individual's primary medical record, and copies should be given to the Agent, as well as any hospital where the individual receives treatment. Family members, DDS employees and provider staff may also receive copies, as determined by the Principal. The individual should be sure to take a copy of the proxy anytime he or she may be admitted to a hospital.

The Health Care Proxy is revoked if the Principal:

- Executes a new Proxy,
- Notifies his or her physician orally or in writing, to revoke the proxy, or
- Engages in any action, which clearly demonstrates that the Principal wants to revoke the proxy, such as tearing up or destroying the document.
- If the Principal regains the capacity to make informed decisions, the Agent's authority will end.

Appendix F Understanding Informed Consent

What is informed consent?

Informed consent is the agreement given voluntarily by an individual or guardian who understands and weighs the risks and benefits involved in a particular decision.

What are the elements of informed consent?

When securing informed consent, a clinician explains the intended outcome of a procedure/ activity, the risks and side effects of the procedure, and alternatives. The person securing the consent should present the information in a manner that can be easily understood, offer to answer questions and explain that consent can be withheld or withdrawn at any time.

According to DDS regulations, whenever informed consent is required, it must be given freely without coercion or inducements of any kind. The consent should be in writing. It must be dated and will expire after the completion of the specific procedure for which it applies, or after one year for ongoing interventions. The written information should include the process used to obtain the consent, the name, position and affiliation of the person securing the consent, and a summary of the information provided to the individual.

When is informed consent required?

According to DDS Regulations 115 CMR 5.08, informed consent is required in the following circumstances:

1. Prior to admission to a facility,
2. Prior to medical or other treatment (informed consent must be obtained annually for routine medical and preventative treatment as well as prior to specific non-routine or preventative medical care, including use of psychotropic medications).
3. Prior to involvement of an individual in research activities,
4. Prior to initiation of Level II or III behavior modification interventions,
5. Prior to release of personal information to other agencies, providers or individuals.

Who gives the informed consent?

An adult over the age of 18, is presumed legally competent to provide consent. However if an individual has been found not competent to make decisions a guardian must provide the consent.

What happens when the individual is not competent to give informed consent?

Where an individual is not competent to give informed consent, a duly appointed legal guardian gives consent on the individual's behalf. The clinician should provide a guardian with the same information on benefits and risks of a given treatment as provided to a competent individual. A guardian can then make treatment decisions in the best interests of the individual.

How does informed consent work?

Informed consent is given by an individual being treated to a treating clinician. In general, when DDS is the provider and employs the treating clinician, that DDS clinician secures the consent. When the treating or prescribing clinician¹ is a community health professional, that clinician, not the DDS Provider, is responsible for securing informed consent. Informed consent is an agreement between a

¹ A clinician is defined here as a physician, psychologist or psychiatrist specializing in clinical studies or practice. American Heritage Dictionary, 2nd College ed. 1982 at 281.

patient and the treating clinician. This is true even when a DDS Provider clinician is carrying out another clinician's treatment order. See below for specifics.

What is the usual role of the Provider in these processes?

For areas in which the DDS Provider employs the clinician who is securing the consent directly, he/she needs to ensure that the informed consent is obtained and properly documented. Records of informed consent need to be stored in an individual's confidential files, and renewed annually.

When the treating clinician is a private practitioner, not employed by a DDS Provider, securing consent is the responsibility of the community practitioner, and an individual's informed consent document is usually found in the medical record in the doctor's office. Sometimes, however, this consent is obtained verbally. The Provider should make every effort to facilitate the consent process.

What about someone who may need a guardian but does not have one?

In this case, the DDS Provider should notify the individual's Service Coordinator that there is a question of competence with respect to the individual. The DDS Area Office will work on identifying appropriate guardians and referring the individual for a Clinical Team evaluation to ascertain whether there is indeed a need for a legal guardian. The advice of the Regional DDS Attorney should be sought in the interim to answer questions about how to proceed until a guardianship determination is final.

Under certain critical circumstances the DDS regulations can be helpful in addressing specific ways to proceed where a guardian has not yet been appointed for an individual who needs one. For example,

- 1) The head of the program can approve the use of certain interventions/ treatments under certain conditions. (115 CMR 5.14(4)(e)(3)(b)).
- 2) For example, under this section, the DDS provider can consent to "that portion of a behavior plan that does not involve the use of Level III interventions" without a legal guardian if an action to initiate proceedings for the appointment of a guardian has been commenced concurrent with this approval.

Informed Consent and Emergency Treatment

There are a number of situations in which an individual can receive needed treatment without the need for informed consent. These essentially constitute emergency medical or mental health situations. For example:

- 1) A treating clinician can provide non-routine medical treatment including administration of psychotropic medications without informed consent in the event that a true medical emergency exists.²
- 2) A treating physician in a hospital setting can administer non-routine medical treatment without informed consent (including administration of psychotropic and antipsychotic medication) in the event a true medical emergency exists. Once the emergency is over however, they must seek special authority to administer antipsychotics to an incompetent individual.

Emergency circumstances when informed consent is not required

The DDS regulations provide additional guidance with regard to allowance of implementation of certain emergency interventions. For example:

- 1) In emergencies DDS Providers may implement physical restraints.³ Chemical restraint may only be implemented in an emergency after it has been authorized by a treating physician. In all instances, any use of mechanical restraints implemented in the community require that a waiver be in place. If the requisite waiver is in place, mechanical restraints may be implemented in an emergency without informed consent. All uses of emergency restraints should be appropriately documented.
- 2) DDS Providers may also implement CPR and call for emergency transportation to the hospital during a medical emergency.
- 3) DDS Providers can implement medical treatments ordered by the treating clinician without the individual's informed consent if a medical emergency exists. This includes the administration of anti-psychotic and behavior modifying medications.⁴

² A "medical emergency", as used here, is a situation in which the individual's medical condition requires medical treatment or attention to prevent immediate, substantial and irreversible deterioration of a serious mental illness. 115 CMR 5.15 (12(d)(1)-(3)).

³ 115 CMR 5.11(1). An emergency here includes the presence of serious self-injurious behavior and/or serious physical assault, or the imminent threat of these acts in which actions indicate a present intention/ inclination to carry out such behaviors immediately

⁴ 115 CMR 5.15(4) (b)(3).

Appendix G. MEDITECH BUSINESS RULES FOR RISK MANAGEMENT PLANS

The following rules note the business policies established within the Meditech for risk plans:

- a. Only one plan per consumer should be recorded in MEDITECH.
- b. 'Date of Plan' field – today's date will be automatically defaulted. This is the date the plan is developed. This field will not be updated once the date is entered the first time.
- c. 'Regional Risk Contact Person:' field is a business-rule required field.
- d. Updates should be entered in the narrative sections for appropriate questions. Updates should be prefixed in these sections with 'Update: *date*:' All updates should be added at the end of the text field.

Tip: Use <Ctrl End> to get to the end of the list.

- e. Not required if there is no update.
- f. 'Risk Category' fields are updated after the first meeting. If new risk categories are identified and documented during the subsequent meetings in the Risk Management Meeting screen, 'Risk Category' fields are updated in the Risk Management Plan screen as well.
- g. All fields under 'Risk Plan Status' are business-rule required fields.
- h. All Risk Plan related activities are to be maintained by Area Offices only. Therefore, whenever a consumer is transferred to a facility from an Area Office, his/her Risk Plan is to be inactivated by a Service Coordinator and reopened only upon consumer's return to the Area Office. If the plan has to be updated with new information during consumer's stay at the facility it is Service Coordinator's responsibility to make all the necessary edits at that time while keeping the status of the plan inactive.
- i. Multiple Risk Plan Meetings can be recorded in the RISK PLAN MEETING screen. Each meeting's record is date-specific, and should be dated by the day of the meeting.
- j. 'Were any action items produced from this meeting:' field is a business-rule required field.
- k. 'Have all action items from this meeting been completed:' field is a business-rule required field.

- l. 'Action' items should be updated after each meeting on a new 'Action items screen'. An action item should be documented for each meeting, even if no action items were identified. In this case, enter 'NO ACTION NEEDED' in the 'Action 1.' field.
- m. Up to five Action Items can be entered after each Risk Plan Meeting. If more than five action items exist, open additional screen with the date of next business day.
- n. List of Action Items is available through the lookup function. Only items on the list can be entered.
- o. 'Date of Decision' – enter the date of the meeting where 'Action Item' was identified.
- p. 'Completed Date' field – enter the actual completion date of the action item.
- q. If new risk categories are identified during the meeting, they should be documented in the 'Risk Category' fields and updated on the page four of the Risk Management Plan screen in the 'Risk Classification' section.
- r. 'Next Scheduled Meeting:' field on 'Action Items Screen' is a business-rule required field and can be up to one year from current date.
- s. If the plan is closed, T+365' should be entered in the 'Next Scheduled Meeting:' field.
- t. Risk Notes category should be used for notes related to Risk Management.
- u. Risk Management Report should be used to print hard copy of Risk Management Plans.

Appendix H. Common Legal Terms used in the Risk Management Manual*

Adjudicate- a finding by the court (judge)

Citation- an official summons to appear (as before a court)

Clinical Team Report is a probate court form developed pursuant to the statute. M.G.L. c. 201, section 6A

Commitment is the term commonly used to define the length of time a person is confined involuntarily.

Competence is defined as: “The quality or state of being functionally adequate.”⁵ Note that an individual might be competent (functionally adequate) for one set of tasks and decisions, but not for another. For example, an individual could be competent to handle a bank account, but not competent to make a major medical decision. Competency at the age of majority is a fundamental understanding in law. Under existing Massachusetts law, anyone 18 years or older is presumed competent to conduct their personal and financial affairs [115 CMR 5.07].

Conservator is a guardian whose duties are limited to the ward’s estate. A conservatorship is sought in the same manner as a full guardianship and requires proof of incapacity in decision making with respect to an individual’s funds.

CORI/CHSB - In 1972 the Criminal Offender Record Information (CORI) Act, established the Criminal History Systems Board as the state agency responsible for maintaining the law enforcement telecommunications network known as the Criminal Justice Information System (CJIS) and the processing and dissemination of Massachusetts criminal background checks for non-criminal justice entities. This agency provides informational assistance to individuals and families that are victims of crime.

Court Requests for Documentation

Subpoenas: *subpoena duces tecum* is defined as “a writ to summon witnesses or evidence before a court.”⁶ This is a request from the Court either for documentation that is in the possession of the Department, or a request for an appearance by a representative of the DDS to appear in court. It is important to note that the threshold for obtaining a subpoena is remarkably low. In most cases, any attorney involved in a case has only to request the Court for a subpoena and it will be granted. Subpoenas may be requested by an attorney who is in an adversarial role with the DDS or one of its individuals. **Subpoenas should not be**

⁵ Source: Webster’s Medical Desk Dictionary

⁶Source: Random House Webster’s College Dictionary

automatically complied with, nor should they be ignored. The implications of releasing the documents and/or appearing in court should be thoroughly analyzed and reviewed with the DDS Legal Office. In most cases, the legal opinion will likely be that the information should be released as requested. However, there may well be situations where the documents should not automatically be released, and the DDS attorney will need to petition the Court to have the subpoena “squashed” or nullified.

Court Orders: Court orders are much more serious than subpoenas. In these situations, the Court itself has determined that the documents or appearance in Court are necessary, and the failure to respond can result in criminal charges for Contempt of Court. The DDS Legal Office is the only area of the Department that responds to a Court Order.

Forensics- matters pertaining to the law. Specifically applying a broad spectrum of sciences to assist the court in carrying out justice, e.g. pathology, psychiatry or psychology

Guardianship is a legal process, utilized when a person can no longer make or communicate safe or sound decisions about his/her person and/or property.

Guardian Ad Litem “guardian at law.” (**GAL**) - The person appointed by the court to look out for the best interests of the child during the course of legal proceedings.

Health care proxy (also known as an “advance health care directive”) permits a competent individual to designate another to make health care decisions on their behalf in the event they should become unable to make or communicate such decisions in the future. (M.G.L. c. 201D).

Hearing – defined as a preliminary listening to arguments. There are a number of court hearings, such as appearance for bail, pretrial motion and guardianship. (Bail, pretrial motions, and other criminal proceedings are included under the section related to forensics).

Lamb Warning* The GAL shall inform the parties how the information gathered by the GAL will be used. The GAL must provide a “Lamb warning” that explains there are no “off the record” discussions and any information collected by the GAL may appear in the GAL report, be disclosed in court or to the other party, Commonwealth v. Lamb, 1 Mass. App. Ct. 530 (1973), or otherwise disclosed as required or permitted by law. As appropriate based on the child’s level of maturity, the GAL should provide a similar explanation of the investigative process and a Lamb warning to a child, but modified to reflect the child’s age and level of understanding. If the GAL interviews other witnesses, they also must receive a Lamb warning.

Commentary. To ensure a person understands the Lamb warning, the GAL should ask the person to summarize it for the GAL. The parties or witnesses should be informed that while they are encouraged to provide information, they may decline to answer a question and have an attorney present during any interview. Increasingly, parties represent

themselves in court. Therefore, the GAL should avoid use of professional jargon or legalese that a party may not understand. The GAL should strive to explain things in simple language and terms as appropriate so that a party with a limited educational background or language ability can better understand what the GAL is communicating .

* Any privilege established by section one hundred and thirty-five of chapter one hundred and twelve or by section twenty B of chapter two hundred and thirty-three, relating to confidential communications, shall not prohibit the filing of reports or affidavits, or the giving of testimony, pursuant to this chapter, for the purpose of obtaining treatment of a mentally ill person; provided, however, that such person has been informed prior to making such communications that they may be used for such purpose and has waived the privilege.

Representative payee is an individual designated by the Social Security Administration to hold and use funds on behalf of another. Appointment of a representative payee does not require court involvement but the payee's authority is limited to funds issued by the SSA. Representative payees must file annual accounts with the SSA.

Rogers' Monitor- An individual appointed by the court (**Massachusetts only**) who will monitor an incompetent individual's treatment with anti-psychotic medication . Sometimes this is the person's guardian.

Appendix I. Incident Categories of HCSIS

INCIDENT CATEGORIES

MAJOR

1. **Unexpected/Suspicious Death** – Any death that is suspicious in that it is unexpected due to the medical status of the individual prior to the time of death, the suddenness of the death, and the age of the individual. This excludes expected, foreseen or imminent death from natural causes and death of an individual getting hospice services. An example of an unexpected death would be a 28 year old man who is in general good health and dies in his sleep.

- **Accidental** – Any death resulting from accidental causes, such as the result of a car accident or choking incident.

- **Suicide** – Any death resulting from a conscious act to take one's own life.

- **Unusual Circumstances** – Any suspicious death, such as one resulting from foul play or a drug overdose.

- **Other Unexpected/Sudden Death** – Any other unexpected or unanticipated death that does not fit into another secondary incident type.

MAJOR
MAJOR

2. **Suicide Attempt** – A serious, intentional, voluntary attempt to take one's own life. This would include an incident that might not in and of itself cause death, if the intention was to take one's own life. This would not include self-injurious behavior unless that behavior was attempted in order to take one's own life.

- **First Known Attempt**

- **Repeat Attempt**

Minor

3. **Unexpected Hospital Visit** – This category is for an unplanned emergency room (ER) visit to an acute care medical or psychiatric hospital for the purpose of evaluation and treatment of an immediate medical or psychiatric concern. This would not include a hospital visit that is a planned hospitalization, nor a hospital visit that is part of routine care, scheduled visit or medical treatment protocol, such as a protocol for replacing a feeding tube, even though the timing for this visit may not be planned, but is an expected step in an individual's medical treatment.

• **Medical Hospitalization** – This category would be used only when an individual is admitted as an inpatient to the hospital for medical treatment as a result of an unplanned ER visit. It would not be used if the individual is only seen and treated in the emergency room, even if the time spent in the emergency room is extensive. Example: An individual is brought to the ER and admitted to the hospital after complaining about stomach pain and looking jaundiced.

• **Psychiatric Hospitalization** – This category would be used when an individual is admitted as an inpatient to a psychiatric hospital, to the psychiatric unit of a hospital or to a detoxification center.

• **E.R. Visit** – This category would be used when any medical assessment and/or treatment provided is through the emergency room as a result of the unexpected hospital visit, regardless of the amount of time spent in the emergency room. Example: An individual is taken to the ER after staff is able to remove a piece of food using the Heimlich maneuver. The individual is examined at ER and released without being admitted.

• **Emergency Psychiatric Services Evaluation** – Emergency psychiatric evaluation that is not part of a regular intervention outlined in an individual's behavior plan. Example: An individual is taken to the ER for psychiatric or emergency team evaluation after threatening staff and self with scissors (a behavior not addressed in a behavior plan).

MAJOR

4. **Inappropriate Sexual Behavior** - This category is used when there is any unwanted sexual advance, contact or activity, such as exposing oneself in a sexual way, inappropriate sexual touching and up to and including rape. Examples that would not rise to the level of an incident include: disrobing in front of others without sexual intent, or accidental touching of someone's breast while passing by. Separate incident reports need to be filed when services are being provided to both victim and perpetrator.

• **Aggressive Sexual Behavior - Alleged Victim & Aggressive Sexual Behavior – Alleged Perpetrator** - This category is used for those events requiring the broader level of review that includes the DSS Regional Office. An incident report would still need to be completed for alleged perpetrators even if the Aggressive Sexual Behavior is being addressed through a behavior plan. Examples include:

- Events with police involvement
- Events with staff involvement (regardless of degree of incident)

- Victims or perpetrators are members of the community or strangers
- Rape or attempted rape
- Use of physical force
- Direct sexual touching of another person's private areas
- Sexual touching outside of the victim's clothes with active force over resistance or in the presence of signs of significant discomfort
- **Sexual Misbehavior – Alleged Victim & Sexual Misbehavior – Alleged Perpetrator** - This secondary category is used when the incident report needs to be reviewed only at the area office level. Examples include nonconsensual sexual touching on the outside of someone's clothes that is short in duration and/or stops if there is any resistance or signs of discomfort. An incident report would not need to be completed for alleged perpetrators if the Sexual Misbehavior is being addressed through a behavior plan with data being kept and used to address ongoing needs. In the event there is significant discomfort, however, this should be reported as an incident of Aggressive Sexual Behavior.

Minor

5. Physical Altercation – This category covers any incident where the physical attack directed at another person presents a **serious** risk of physical harm to the other person or results in visible physical injury to the other person, whether or not first aid or medical treatment is required. An attack includes, but is not limited to, intentional or willful grabbing, shaking, dragging, shoving, yanking, slapping, hitting, kicking, choking, pinching, biting, strangling, or punching. Example 1: An individual pulls another individual out of his wheelchair, sits on top of him and holds him to the floor. Example 2: An individual becomes physically aggressive towards staff and hits staff causing staff's glasses to be knocked off.

• **Individual to Individual – Alleged**

Victim – This category is used when an individual is the alleged victim of a physical altercation by another individual. An example would be an individual being grabbed by the throat by another individual and is in danger of choking but for the intervention of staff.

• **Individual to Individual – Alleged**

Perpetrator – This category is used when the individual is the alleged perpetrator of a physical altercation against another individual.

Minor

• **Individual to Staff** – This category is used when the individual is the alleged perpetrator of a physical altercation against a staff person.

• **Individual to Other** – This category is used when the individual is the alleged perpetrator of a physical altercation against a person, other than another individual or staff, such as a family member, neighbor or stranger. Example: An individual picks up a sharp knife and threatens his sister while attending a barbeque at his mother's home.

Minor

6. Significant Behavioral Incident – This category covers any behavioral episode of an individual that would have resulted in imminent, serious physical harm to that individual acting out if not for immediate intervention. Example 1: An individual opens her second floor bedroom window and attempts to crawl out. Example 2: An individual who insists on running away and puts a pushpin in her mouth while attempting to run out the house.

MAJOR

7. Missing Person – Any individual who is missing and considered to be at risk. This could include someone who is missing for any period of time, if considered in immediate jeopardy, or someone who is missing for more than 24 hours without prior arrangement, unless the person's ISP Team specifies that an individual could safely be out of contact for a period of time longer than 24 hours.

- Law Enforcement Contacted
- Law Enforcement Not Contacted

Minor

8. Medical or Psychiatric Intervention Not Requiring a Hospital Visit – This category is appropriate when there is emergency medical treatment beyond first aid, or when emergency psychiatric services, such as a psychiatric evaluation, are provided in a non-hospital setting such as the home, or day program.

- Medical Examples: include wound closure by a medical professional or other treatment provided in a health care practitioner's office or on site by agency medical or nursing personnel (RN, LPN, etc.). This category would also include evaluation of a possible injury by emergency personnel in response to a 911 call.

- Psychiatric Example: Crisis team is called to evaluate an individual in her home because of escalating behavior and decides that an inpatient psychiatric hospitalization is not required

9. **Fire** – Any incident involving a fire in an individual’s environment that requires active involvement of firefighter or the use of a fire extinguisher.

- **Alleged Started By Individual** – This category is used when the fire is allegedly started intentionally or accidentally by an individual. Example 1: An individual burns papers or material with matches in the house. Example 2: An individual starts a grease fire while cooking and staff put out with a fire extinguisher.

- **Not Started by Individual – Fire of Known Origin** – This category is used when someone other than an individual, intentionally or accidentally starts a fire, such as toast catching on fire that is put out by a fire extinguisher.

- **Fire of Unknown Origin**

Minor

10. **Suspected Mistreatment** – This category includes any intentional or negligent action or omission by staff or other caregiver that causes or exposes an individual to a serious risk of physical or emotional harm.

- **Alleged Victim of Psychological Abuse** – This category includes acts other than physical and verbal that may inflict serious emotional harm, invoke fear or humiliate or intimidate an individual. Example 1: A staff person hides a treasured trinket from an individual as a way of making fun of or intimidating the individual. Example 3: A staff person threatens an individual with withholding a favorite dessert if the individual reveals information about an incident.

Minor

- **Alleged Victim of Verbal Abuse** – This category covers verbalizations that may inflict serious emotional harm, invoke fear or humiliate, intimidate or demean an individual or potentially seriously damage an individual's self respect. Example: A staff person who yells profanities at an individual.

- **Alleged Victim of Physical Abuse** – This category covers physical contact that exposes an individual to serious physical or emotional harm. Example 1: A caregiver or staff hits an individual and causes bruises. Example 2: A staff person accidentally scalds an individual during bathing.

- **Alleged Omission – Failure To Provide Needed Supports** – This category is used when there is failure to provide services and supports determined to be necessary or otherwise required by law, regulation or contract. Example 1: Staff makes no attempt at getting a bed shaker alarm fixed for an individual who is hard of hearing. Example 2: Staff does not intervene when a housemate blocks an individual from entering the family room to watch TV and causing the individual to be afraid to come into the room.

- **Alleged Omission – Failure To Provide Needed Supervision** – This category is used for failure to provide supervision determined to be necessary or otherwise required by law, regulation or contract. Example: A staff person leaving an individual who needs ongoing supervision alone in a van while going into a store.

Minor

11. Property Damage – This category is used when (i) an individual deliberately causes damage or destruction and the approximate value of the item exceeds \$200, or (ii) when the property has significant intrinsic value to the owner (such as a family heirloom) and the deliberate destruction causes unusual or significant distress to the individual. Evidence of distress would include an extended period of crying, withdrawal, depressed affect or other distraught behavior. Example: An individual goes into his housemate's bedroom and slashes a picture of his housemate's mother. Upon discovery, the housemate cries for hours and repeating that, "he hurt her." Two reports would be filed, one for the housemate as the alleged victim and a second for the individual as the alleged perpetrator.

- Alleged Victim
- Alleged Perpetrator

MAJOR

12. Theft – Unlawful taking of money, other financial assets and/or personal property that is reported to DPPC and/or law enforcement.

- Alleged Victim Examples including an individual's banking passbook, ATM card, or television being stolen and reported to the police.

- Alleged Perpetrator An example would be an individual arrested for shoplifting.

13. Other Criminal Activity – Any criminal activity that is reported to law enforcement and is not covered by incident type of theft. Examples include violation of a restraining order and stalking.

- **Alleged Victim** Example: An individual's home is used for drug dealing by staff.
- **Alleged Perpetrator** Example: An individual is arrested for drug possession.

Minor

14. Transportation Accident – This category is used for traffic accidents when police is involved. It would not include minor fender benders.

- **Pedestrian** – This category is used if an individual was a pedestrian involved in a traffic accident. An individual tells staff that he was brushed by a car while crossing the street and then asked by police if he was ok which he replied that he was.

- **Motor Vehicle Accident** - This category is used if an individual was a passenger at the time of the accident. Example: An individual riding in a taxi cab that struck a pedestrian. Individual is not hurt and police is called.

- **Other** – This category includes, but is not limited to, an individual who is in a biking or boating accident.

Minor

15. Emergency Relocation –

Individual(s) relocation on an emergency basis for more than 24 hours or overnight due to fire, local disaster, weather conditions, or as a result of immediate eviction.

Minor

16. Unplanned Transportation

Restraint – The use of physical holding or a mechanical device to keep an individual safe during transportation that has not been planned for in the individual's ISP. A restraint form is not required in these circumstances, however, an Incident Report is required if the intervention is not written into the individual's ISP. Example: An individual who boards a van agitated, refuses to fasten seatbelt and tries to grab steering wheel and is held down by staff while having his seatbelt refastened.

Minor

17. Other – This category covers incidents that do not easily fit into one of the other incident types. This category should rarely be used because most incidents that are reportable would likely fit into one of the identified categories.