

# Commonwealth of Massachusetts

## Department of Mental Retardation

### 1. Introduction to Risk Management:

#### Finding the Balance

The focus of the DMR Risk Management System is to address the challenge of balancing the responsibility as a public agency to keep individuals with mental retardation safe, with the goal of promoting independence and self determination. The System is grounded in the recognition by DMR staff that enabling individuals (and their families) to consider options and make real choices will be most successful if people work as partners in the process. All involved must also recognize the reality of risk in people's lives and the fluidity of the service system and work to create an environment which provides appropriate safeguards and promotes care, effective supports and respect. Distinguishing between reasonable and unreasonable risk in the lives of individuals is sometimes obvious; however, more often, it is a complex task that requires the exercise of professional judgment. All those who support individuals served by DMR must receive training, support and guidance if they are to respond promptly and effectively to those risks which present a danger.

More and more individuals 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 experiencing the consequences of those choices. DMR 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 result in an unreasonable risk to the individual or to others. Clear guidance and direction must be provided to assist staff in supporting individuals who are considered competent to make informed decisions, but who continue to exercise poor judgment and place themselves or others in risky situations. The Investigations Advisory Panel, in the Report issued in April of 1998, stated: "To assume that persons with mental retardation who are known or suspected to be in a potentially or blatantly risky, exploitative, or abusive situation are exercising their 'rights' to be at risk is to abandon a basic rationale for public services. The panel felt very strongly that no one with mental retardation 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, particularly families and guardians. It 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. As a public agency, DMR must also ensure that these local, individual processes are occurring within the framework of a strong management system and are receiving the level of supervision and oversight necessary to ensure quality services which reflect the responsible use of public funds. The DMR Risk Management System will provide the agency wide standards, educational strategies and support mechanism necessary to meet those requirements.

Exposure to risk is a part of life and it is only through making choices and developing judgment that we all learn and mature. People with mental retardation, however, can 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. It is essential that staff receive training and support that prevents overprotective approaches that deny an individual the opportunity to learn and grow, or approaches that place the individual, or others, at risk by over-estimating the ability to make informed choices. Those working with individuals with mental retardation must also recognize the importance of assessing the impact of environmental or other external factors and secondary issues like mental illness, criminal activity, substance abuse, or refusal of services on the person's ability to remain safe. A small, but highly visible, number of individuals in these categories pose a public safety risk and DMR staff need extensive training and support in addressing these complex issues. The Risk Management system will incorporate internal and interagency initiatives to expand DMR's efforts to provide the safest and most effective options for supporting these individuals.

The evolving structure of the community system during its enormous growth in recent years must also be considered in risk management planning. That growth has been a dynamic process of continuous development, with varying factors influencing the types of administrative and programmatic structures needed to manage a large network of support systems in a frequently changing climate. Some of the increase in administrative and oversight systems in the community has come from sheer growth and the need to organize the work, but an equal measure has come in response to incidents that highlighted areas where the systems should have done more to keep people safe.

Over the years, DMR has responded to many serious incidents by adding new administrative requirements. Many stakeholders view some of those measures as serving to undermine the concept of community. They feel that individuals would be better served if efforts were focused on strengthening personal and family relationships, building natural supports and addressing broader systemic issues, such as isolation in the community, which increase risk and can lead to abuse and neglect of individuals. Attention to building relationships with others in the community is essential in supporting individuals, but the process evolves slowly and requires a long term commitment. It cannot stand alone, however. To meet its responsibilities as a public agency DMR must have a management system that includes guidelines for addressing risk and for incorporating risk management principles into individual support planning, as well as the broader operational and planning activities of its community and facility systems. The system must reinforce and support the critical role of supervisors who support and direct the judgments made every day at the local level. Strong central oversight and monitoring systems and standardization of operational activities are also essential to the effectiveness and accountability of the DMR decentralized management structure.

The Department's Risk Management System is designed to promote locally driven efforts, foster true partnerships among all stakeholders and create a learning environment that strengthens and supports local efforts to keep people safe while promoting personal autonomy. It is also designed to provide the necessary level of administrative structure and oversight and to draw upon the strength and expertise of DMR's family and citizen boards (e.g., Advisory Boards, Human Rights Committees), oversight agencies and a variety of other internal and external resources. In addition, the System must be closely linked with the planning and implementation of the new DMR Investigations System. The two systems must work in concert to ensure a comprehensive approach by DMR to the issue of serious risk in the lives of people with mental retardation.

# I

## II Guiding Principles

The following guiding principles articulate the Department's fundamental goals for its Risk Management System:

- While it is not possible to eliminate all risk from an individual's life, a risk management system primarily should emphasize safeguards and strategies that will address issues and create situations where risk is reasonable.
- The process of identifying and addressing unreasonable risk should be respectful of an individual's rights while responsibly addressing questions of competency and capacity to make choices. There must be a balance of risks and responsibilities.
- The determination of who is at risk should involve, among others, those who know the individual best. It should be based on professional/clinical assessments, when indicated, and an understanding of any cultural and linguistic issues. The process should be integrated into the ISP process.
- A risk management system should recognize that the only successful approach to assessing and addressing risk issues involves a true partnership among the individual, DMR, providers, family, friends and the community at all levels of the process.
- A risk management system should be locally based, user friendly and implemented by individuals trained, supervised and supported in making knowledgeable decisions through a collaborative group process.
- A risk management system must weigh the capacity of an individual to make informed choices and to learn from those choices with the necessity of assisting an individual to be safe.
- A risk management system must be based upon a clear process for identifying unreasonable risk.
- The open, honest and clear communication that is a cornerstone of risk management occurs only where a climate of support exists for those making difficult decisions with and on behalf of individuals at risk.
- Those making determinations about responsive courses of action must have timely access to clinical, legal and administrative consultation and have access 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 the promotion of a learning environment.

### **III Who is at Risk?**

A risk management system with a strong prevention focus is essential because individuals receiving any of the wide array of supports offered by DMR can find themselves in a situation that presents a serious risk of harm to themselves or others. Oftentimes, those most at risk are individuals who receive minimal support, either by choice or because of inadequate resources to address all their needs. For individuals known to DMR, there is no single profile of at risk individuals. They generally fall into one of three categories, however. The first group includes individuals who receive extensive DMR support, but who present significant medical and/or behavioral challenges and require a high level of oversight and attention to a variety of potential risks in their lives. The second group of individuals often do not wish to be labeled as mentally retarded and do not perceive themselves as "clients" of the Department. Many of them are, or have been, in disadvantaged situations and face significant challenges, that may include poverty, unemployment, mental illness, substance abuse and/or involvement with the criminal justice system. They often are involved with other agencies and because they are protective of their independence, DMR must try to engage them in a manner which is not so intrusive that they reject DMR supports altogether. The third group of individuals require more support than they are receiving and would most likely accept additional assistance with their physical or mental health issues or other challenges in their lives.

There is, however, an important fourth group of individuals, those not previously known to DMR, who become identified as being at risk and requiring support, often immediately, because of an emergency risk situation. These individuals will also be covered by the Risk Management System as soon as they become known to the Department.

In the course of providing family support, DMR staff can become aware of situations where a child presents as being at risk because of abuse or neglect or some other circumstance. As mandated 51A reporters, staff are responsible to file a report with DSS when they are aware of such issues and to provide information and assistance when indicated.

## **IV Overview of the DMR Risk Management System**

Risk management is an integral part of the daily work of the Department in supporting individuals and will not be treated as a separate activity. For example, risk assessment will be an ongoing, rather than annual, process that will become an integral part of the routine work of staff who support the individual. Training, consultation and support will be strengthened to enable staff to better identify and address risk by using a proactive and preventive approach. Providers (of state, as well as, contracted services) are significant partners in this process and training and consultation activities will focus on supporting providers in their role as the primary contact with many of these individuals. Outreach and training activities will also be extended to include police, courts, health care providers, other human service agencies and a variety of community stakeholders. It is important to foster relationships with these external entities since they are resources and partners who often have information and involvement with individuals who may be at risk and about whom DMR has little or no knowledge.

The DMR Risk Management System has four basic components: 1) Risk Identification and Prevention; 2) Risk Assessment and Planning; 3) Risk Training, Consultation and Support; and 4) Risk Management System Oversight Activities. Although the work will be locally focused and directed by the areas, facilities and regions and overseen by a Regional Risk Management Coordinator in each DMR Region, there will be strong Central Office involvement in the standardization of processes and in oversight and monitoring of all components to ensure the System's effectiveness in prevention and response activities related to risk.

## **V Components of the DMR Risk Management System**

### **A Risk Identification and Prevention**

The identification of individuals at risk will usually occur through a review process that examines the situation and circumstances of each individual assigned to a service coordinator or QMRP, using specific risk factors as a guideline. The DMR Risk Management Case Review Form will be used to review all individuals and identify any individual found to be a high risk situation and in need of a plan to address the risk. The reviews will require service coordinators (or QMRP's) and their supervisors, with support from others, to use their professional judgment in striking a balance between autonomy and protection concerns before deciding whether additional or different state action is warranted. Staff will be encouraged to utilize the training and consultation resources available as part of the Risk Management System, in conjunction with the support and guidance available within the area, region or facility. Extensive preliminary training will include components that will strengthen staff's ability to recognize situations, environmental issues and behaviors and respond to them before a serious incident occurs. Risk may also be identified by families/guardians and providers (who are key members of the risk management team) and a variety of others, both internal (e.g., surveyors, investigators) or external (e.g. neighbors, police) to the Department. When issues of risk are brought to the attention of the Department, they will be referred to the appropriate Area Office/Facility for inclusion in the local Risk Management System review process. Major incidents involving individuals at serious and immediate risk will, however, also require activation of the Critical Incident Reporting System, described in Section VI.

#### **A.1 Definition of Serious Risk**

The DMR Risk Management System will focus on situations that seriously threaten the individual's health or safety and situations where the individual poses such a harm to the community. It is designed to identify individuals at risk as those with a probability of harm from one of the following categories: (1) 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, exploitation, or regularly neglectful care or supervision; (2) the individual's behaviors, including substance abuse, behaviors that are dangerous to self or others, financial mismanagement, frequenting places where there are dangerous people, refusal of some critical services or treatment, or lifestyle choices that put them at serious risk or that pose a serious risk to others; (3) medical condition(s) that requires significant medical safeguards; (4) or any other situation that does not fit into the previous categories listed, but places the individual at serious risk or poses a serious risk to others.

#### **A.2 Risk Factors**

(1) 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.

These categories of risk are meant to assist in the identification of risk. They are not exhaustive.

- Loss of home
- Eviction
- Difficulties with relationship with landlord

- Unsanitary living conditions
- Frequent moves without good cause
- Dangerous neighbors
- Indebtedness
- Financial exploitation
- Loss of caretaker or natural supports
- Significant benefit loss, reduction
- Social isolation by caretaker
- Refusal of services by caretaker
- Poor compliance with treatment by caretaker
- Significant poor hygiene, personal appearance (Particularly if a change from usual practices)
- History of abuse or neglect
- History of omission of care
- Incapacitated caretaker
- Pregnancy and parenthood

(2) The individual's behaviors, including substance abuse, behaviors that are dangerous to self or that threaten public safety, financial mismanagement, frequenting places where there are dangerous people, refusal of some critical services or treatment, or lifestyle choices that put them at serious risk or that pose a serious risk to others.

These categories of risk are meant to assist in the identification of risk. They are not exhaustive.

- Loss of home
- Eviction
- Difficulties with relationship with landlord
- Unsanitary living conditions
- Frequent moves without good cause
- Loss of job or day supports
- Frequent job changes
- Indebtedness
- Gambling - excessive
- Making loans to others
- Substance abuse
- Significant poor hygiene, personal appearance (Particularly if a change from usual practices)
- Social isolation
- Sexual risky behaviors
- Elopement
- Suicidal ideation or behavior
- Poor compliance with treatment
- Refusal of services
- Criminal justice involvement
- Fascination with fire
- History of fire setting
- History of sexually aggressive behavior
- Dangerous sexual behaviors
- Excessive fascination with children
- Sexual abuse of children
- Assault
- Significant threats

Destruction of property  
Predatory behavior  
Verbal threats of violence  
Self injury  
Street safety issues

(3) Individuals who have a medical condition(s) and are in need of significant medical safeguards.

These categories of risk are meant to assist in the identification of risk. They are not exhaustive.

Multiple medical or psychiatric hospitalizations - two or more in one year, including emergency room admissions.  
A person living alone or with family and who takes multiple medications with little or no support.  
Post hospitalization treatment  
Medical benefit loss  
Significant change in health status or mental status  
Increased physician visits (medical/psychiatric)  
Significant changes in sleep/eating habits  
Non-compliance with medication regime  
Poor or non-compliance with treatment  
Refusal of services  
Multiple falls/fractures  
Mobility impairment  
Significant weight loss or weight gain  
Swallowing disorders/choking/aspiration pneumonias  
Episodes of skin breakdown  
Obesity

## ***B Risk Management Review and Planning***

All individuals classified through the review process as being "At Risk - Plan Needed" will be referred for assessment and plan development. The process will be initiated by completion of the Risk Management Review Form, which will be used in determining the need for clinical/professional assessments, for the development of a plan to respond to the risk and for determining whether the issue should be presented to the Area/Facility/Regional Risk Management Committee.

After the plan has been implemented, the team will evaluate the outcomes and determine whether the individual has met the criteria for removal from the at risk category, and/or determine whether additional interventions are required.



## **C Risk Management Training, Consultation and Support**

The training, consultation and support components of the DMR Risk Management System strengthen and support the capacity of staff to recognize and respond to risk in their daily work. Initial training efforts will focus on DMR staff with subsequent introduction of the DMR Risk Management System to providers who are essential partners in identifying and addressing risk issues for individuals they support. The Central Office Risk Management Director will be responsible for the development and implementation of statewide training, consultation and support systems and will work with the Regions to support their internal efforts in these areas. He/she will also coordinate community education initiatives and involve stakeholders in the Department's efforts to address risk through prevention and early intervention efforts.

### **C.1 Training**

Prior to implementation of the DMR Risk Management System extensive training for DMR staff will be completed to introduce the process and to train them to recognize and address the different types of risk often faced by individuals with mental retardation. Training initiatives will include both introductory, process components and ongoing training to better prepare staff for identifying and addressing the more challenging types of risk. Although the initial focus of training will be DMR staff, provider training initiatives and public education efforts will also be provided. The Central Office Risk Management Director will establish a system for ongoing training programs to maintain currency and to respond to needs identified as the Risk Management System evolves.

A statewide survey of DMR staff was utilized by the planning committee in developing the following preliminary outline of the topics to be covered. Some topics will be covered in the initial training and others will be included in an ongoing program of risk training, workshops and case study presentations by a team of forensic experts who will work extensively with one region at a time to ensure a strong foundation in these issues. Regional and Area Forensic Liaisons will receive more extensive training and serve as resources to local staff.

#### **\*RISK MANAGEMENT OVERVIEW AND PHILOSOPHY**

- a. Definition of Risk
- b. Impact of Risk on Choice
  - Competency
  - Capacity to Make Informed Decisions
- c. Impact of Risk on Human Rights
- d. Impact of Supports Offered on Risk
- e. Impact of Staff Roles and Responsibilities on Risk
  - Staff liability/accountability - control of outcome
  - Approach to "suspected" risk
  - Assisting families with medical/clinical decisions
  - Communication skills
  - Neutral writing
- f. Team Approach to Risk Planning
- g. Promoting a Supportive Learning Environment at All Levels of Organization

- h. Relationship of Risk Management to ISP
- i. Communication and Documentation (Neutral Writing)

### **\*RISK DEFINITION AND IDENTIFICATION**

- a. Risk Identification Tool: Reasonable v. Unreasonable Risk
- b. Recognizing the More Challenging Risk Areas: Objective Identification of Risk Indicators.
  - Sexual Issues and Behaviors (individual as victim or perpetrator)
  - Criminal Offending Behavior (including fire setting)
  - Substance Abuse
  - Domestic Violence
  - Caretaker/Peer Issues
  - Medical/Health Issues
  - Financial Exploitation/Mismanagement

### **\*RISK ASSESSMENT**

- a. Process
- b. Accessing Consultants and Obtaining Assessments
  - Clinical, Medical, Psychiatric Issues - Including unreasonable risks, forensic and behavioral issues, sexuality concerns and medical issues/decisions.
  - Legal
    - i) Competency - civil, criminal
    - ii) Protective services - removal, restraining order, refusal of services by individual/guardian
    - iii) Guardianship - removal, modification, substituted judgment
    - iv) Court involved individuals (bail/pre-trial release/release from jail, mental health commitments.
    - v) Financial exploitation/mismanagement (rep. payee, guardian of estate, conservator)
    - vi) DMR policies/regulations (life sustaining treatment, confidentiality, records release)
    - vii) vii. Lawyer referral and facilitation (housing, estate planning)
  - Administrative
    - i) Mandatory vs optional consultation
    - ii) DMR philosophy/policy - clarification/interpretation
    - iii) Availability of DMR funding
- c. Effective Use of Consultants
- d. Available Supports/Interventions to Assist Staff in Managing Risks
  - Resource guides and training manuals
  - Additional emergency resources (crisis team, respite)
  - Interagency collaboration
  - Establishing relationships with police, courts, physicians and hospitals
  - Housing options

### **\*PLAN DEVELOPMENT**

- a. Preliminary Planning
  - Team composition including individual and family
  - Information gathering/obtaining consultations
- b. Developing the Plan

- Process and format
  - Intervention & support options
  - Implementation strategies
    - i) Individuals easily victimized & exploited including financial
    - ii) Individuals who are non-compliant, resistant to supports
    - iii) Individuals who live dangerously and use poor judgment, make bad decisions
    - iv) Individuals who abuse alcohol and/or drugs
    - v) Individuals with criminal offending behaviors
    - vi) Individuals with self-injurious behaviors
    - vii) Victims of caregiver abuse, neglect, omission
    - viii) Homeless Individuals
    - ix) Individuals who are medically fragile or have serious health issues
  - Ethical considerations and human rights.
  - Individual education and training - linkages to ISP/proactive planning
- c. Local Follow-Up and Monitoring of Plan
- Tracking system
  - Timelines
  - Person(s) responsible
- d. Removal of Individual from at Risk Categorization

**\*CRITICAL INCIDENT REPORTING SYSTEM**

- a. Threshold Criteria
- b. Use and Dissemination of Report
- c. Linkage with Risk Plan Development/Review Process
- d. Role of Central Office Risk Management Director and Senior Staff

**\*RISK MANAGEMENT SYSTEM OVERSIGHT AND MONITORING**

- a. Area, Regional, Central Office Roles and Responsibilities
- b. Creating a Learning Environment - Use of Information in Training/Prevention Activities
- c. Proactive Planning and Use of Data Collection to Analyze Patterns/Trends
- d. Sharing Success Stories and Best Practices and Examples of Attempts that were Not Successful

## C.2 Consultation and Support

In addition to extensive staff training, a variety of consultation and support mechanisms will be developed to provide prompt and relevant advice and assistance to staff as they address risk issues. This will include; development of electronic and print Training and Resource Manuals, Protocols for addressing specific challenging risk situations, mechanisms for prompt access to clinical, administrative and legal resources to support and supplement local resources and access to information and consultation from the following Central Committees: Forensics Liaisons Advisory Group, Mental Health Services Planning Group and the Substance Abuse Work Group. The Central Office Risk Management Director will be responsible for developing and implementing these supports and working with the Regions to support their local initiatives in this area.

## **D Risk Management System Oversight Activities**

### **D.1 Oversight Principles and Guidelines**

Activities related to oversight and monitoring of DMR's efforts to address risk focus on promoting a constructive, learning environment to support staff in dealing with these complex issues and on strengthening and improving DMR's service delivery and management systems. The Regional Risk Management Coordinator will be responsible for area, facility and regional oversight activities and for the collection, analysis and submission of related information to the Central Office Risk Management Director.

The development of the oversight process was based on the following principles:

- a. A monitoring and oversight system should provide important information to key stakeholders about the quality of efforts in place to support people at risk.
- b. The system should be uncomplicated and collect only information with demonstrated necessity and utility in reviewing risk.
- c. The information should be compiled, analyzed and shared in an environment that fosters learning and system improvement.
- d. Information should be standardized and whenever possible, based on existing systems rather than creating new ones.

With these principles in mind, the following general guidelines were developed to steer the oversight process:

- a. The review process should not create an inordinate amount of documentation and data collection requirements that unnecessarily divert areas and regions from supporting people to manage risk.
- b. Despite best efforts and systems in place, there are times when individuals will have outcomes that may not be optimal. Such outcomes may derive from a variety of circumstances over which the areas and regions have no control. Therefore, a risk management oversight system needs to focus on the systems and processes that areas and regions have in place, ascertain whether everything that could be done was, in fact, done for an individual and determine whether new or revised systems should be developed.
- c. The risk management oversight system must be designed for the primary users, that is, the DMR areas and regions, and should be locally implemented. While other stakeholders will need ongoing information, the systems review process should focus on providing information to staff who on a day-to-day basis are implementing risk management systems.

### **D.2 Oversight Process**

Oversight of the DMR Risk Management System will be a standardized process. It will be coordinated by the Central Office Risk Management Director who will conduct ongoing reviews of local risk management processes in conjunction with the Regional Risk Manager, work with the Regional Risk Managers to gather and analyze information and prepare an annual DMR Risk Management Report.

#### **a. Individual Reviews**

Oversight will begin with the Regional Risk Management Coordinator reviewing a sample (proposed at 10%) of the individuals identified by each area office as being at risk and in need of a risk

management plan. Although the process has not yet been finalized, a representative sample will be used. Factors under consideration for selecting the sample include:

- Different risk categories
- Different service coordinators
- Presence or absence of provider supports

A process will also be developed for reviewing a small number of individuals who were not designated as "at risk" to ensure that risk is being identified.

The Regional Risk Management Coordinator will complete an Individual Review Form for each individual reviewed as part of the sample. He/she will meet with area office and facility staff to review the results for the purposed of learning and service enhancement. In addition to the sample done at the regional level, the Central Office Risk Management Director will conduct periodic individual reviews in each region and meet with staff to review the results.

An electronic form would be completed for each of the individuals reviewed as part of the 10% sample for each area/facility. The reviews would be staggered over the course of the year and results would be shared for the purpose of learning. The information would remain local, but summary information would be included in the annual DMR analysis and report.

Development of plan -

- Description of how plan was developed
- Description of clinical, legal, human rights and other resources accessed in addressing this issue.
- ISP team involvement
- Were all the appropriate parties apprised of the plan?
- Was necessary support and training in place?
- Was it clear who was responsible for implementation and oversight of specific aspects of the plan?
- What was the process for ongoing review and evaluation?
- Was the plan modified as needed?
- Were the individual's interest upheld and balanced against risk to self and others?

#### b. Annual Report

At the end of the Fiscal Year, each area office and facility will complete the Annual Report - Risk Management System-Area/Facility in collaboration with the Regional Risk Management Coordinator. The Regional Risk Management Coordinator will then compile those reports, complete the Regional Annual Report - Risk Management System and submit it to the Central Office Risk Management Director, who will analyze the information and produce the annual DMR Statewide Risk Management Report. Information from individual reviews completed by the Central Office Risk Management Director and Critical Incident Reporting data will also be included in the report, as well as other data to be determined as the oversight system is further developed.

#### c. Annual Report Formats: Areas/Facilities/Regions:

This report will summarize the work of each area office and facility through inclusion of a systems review and a summary of individual reviews conducted. The report will be used by the Regional Risk Management Coordinator to prepare the Region's Annual Report.

SUMMARY OF INDIVIDUAL REVIEWS - This section summarizes the results of individual reviews done by the Regional Risk Management Coordinator and/or the Central Office Risk Management Director.

Unlike the individual reviews which will contain specific information relating to each person, the area/facility report will present information in aggregate form, with patterns and trends identified. For example, if 10 individuals were reviewed, the report might state that there was an ISP team for 8/10 of the individuals, and that in all 8 instances the ISP team was actively involved, or for 4 of the individuals reviewed a weekly meeting was conducted due to the critical nature of the situation, while the remaining 6 were reviewed monthly.

### **D.2.a Individual Reviews**

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Development of plan -

- Description of how plan was developed
- Description of clinical, legal, human rights and other resources accessed in addressing this issue.
- ISP team involvement
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- Was necessary support and training in place?
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## D.2.b Annual Report

At the end of the Fiscal Year, each area office and facility will complete the Annual Report - Risk Management System-Area/Facility in collaboration with the Regional Risk Management Coordinator. The Regional Risk Management Coordinator will then compile those reports, complete the Regional Annual Report - Risk Management System and submit it to the Central Office Risk Management Director, who will analyze the information and produce the annual DMR Statewide Risk Management Report. Information from individual reviews completed by the Central Office Risk Management Director and Critical Incident Reporting data will also be included in the report, as well as other data to be determined as the oversight system is further developed.

## D.2.c Annual Report Formats: Areas/Facilities/Regions

ANNUAL REPORT  
RISK MANAGEMENT SYSTEM  
AREA/FACILITY \_\_\_\_\_  
7/1\_\_\_ TO 6/30\_\_\_

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- NUMBER OF INDIVIDUALS SAMPLED\_\_\_
- Cumulative information regarding individuals reviewed:
  - Description of how plans were developed
  - Description of clinical, legal, human rights and other resources involvement
  - ISP team involvement
  - Were all the appropriate parties apprised of the plan?
  - Was necessary support and training in place?
  - Was it clear who was responsible for implementation and oversight of specific aspects of the plan?
  - What was the process for ongoing review and evaluation?
  - Was the plan modified as needed?
  - Were the individual's interests balanced against risk to self and others?

### SYSTEM REVIEW

- Issues Identified
- Identification of successful strategies and interventions
- Recommendations for modifications and improvements to the DMR Risk Management System

CRITICAL INCIDENT REPORTS: Number of incidents reported\_\_\_\_\_

Identify any issues, successful strategies and recommendations for system improvements.

ANNUAL REPORT  
RISK MANAGEMENT SYSTEM  
REGION - \_\_\_\_\_  
7/1 \_\_\_ to 6/30 \_\_\_

This form provides a summary of risk management activities for the region. Back up pages will provide information specific to each area's and facility's systems and processes. This report will be sent to the Central Office Risk Management Director.

**SUMMARY INFORMATION**                      REGION \_\_\_\_\_

AREA/FACILITY	# OF PEOPLE AT RISK - PLAN NEEDED	# PEOPLE IDENTIFIED IN EACH CATEGORY*			
		1	2	3	4
1.					
2.					
3.					
4.					
<b>TOTAL</b>					

\*(1) 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, exploitation, or regularly neglecting care of supervision needs; (2) the individual's behaviors, including substance abuse, dangerous behaviors, financial mismanagement, frequenting places where there are dangerous people, refusal of some critical services or treatment, or lifestyle choices that put them at risk or that post a risk to others; (3) a congenital or acquired medical condition(s) that requires significant medical safeguards; (4) or any other situation that does not fit into the previous categories listed, but you feel places the individual at serious risk or poses a serious risk to others.

**ISSUES IDENTIFIED:** This section will summarize issues identified during the course of the year. This could include information regarding clustering of different types of risk situations, challenges faced by individuals refusing services or other significant issues.

**D.2.d IDENTIFICATION OF SUCCESSFUL STRATEGIES AND INTERVENTIONS**

This section will highlight "best practices," particular systems or strategies that were successful in your region that might be replicated in the region or statewide.

**RECOMMENDATIONS FOR MODIFICATIONS, IMPROVEMENTS TO RISK MANAGEMENT SYSTEM; ADDITIONAL RESOURCES NEEDED**

This section will point out areas where the risk management system might be strengthened and where additional clinical, legal, training, administrative or other resources might be helpful.

**CRITICAL INCIDENT REPORTS:** Number \_\_\_\_\_

Identify any issues, successful strategies and recommendations for system improvements.



## VI Critical Incident Reporting System

The DMR Risk Management System is expected to reduce the number of very serious incidents that require the immediate notification and involvement of Regional and Central Office senior management. Such incidents will, however, still occur and the Critical Incident Reporting System implemented in 1997, is being revised and automated to improve its timeliness and effectiveness. It will also be incorporated into the Risk Management System.

The Critical Incident Reporting System is used by Regional Directors or their designees to provide immediate communication to Central Office senior management of all major incidents involving individuals at serious risk and to bring prompt support and direction to staff in responding to these incidents. The decision to activate the Critical Incident Reporting System is a judgment call, but the following factors are to be considered as to the types of incidents which are reported:

- Police involvement or indication that a felony may have been committed.
- Serious physical injury, including death, of a consumer or allegedly caused by a consumer.
- Likely media interest or involvement in a situation.
- Involvement of another oversight/regulatory agency (other than DPPC involvement)
- Situations in which a protective order is being sought.

### **Critical Incident Reporting Procedure:**

The first tier of the Critical Incident Reporting System begins when the incident is made known. This will most probably occur at the Area Level, but could also occur at the Facility, Regional or Central Office Level. In all cases, the matter must be brought to the immediate attention of the Area Director (or Facility Director). It is the Area Director, or Facility Director, who has responsibility for the individual and for implementation of a protective or corrective action plan.

The person who has the initial information regarding the circumstances of an incident and the risk involved, will notify the Area Director/Designee, or Facility Director, who will be responsible for completing the Critical Incident form. As directed by the Regional Director, or designee, the form will be activated and electronically routed to the following individuals:

- Area Director and Designee, or Facility Director and Designee
- Regional Director and Designee
- Regional Risk Management Coordinator
- Senior Investigator and Designee
- Regional Legal Counsel
- General Counsel and Designee
- Assistant Commissioner for Quality Management
- Central Office Risk Management Director
- Assistant Commissioner for Field Operations
- Chief of Staff
- Director of Investigations
- Director of Human Rights
- Director of Communications
- Director of Public Information

The form may be routed to other individuals as necessary and appropriate.

## **VII Implementation Schedule**

The Risk Management System Proposal will undergo a process of extensive review and comment both internal and external to the Department. Issues related to risk are challenging and complex and dMR is seeking the wisdom and counsel of all its stakeholders in designing a process for addressing risk in the lives of individuals it supports.

## **VIII Acknowledgements**

Dorothy Mullen, Assistant Commissioner for Quality Management

Sub-Committee Chairpersons

Gail Grossman - Deputy Assistant Commissioner - OQM  
Allegra Munson - Assistant General Counsel - Southeast Region  
Teresa O'Hare - Regional Director - Western Region  
Richard O'Meara - Regional Director - Southeast Region  
Alicia Ellard - Director of Quality Management - Metro Region