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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

June 6, 2005

Sharon E. Carpinello, RN, Ph.D.
Commissioner
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Re: Incident Management Practices at
Selected Psychiatric Centers
Report 2003-S-53

Dear Dr. Carpinello,

According to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we audited incident management practices at five psychiatric centers operated by the Office of Mental Health. Our audit covered the period January 1, 2002 through December 31, 2003.

A. Background

The Office of Mental Health (Department) is responsible for the oversight of all public mental health services in New York State. The Department operates 28 psychiatric centers (Centers) located throughout the State. These 28 Centers provide mental health services to an estimated 75,000 inpatients and outpatients annually.

In the mental health field, an incident is defined as an event involving a client that has or may have an adverse effect on the life, health or welfare of the client and/or another person. The Centers are required by Part 524 of the New York State Codes, Rules and Regulations (Regulations) to report all incidents to the Department. In addition, certain types of incidents must be reported to external parties, such as the Commission on Quality of Care, the Mental Hygiene Legal Services and Board of Visitors, the New York State Central Child Abuse and Maltreatment Registrar, the appropriate District Attorney and/or law enforcement officials, and the client's next of kin or legal guardian.

The Department's expectation is that all incidents be reported promptly. In addition, Department regulations require that certain types of incidents (such as those involving abuse, neglect or serious injury) be reported immediately. "Promptly" and "immediately" are not specified in Regulations or policy, but Department officials stated that their expectation for reporting is for incidents to be reported within 24 hours of occurrence.

The Centers are also required by the Regulations to investigate all incidents. In the case of certain high-risk incidents involving abuse, serious injury or death, special investigations must be performed. Investigations of incidents are to be performed in a prompt manner. Further, investigations of significant incidents must also be thorough. "Prompt" and "thorough" are not defined in the Regulations, but Department officials stated it is their expectation that investigations be completed within 30 days of an incident's occurrence. In addition, the thoroughness of the investigations is governed by Department guidelines, which are contained in a manual entitled *Guidelines for Investigations of Significant Incidents at OMH Facilities*. According to these guidelines, interviews must be conducted with all the people involved in an incident, the findings of the investigation must be documented, and a written investigation report must be prepared.

The most serious type of high-risk incidents are called sentinel events. Sentinel events occur when a client receiving around-the-clock care dies unexpectedly, commits suicide or has sexual relations with a staff member. According to the Regulations, a Center's investigation of a sentinel event must take the form of a root cause analysis, which is a comprehensive analysis of the incident and the circumstances leading up to the incident. Root cause analyses are to be performed in accordance with Department guidelines.

The Centers are required to report incident information electronically through the New York State Incident Management and Reporting System (Reporting System). The Reporting System is maintained by the Department's Bureau of Quality Management, which is responsible for monitoring the quality of client care at the Centers. If an incident must also be reported to one of the external parties that are to be notified in certain circumstances, the Centers are responsible for reporting such incidents directly to each interested party.

The Centers are also required to develop a written Incident Management Plan that includes policies and procedures for identifying, documenting, reporting and investigating incidents. The Plan should also include procedures for reviewing incidents, both individually and in aggregate, to facilitate the development and implementation of preventive and/or corrective action when warranted. Each Center is further required by the Regulations to have an Incident Review Committee that meets at least quarterly to review incidents and discuss incident trends.

B. Audit Scope, Objectives and Methodology

We audited incident management practices at five selected Centers for the period January 1, 2002 through December 31, 2003. The objectives of our performance audit were to determine whether (1) incidents were reported to all required parties within the expected timeframe, (2) incidents were thoroughly investigated and the investigations were completed within the expected timeframe, and (3) Incident Management Plans had been developed and Incident Review Committees were functioning in accordance with requirements.

The five Centers selected for audit were Bronx, Creedmoor, Mid-Hudson, Middletown and St. Lawrence Psychiatric Centers. We selected these five Centers after analyzing incident data for the year ended December 31, 2002. As part of our analysis, we calculated the number of incidents per client at each of the 23 Centers reporting 25 or more incidents that year. We then stratified the 23 Centers into five groups (high, medium-high, medium, medium-low and low incidence rates) based on their incident rates and selected one Center from each stratum for audit. Thus, the five Centers are intended to be representative of all Centers statewide. According to the information on the Reporting System, during the two years ended December 31, 2003, the five Centers reported a

combined total of 9,538 incidents, and 541 of these incidents (5.7 percent) required a special investigation.

To accomplish our audit objectives, we interviewed Department and Center officials. We also reviewed applicable laws, rules, regulations, policies and procedures. We obtained a download of Reporting System data for the two years ended December 31, 2003 and analyzed the data by Center. We also visited the five Centers and reviewed selected incident files at each Center. We reviewed a combined total of 145 incident files (35 each at Bronx and Creedmoor, and 25 each at Mid-Hudson, Middletown and St. Lawrence), generally focusing on incidents that required a special investigation. We also reviewed each Center's Incident Management Plan and the minutes from the Incident Review Committee meetings held at each Center during the two years ended December 31, 2003. Details about our sampling methodologies are provided in the sections of the report that describe our audit findings.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and do our audit to adequately assess the practices of the Department that are included in our audit scope. Further, these standards require that we understand the Department's internal control structure and its compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions, and recommendations.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily-mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

C. Results of Audit

We found that the five Centers are largely in compliance with the requirements for incident reporting and incident investigation. In particular, the Centers are performing special investigations and root cause analyses in accordance with Department expectations. An appropriate Incident Management Plan has been developed by each Center, and Incident Review Committees at each Center meet at least quarterly and regularly review reports describing incident trends at the Centers.

The Centers' compliance with incident management requirements can be attributed to a diligent attitude on the part of Center risk management officials as well as positive direction from the Department's Bureau of Quality Management. We note that Center and Bureau officials stress the importance of ensuring that all incidents are reported, even if the incidents are minor in nature. This approach increases the likelihood that all incidents will be reported and, consequently, will be available for trend analysis. In this environment, corrective actions that promote the safety of clients

are more likely to be taken when necessary.

Improvements are needed in certain Center documentation practices and in the Centers' use of the Reporting System. Improvements are also needed in the Department's monitoring of information on the Reporting System.

1. Compliance with Reporting Requirements

The Centers are required to report all incidents to the Department and some incidents to external parties. Serious incidents should be reported to the Department within 24 hours of occurrence.

To determine whether the five Centers complied with these reporting requirements, we reviewed a sample of 125 incident files (25 at each Center). At Mid-Hudson, Middletown and St. Lawrence Psychiatric Centers, we focused exclusively on incidents that required a special investigation, and at each Center, we randomly selected 25 such incidents from those occurring during our two-year audit period (75 in total). At Bronx and Creedmoor Psychiatric Centers, we selected our samples from all the incidents that occurred during our two-year audit period, and randomly selected 25 incidents at each Center (50 in total).

We found that all 125 incidents were reported to the Department, as required by the Regulations. In addition, 78 of these incidents should have been reported to at least one (and, in many cases, more than one) external party. We determined that, for the most part, these external reporting requirements were met, with the following exception.

According to the Regulations, a client's next of kin or legal guardian must be notified about any incident in which the client is reportedly missing, abused, neglected, injured or dead, unless the client is a capable adult who objects to such notification. Based on the information in the incident files, 75 of the incidents that we reviewed appeared to be subject to this reporting requirement. To determine whether the reporting requirement was met in these 75 instances (i.e., whether the appropriate family member was notified, and if not, whether the client was a capable adult who objected to such notification), we reviewed the incident files and certain other documentation made available to us by Center officials (i.e., the client progress notes maintained by clinical staff, which are used to document such notifications).

We found that, in 28 of the 76 incidents, the documentation indicated that the client's next of kin or legal guardian was notified. However, in the remaining 48 incidents, there was no documentation indicating that (a) the appropriate family member was notified or (b) the client was a capable adult who objected to such notification.

Department officials noted that, according to the privacy requirements of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), a client's objection to such notifications may be expressed orally and does not have to be documented. Thus, it is possible that the family reporting requirement was in fact met for some or even all of these 48 incidents. Notification of a family member may not have been required because the clients may have been capable adults who objected to such notification, and the clients' objections may not have been documented because of the privacy requirements of HIPAA.

However, it is also possible that the family reporting requirement was not met for some or all of the 48 incidents. Notification of a family member may have been required, because the clients

may not have been capable adults or they may not have objected to such notification. If family notification was in fact required but was not provided, the clients' families were not kept appropriately informed about the welfare of the clients.

As a result of this uncertainty, we cannot determine whether the Centers complied with the family reporting requirement. Moreover, in these and other such instances, Center and Department officials have no assurance the requirement was in fact met. To provide such assurance, we recommend the Centers be required to maintain documentation that (1) identifies all the incidents that are subject to the family reporting requirement and (2) positively affirms that the requirement was met for these incidents. To ensure compliance with the privacy provisions in HIPAA, the affirmation of compliance need not indicate whether the appropriate family member was notified or whether the client objected to such notification. Rather, the affirmation of compliance, which could be maintained in the incident file, need only state that the reporting requirement was met.

We also assessed Center compliance with the reporting timeframe for serious incidents (24 hours). A total of 82 of the 125 incidents in our sample were serious incidents, and thus should have been reported to the Department within 24 hours. To determine whether the incidents were reported within this timeframe, we compared the date each incident was reported to the Department (as recorded on the Reporting System) to the date the Center first became aware of the incident (as documented in the incident file).

We found that 66 of the 82 serious incidents were reported to the Department within 24 hours. However, the remaining 16 serious incidents were not reported (i.e., recorded on the Reporting System) within 24 hours. In addition, there was no documentation in the incident files indicating that these incidents were reported to the Department by telephone or email before they were recorded on the Reporting System.

Department officials noted that such documentation may not always be maintained. According to the officials, in some cases, a serious incident may be reported to the Department within 24 hours by telephone or email, but the notification may not be documented in the incident file and the incident may not be entered on the Reporting System for several days. In such instances, the incident would be reported within the expected timeframe, but the Reporting System would show that the incident was reported late and the incident file would contain no documentation to the contrary.

We recommend that Centers reporting serious incidents by telephone or email be instructed to maintain documentation of the notification in the incident file. However, we also recommend that the Centers be instructed to use the Reporting System, whenever possible, for such notifications.

In addition, we obtained for the purposes of analysis a download of Reporting System data for the two years ended December 31, 2003. To provide assurance the download was complete, we selected an additional 25 incident files at each Center to determine whether the incidents were recorded on the Reporting System. We found that all 125 incidents were recorded on the Reporting System.

2. Compliance with Investigation Requirements

Our examination of investigation practices at the five Centers focused on high-risk incidents

that require a special investigation. All such investigations must be completed within 30 days of the incident's occurrence, and must be performed in accordance with Department requirements that are intended to ensure thoroughness. For certain very serious high-risk incidents, a comprehensive analysis of the incident and the circumstances leading up to the incident (a root cause analysis) must be performed.

To determine whether the five Centers complied with the requirements for special investigations, we reviewed a sample of 95 incident files. At Mid-Hudson, Middletown and St. Lawrence Psychiatric Centers, we reviewed the same 75 incidents (25 at each Center) that we reviewed in our assessment of Center compliance with reporting requirements. These incidents were randomly selected from the incidents requiring special investigations at each Center. At Bronx and Creedmoor Psychiatric Centers, we reviewed 20 incidents (10 at each Center), randomly selecting the incidents from those that required a special investigation. In addition, to determine whether the Centers complied with the requirements for root cause analyses, we reviewed the incident files for all eight incidents at the five Centers that required a root cause analysis during our two-year audit period.

We found that special investigations were performed for all 95 incidents in our sample, and these investigations were performed, for the most part, in accordance with the Department's requirements for thoroughness. We also found that a root cause analysis was performed for all eight of the incidents that required such an analysis, and these root cause analyses were performed in a manner that was consistent with Department expectations.

However, when we examined whether special investigations were completed within the expected timeframe of 30 days, we identified a number of apparent exceptions. First, on the basis of the information on the Reporting System, it appeared that 36 of the 95 incidents in our sample (38 percent) were not completed within 30 days. Second, when we analyzed our download of Reporting System data for the two years ended December 31, 2003, it appeared that 206 of the 541 (38 percent) special investigations performed by the five Centers during this period were not completed within 30 days.

To identify the reasons for these apparent delays, we reviewed the incident files for 52 of the special investigations that appeared to take more than 30 days to complete. These 52 investigations included all 36 from our sample and 16 from our download of Reporting System data. We selected the 16 additional investigations by identifying, at each Center, two to four investigations that took the longest amount of time to complete.

We found that 29 of the 52 investigations were actually completed within 30 days, but the investigation's end date was not properly recorded on the Reporting System. We also found that ten investigations were delayed for legitimate reasons that were documented in the incident files. The remaining 13 investigations were not completed within 30 days and there was no documentation in the incident files justifying the delays. We therefore conclude that, while some improvement may be needed in the timeliness of the Centers' investigation process, most of the investigations we reviewed were not unduly delayed by the Centers. The results of our review are summarized as follows:

- In 29 instances, Center staff entered the wrong investigation end date on the Reporting System. In 16 of these 29 instances, Center staff entered the date the incident was reviewed by the Center's Incident Review Committee rather than the date the incident investigation was completed. In the remaining 13 instances, the incorrect end date was

entered for other reasons, such as erroneous keystrokes. In all 29 instances, documentation in the incident file indicated that the investigation was completed within 30 days.

- In 10 instances, the investigation was delayed and not completed within 30 days for legitimate reasons that were documented in the incident file. For example, in some instances, the Center needed to obtain certain information from external parties (such as a death certificate or a police report) before it could complete the investigation, but the information was not provided to the Center within 30 days.
- In 11 instances, the investigation was delayed and not completed within 30 days and there was no documentation in the incident file explaining the delay.
- In two instances, the end date was not recorded on the Reporting System. In both instances, documentation in the incident file indicated that the investigation took more than 30 days to complete, and in both instances, no explanation was provided for the delay in the file.

To provide better assurance investigation end dates are entered correctly on the Reporting System, we recommend the Centers be issued instructions describing the correct process. We also recommend the Department monitor the data on the Reporting System and take corrective action when the data indicates that Department expectations are not being met.

3. Incident Management Plans and Incident Review Committees

Each Center is required to develop a written Incident Management Plan that meets certain specified requirements. Each Center is also required to have an Incident Review Committee that meets at least quarterly to review incidents and discuss incident trends.

We reviewed the Incident Management Plans that had been developed by each of the five Centers. We also reviewed the minutes from all the Incident Review Committee meetings that were held at the Centers during the two years ended December 31, 2003. We found that each Center had developed an appropriate Incident Management Plan. We also found that each Center had an Incident Review Committee, and at each Center, the Committee met at least quarterly and regularly reviewed reports describing incident trends at the Centers. We therefore conclude that the Centers fully met the Department's requirements for Incident Management Plans and Incident Review Committees.

Recommendations

- 1. Establish a policy requiring the Centers to maintain documentation identifying all the incidents subject to the family reporting requirement and positively affirming that the requirement was met for these incidents.*
- 2. Instruct Centers reporting serious incidents by telephone or email to maintain documentation of the notification in the incident file. Also instruct the Centers to use the Reporting System, whenever possible, for such notifications.*
- 3. Issue instructions to the Centers describing the correct process for entering investigation end dates on the Reporting System.*

4. *Monitor the data on the Reporting System and take corrective action when the data indicates that Department expectations are not being met.*

We provided draft copies of the matters contained in this report to Department officials for their review and comment. The Department agrees with our recommendations. Comments of Department officials are included as Appendix A.

Within 90 days after the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office of Mental Health shall report to the Governor, the State Comptroller and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Major contributors to this report were Walter Irving, Brian Krawiecki, Tom Kulzer, Peter Pagliaro, Thierry Demoly, Alicia Bialy and Dana Newhouse.

We wish to thank the management and staff of the Office of Mental Health and the five psychiatric centers for the courtesy and cooperation extended to our auditors during this audit.

Yours truly,

David R. Hancox
Director
State Audit Bureau

cc: Robert Barnes, Division of the Budget



Sharon E. Carpinello, RN, Ph.D.
Commissioner

44 Holland Avenue
Albany, New York 12229

Barbara L. Cohn
Executive Deputy Commissioner

April 28, 2005

David R. Hancox
Director
State Audit Bureau – 11th Floor
Office of the State Comptroller
110 State Street
Albany, NY 12236

Dear Mr. Hancox:

The Office of Mental Health has reviewed draft audit report 2003-S-53 entitled, *Incident Management Practices at Selected Psychiatric Centers*. Our comments to the findings and recommendations contained in the report are enclosed.

The Office of Mental Health appreciates the Office of the State Comptroller's efforts to recommend improvements to the incident management practices at our Psychiatric Centers.

Thank you for your continued help and cooperation.

Sincerely,

A handwritten signature in black ink, appearing to read "B.L. Cohn".

Barbara L. Cohn
Executive Deputy Commissioner

Enclosure



**OFFICE OF MENTAL HEALTH
RESPONSE TO THE OFFICE OF THE STATE COMPTROLLER
DRAFT AUDIT REPORT 2003-S-53
INCIDENT MANAGEMENT PRACTICES AT FIVE PSYCHIATRIC
CENTERS OPERATED BY THE OFFICE OF MENTAL HEALTH**

Overall OMH Comments

The Office of Mental Health wishes to acknowledge the thorough and professional job performed by OSC's audit staff on this challenging assignment. The auditors began this review by learning various aspects of NIMRS, then made site visits to five psychiatric centers, where they performed their tasks efficiently and in a manner that minimized disruption to facility operations.

We were pleased that OSC determined the psychiatric centers were largely in compliance with requirements for incident reporting and incident investigation, and that facility staff were performing special investigations and root cause analyses in accordance with applicable guidelines. OMH agrees with the auditors' conclusion that ". . . [the] Centers' compliance can be attributed to a diligent attitude on the part of Center risk management officials as well as positive direction from the Department's Bureau of Quality Management."

We have a few editing suggestions for your consideration when preparing the final report. The Background section of the report states that OMH operates 27 psychiatric centers; that should be revised to 28. The Background also defines the New York State Incident Management and Reporting System as "Reporting System." We suggest that, instead, it should be defined in the report by its better known acronym, "NIMRS." We also request that OSC amend the title of the report to: "Review of NIMRS and Related Incident Management Practices at Selected Psychiatric Centers."

OMH Response to OSC Recommendations

OSC Recommendation No. 1 – Establish a policy requiring the Centers to maintain documentation identifying all the incidents subject to the family reporting requirement and positively affirming that the requirement was met for these incidents.

OMH Response to OSC Recommendation No. 1:

OMH agrees that it is important that, in cases where family notification is permissible under both federal and state privacy law and regulations, such notifications should be made and documented by appropriate clinical staff. This should currently be the routine

practice. For this reason, rather than establish a new policy (which may suggest it is a new requirement), OMH believes it would be most expeditious and effective to remind facilities of the existing policy and the importance of ensuring that in cases where families should be notified, such notifications will be duly documented in the clinical record. OMH will take appropriate action in this regard.

OSC Recommendation No. 2 – Instruct Centers reporting serious incidents by telephone or email to maintain documentation of the notification in the incident file. Also instruct the Centers to use the Reporting System, whenever possible, for such notifications.

OMH Response to OSC Recommendation No. 2:

The Bureau of Quality Improvement will send out a communication to all of the psychiatric centers to remind them to utilize NIMRS to report serious incidents to OMH Central Office. For those occasions when NIMRS cannot be accessed in a timely manner and the initial notification is made by phone or fax, they will be reminded to document that such notification was made.

OSC Recommendation No. 3 – Issue instructions to the Centers describing the correct process for entering investigation end dates on the Reporting System.

OMH Response to OSC Recommendation No. 3:

The Bureau of Quality Improvement will send out a communication to all of the psychiatric centers to remind them to use the date an investigation was concluded when entering the Special Investigation End Date field in NIMRS.

OSC Recommendation No. 4 – Monitor the data on the Reporting System and take corrective action when the data indicates that Department expectations are not being met.

OMH Response to OSC Recommendation No. 4:

The Bureau of Quality Improvement will continue to monitor the data in NIMRS and follow-up with individual psychiatric centers when indicated.