STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, April 1, 2013

CF OPERATING PROCEDURE
NO. 215-6

Safety

INCIDENT REPORTING AND ANALYSIS SYSTEM (IRAS)

1. Purpose. This operating procedure establishes the guidelines for reporting and analyzing critical incidents as defined below. The analysis of incidents should be considered part of the overall risk management program and quality improvement process of the Department, its employees, and its licensed and contracted service providers.

2. Scope.

a. This operating procedure applies to all critical incidents occurring within the following Department of Children and Families program areas:

(1) ACCESS;

(2) Administration;

(3) Adult Protective Services;

(4) Family Safety;

(5) Mental Health; and,

(6) Substance Abuse.

b. Incidents to be reported are those that occur:

(1) Involving a client, Department employee, or a licensed or contracted provider serving clients of the Department, or involving an employee of a licensed or contracted provider serving clients of the Department in the identified program areas; or,

(2) Involving any licensed public or private substance abuse provider agency licensed in accordance with Chapter 397, Florida Statutes (F.S.), and Chapter 65D-30, Florida Administrative Code (F.A.C.), and their employees. Compliance with this procedure is a condition of substance abuse licensure regardless of whether or not the provider serves any clients funded by the Department.

c. The Incident Reporting and Analysis System (IRAS) allows for the timely notification of critical incidents, provision of details of the incident and immediate actions taken, and the ability to track and analyze incident-related data.

d. The IRAS is not a case management system, and cannot be utilized to capture ongoing and specific case management information, such as the progression of events and actions following the occurrence of a critical incident.

This operating procedure supersedes CFOP 215-6 dated December 1, 2012.
OPR: Assistant Secretary for Operations
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e. State mental health treatment facilities, public and private, are required to adhere to CFOP 155-25, Critical Event Reporting in State Mental Health Treatment Facilities, and are specifically excluded from compliance with this operating procedure.

f. The incident reporting procedures do not replace:

(1) The mandatory reporting requirements to the Florida Abuse Hotline for abuse, neglect and exploitation reporting protocols, as required by law. Allegations of abuse, neglect, or exploitation must always be reported immediately to the Florida Abuse Hotline.

(2) The investigation and review requirements provided for in CFOP 175-17, Child Fatality Review Procedures.

(3) The reporting requirements provided for in CFOP 175-85, Prevention, Reporting and Services to Missing Children.

(4) The reporting requirements provided for in CFOP 180-4, Mandatory Reporting Requirements to the Office of the Inspector General.

3. Definitions.

a. Abuse. Any willful or threatened act or omission that causes or is likely to cause significant impairment to a child or vulnerable adult's physical, mental or emotional health.

b. Department. The Department of Children and Families.

c. Hospital. A facility licensed under Chapter 395, F.S. This includes facilities licensed as specialty hospitals under Chapter 395, F.S.

d. Incident Coordinator. The designated Department or provider/agency staff whose role is to add and update incidents, create and send initial and updated notifications and change the status of an incident. Department Incident Coordinators are designated by their respective Circuit/Region/Headquarters leadership.

e. Neglect. The failure or omission on the part of the caregiver to provide the care, supervision and services necessary to maintain the physical and mental health of a child or vulnerable adult; or the failure of a caregiver to make reasonable efforts to protect a child or vulnerable adult from abuse, neglect, or exploitation by others.

f. Restraint. Any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the individual's body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one's body.

g. Seclusion. The physical segregation of a person in any fashion, or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area.

4. Policy. It is the responsibility of all Departmental personnel, and Department licensed or contracted providers, to promptly report within one business day all critical incidents in accordance with the requirements of this operating procedure. Failure by a Department employee to comply with this operating procedure may lead to disciplinary action. Failure by a Department licensed or contracted provider to comply with this operating procedure constitutes a lack of compliance with licensure status or contract provisions.

5. Critical Incidents To Be Reported.

a. Adult Death. An individual 18 years old or older whose life terminates *while* receiving services, during an investigation, or when it is known that an adult died within thirty (30) days of discharge from a treatment facility. For the Adult Protective Services program, deaths that are a result of the vulnerable adult's documented condition are not subject to critical incident reporting requirements. The manner of death is the classification of categories used to define whether a death is from intentional causes, unintentional causes, natural causes, or undetermined causes.

(1) The final classification of an adult's death is determined by the medical examiner. However, in the interim, the manner of death will be reported as one of the following:

(a) Accident. A death due to the unintended actions of one's self or another.

(b) Homicide. A death due to the deliberate actions of another.

(c) Suicide. The intentional and voluntary taking of one's own life.

(d) Undetermined. The manner of death has not yet been determined.

(e) Unknown. The manner of death was not identified or made known.

(2) If an adult's death involves a suspected overdose from alcohol and/or drugs, or seclusion and/or restraint, additional information about the death will need to be reported in IRAS.

b. Child Arrest. The arrest of a child in the custody of the Department.

c. Child Death. An individual less than 18 years of age whose life terminates while receiving services, during an investigation, or when it is known that a child died within thirty (30) days of discharge from a residential program or treatment facility or when a death review is required pursuant to CFOP 175-17, Child Fatality Review Procedures. The manner of death is the classification of categories used to define whether a death is from intentional causes, unintentional causes, natural causes, or undetermined causes.

(1) The final classification of a child's death is determined by the medical examiner. However, in the interim, the manner of death will be reported as one of the following:

(a) Accident. A death due to the unintended actions of one's self or another.

(b) Homicide. A death due to the deliberate actions of another.

(c) Natural Expected. A death that occurs as a result of, or from complications of, a diagnosed illness for which the prognosis is terminal.

(d) Natural Unexpected. A sudden death that was not anticipated and is attributed to an underlying disease either known or unknown prior to the death.

(e) Suicide. The intentional and voluntary taking of one's own life.

(f) Undetermined. The manner of death has not yet been determined.

(g) Unknown. The manner of death was not identified or made known.

(2) If a child's death involves a suspected overdose from alcohol and/or drugs, or seclusion and/or restraint, additional information about the death will need to be reported in IRAS.

d. Child-on-Child Sexual Abuse. Any sexual behavior between children which occurs without consent, without equality, or as a result of coercion. This applies only to children receiving services from the Department or by a licensed, contracted provider, e.g. children in foster care placements or in residential treatment.

e. Elopement.

(1) The unauthorized absence beyond four hours of an adult during involuntary civil placement within a Department-operated, Department-contracted or licensed service provider.

(2) The unauthorized absence of a forensic client on conditional release in the community.

(3) The unauthorized absence of any individual in a Department contracted or licensed residential substance abuse and/or mental health program.

f. Employee Arrest. The arrest of an employee of the Department or its contracted or licensed service providers for a civil or criminal offense.

g. Employee Misconduct. Work-related conduct or activity of an employee of the Department or its contracted or licensed service providers that results in potential liability for the Department; death or harm to a client; abuse, neglect or exploitation of a client; or results in a violation of statute, rule, regulation, or policy. This includes, but is not limited to, misuse of position or state property; falsification of records; failure to report suspected abuse or neglect; contract mismanagement; or improper commitment or expenditure of state funds.

h. Escape. The unauthorized absence of a client who is committed by the court to a state mental health treatment facility pursuant to Chapter 916 or Chapter 394, Part V, Florida Statutes.

i. Missing Child. When the whereabouts of a child in the custody of the Department are unknown and attempts to locate the child have been unsuccessful.

j. Security Incident – Unintentional. An unintentional action or event that results in compromised data confidentiality, a danger to the physical safety of personnel, property, or technology resources; misuse of state property or technology resources; and/or denial of use of property or technology resources. This excludes instances of compromised client information.

k. Sexual Abuse/Sexual Battery. Any unsolicited or non-consensual sexual activity by one client to another client, a DCF or service provider employee or other individual to a client, or a client to an employee regardless of the consent of the client. This may include sexual battery as defined in Chapter 794 of the Florida Statutes as “oral, anal, or vaginal penetration by, or union with, the sexual organ of another or the anal or vaginal penetration of another by any other object; however, sexual battery does not include an act done for a bona fide medical purpose.” This includes any unsolicited or non-consensual sexual battery by one client to another client, a DCF or service provider employee or other individual to a client, or a client to an employee regardless of consent of the client.

l. Significant Injury to Clients. Any severe bodily trauma received by a client in a treatment/service program that requires immediate medical or surgical evaluation or treatment in a hospital emergency department to address and prevent permanent damage or loss of life.

m. Significant Injury to Staff. Any serious bodily trauma received by a staff member as a result of work related activity that requires immediate medical or surgical evaluation or treatment in a hospital emergency department to prevent permanent damage or loss of life.

n. Suicide Attempt. A potentially lethal act which reflects an attempt by an individual to cause his or her own death as determined by a licensed mental health professional or other licensed healthcare professional.

o. Other. Any *major* event not previously identified as a reportable critical incident but has, or is likely to have, a significant impact on client(s), the Department, or its provider(s). These events may include but are not limited to:

(1) Human acts that jeopardize the health, safety, or welfare of clients such as kidnapping, riot, or hostage situation;

(2) Bomb or biological/chemical threat of harm to personnel or property involving an explosive device or biological/chemical agent received in person, by telephone, in writing, via mail, electronically, or otherwise;

(3) Theft, vandalism, damage, fire, sabotage, or destruction of state or private property of significant value or importance;

(4) Death of an employee or visitor while on the grounds of the Department or one of its contracted or licensed providers;

(5) Significant injury of a visitor (who is not a client) while on the grounds of the Department or one of its contracted, designated, or licensed providers; or,

(6) Events regarding Department clients or clients of contracted or licensed service providers that have led to or may lead to media reports.

6. Guidelines for Reporting Incidents.

a. Notification/Reporting and Actions Taken – Staff Discovery of an Incident.

(1) Any employee of the Department, or one of its contracted or licensed providers, who discovers that a reportable critical incident, as described herein, has occurred, will report the incident as outlined in this operating procedure.

(2) The employee's first obligation is to ensure the health, safety, and welfare of all individual(s) involved.

(3) The employee must immediately ensure contacts are made for assistance as dictated by the needs of the individuals involved. These types of contacts may include, but are not limited to: emergency medical services (911), law enforcement, or the fire department. When the incident involves suspected abuse, neglect, or exploitation, the employee must call the Florida Abuse Hotline to report the incident. The employee must ensure that the client's guardian, representative or relative is notified, as applicable.

(4) Once the situation is stabilized and the staff has addressed any immediate physical or psychological service needs of the person(s) involved in the incident, the employee must report the incident to the Incident Coordinator. Each service provider/agency will use their internal reporting process and timeframes for notifying provider/agency leadership of incidents. *All critical incidents must be entered into IRAS within one business day of the incident occurring.*

(5) In the case of subcontractors, Managing Entities, or Lead Agencies, the responsibility for reporting critical incidents to the Department rests with the Department's contracted provider.

b. Notification/Reporting and Actions Taken by the Provider's/Agency's Incident Coordinator or the Coordinator's Designee.

(1) Each Department licensed or contracted service provider will designate one staff person to be the Incident Coordinator for the provider/agency. This person will manage the provider's/agency's incident notification process. Additional staff may be designated to enter incident information into the IRAS at the discretion of the service provider/agency.

(2) When a supervisor is informed of a critical incident, that person shall verify what has occurred, confirm the known facts with the discovering employee, and ensure that appropriate and timely notifications and actions occurred. The service provider/agency shall develop internal procedures regarding reporting incidents to their Incident Coordinator or designee.

(3) If the incident qualifies as a critical incident according to the definitions contained in this operating procedure, the provider's/agency's Incident Coordinator will review the incident information and clarify or obtain any necessary information before forwarding the incident report to the Department's designated Incident Coordinator or designee. The provider's/agency's Incident Coordinator will provide the information regarding the incident to the Department's Incident Coordinator or designee via the IRAS.

(4) The service provider/agency will ensure timely notification of critical incidents is made to appropriate individuals or agencies such as emergency medical services (911), law enforcement, the Florida Abuse Hotline, the Agency for Health Care Administration (AHCA), or Center for Mental Health Services (for licensed mental health facilities), as required. The IRAS reporting process does not replace the reporting of incidents to other entities as required by statute, rules or operating procedure.

c. Notification/Reporting and Actions Taken by Department's Incident Coordinator(s) or the Coordinator's Designee.

(1) The Department's Incident Coordinator or designee at the Circuit/Region level will review the incident information and clarify or obtain any necessary additional information from the applicable service provider and make revisions as necessary.

(2) The Department's Incident Coordinator or designee will make a determination regarding any required notifications that should be sent to Department leadership. The Department's Incident Coordinator or designee is responsible for ensuring appropriate notification is provided and serves as the contact person regarding the IRAS. In addition to Department's leadership staff, the Department's Incident Coordinator or designee will notify the Circuit/Region Public Information Officer within two (2) hours of any incident that may have Department impact or media coverage.

(3) The entry of the incident into IRAS does not substitute for a direct phone call to the Department's leadership staff when the incident type or severity of the incident warrants such contact. This determination is to be made by the Department's Incident Coordinator or designee in consultation with other Department leadership staff, as needed.

(4) The Department's Incident Coordinator or designee should submit incidents in IRAS even in cases where there is missing information not readily available. When the information is obtained, the Incident Coordinator or designee should submit an update in IRAS as soon as possible.

(5) The Department's Incident Coordinator or designee shall ensure all necessary information is entered into the IRAS in order to have a complete notification. The incident report is considered to be "complete" when the initial notifications have been made and sufficient information regarding the incident has been submitted. Additional information, such as from an autopsy or medical

examiner report regarding an incident can be submitted into the IRAS after the incident has been determined to be “complete.”

(6) Each Circuit/Region shall develop an internal process for reviewing and analyzing trends regarding critical incidents within their Circuit/Region across all Department program areas. Each service provider/agency including Managing Entities will establish a system for reviewing critical incidents to determine what actions need to be taken, if any, to prevent future occurrences and a follow-up process to assure such needed actions are implemented.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

PETER DIGRE
Assistant Secretary for
Operations

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

This operating procedure was revised to specify the Department of Children and Families programs which are subject to the requirements of this operating procedure, and to separate the requirements for reporting adult deaths and child deaths.