

# Pathways to Housing DC

# Safety Manual

## Agency Policies and Guidelines

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## INTRODUCTION

*The policies, procedures and guidelines included in this safety manual were adapted from a compilation of safety guidelines approved by SAMHSA and recommended by the Health Care for the Homeless Clinicians' Network.\* The guidelines in this manual review safety recommendations and policies adopted by Pathways to Housing DC (PTHDC) intended for use in a variety of agency settings, including offices, community members' homes, outreach and other community settings. They were developed for use by both clinical and support staff.*

*The guidelines in this manual are valuable because they clearly state in writing the agency response to escalating and violent incidents. Training in violence prevention, de-escalation, and emergency response policies can increase the confidence and security of staff and the people we serve, thereby decreasing the number of potentially dangerous incidents that occur.*

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## I. Introduction

The primary goal of the Pathways to Housing DC (PTHDC) Safety Manual is to promote a safe space for all those involved in or connected with the Pathways to Housing network, including the people we serve, employees, staff, and visitors. The secondary goal is to ensure that all PTHDC staff are aware of agency policies and behavior guidelines, receive regular safety training, participate in drills, and are empowered to identify and respond to problem behaviors effectively and appropriately before they escalate into a crisis situation.

Regardless of our role at PTHDC, when serving community members we are equally responsible for our own behavior and for protecting the security of people we serve and colleagues alike. All staff and community members are expected to conduct themselves according to the PTHDC Standards of Behavior.

### **Standards of Behavior at Pathways to Housing DC**

All people we serve and staff are expected to behave in a safe and respectful manner. The following behaviors are not considered safe or respectful and therefore will not be tolerated in any setting where PTHDC staff are providing services (offices, homes, community settings):

- Violence
- Threats of violence
- Bringing weapons, drugs\* or alcohol onto PTHDC property
- Public Indecency
- Sexually explicit/discriminatory comments or behaviors
- Sexual Acting out

\*Drugs include synthetic drugs such as synthetic marijuana (K2, Scooby Snax), bath salts and other harmful or non-prescribed, controlled substances, as determined by SAMHSA and/or PTHDC.

### **Definitions**

**Violence-** any act or attempted act of physical aggression intended to hurt or harm oneself, another person or property. Physical aggression includes assaultive physical contact such as slaps, kicks, punches, tripping, pushing, head butting, and shoving, as well as the use of weapons or the destruction of property. PTHDC does not tolerate violence or threats of violence in the office, in homes, or in community settings where staff are working.

**Weapons-** Firearms, knives, clubs, or any device, instrument, material, or substance, animate or inanimate, that is used for, or is readily capable of, causing death or serious bodily injury.

**FD-12-** Application form used by an Officer Agent for emergency hospital admission for observation and diagnosis. This application process may be initiated when an Officer Agent, law enforcement officer, or physician/psychiatrist determines that “a person who is believed to be mentally ill and who, because of such illness, is likely to injure self or others if not immediately detained” (DMH Policy 220.1).

**Officer Agent-** A person who has been certified by the Department of Mental Health, pursuant to DCMR Title 22, Chapter 76, to complete an FD-12 application. See Appendices for the most recent list of PTHDC Officer Agents.

**Crisis Evaluation-** Process in which the leader on duty, psychiatrist, or an Officer Agent is called on by a Pathways staff member to assist with assessment and de-escalation, and, if necessary, to determine the next course of action, (FD-12, call to police).

## II. Prevention

Our goal of preventing violent behavior can be achieved by effectively employing these four basic steps:

1. Observing,
2. Skilled Listening,
3. Talking, and
4. Actions.

The first and best method for managing physically or emotionally assaultive behavior is to anticipate and prevent. Management can be achieved by early assessment. For example, what are her/his needs? Can we meet these needs? If not, what options can we offer the people we serve? (e.g.. "Would you like to speak to a supervisor?") Consider whether there is another facility that can assist the individual and ask, "Can we make a referral for you?" or "Would another time be more appropriate?"

**Observation** As you work, pay attention to the following warning signals that may hint of escalating tensions:

- Defiant attitude
- Excessive swearing
- Aggressive motions
- Unusual demands
- Increase or decrease in voice volume
- Challenging demeanor
- Tightening of jaws
- Deep sighs
- Fidgety movements
- Rapid pacing
- Clenched fists
- Advance or retreat actions

### **Stress and Special Extenuating Circumstances**

It is important to keep in mind the extremely adverse conditions faced by the people we serve. Stressful living situations break down morale and social behaviors, such as courtesy and patience. Under these circumstances, it can be challenging to deal with such a person. If a person is involved with drugs or alcohol, suffers from a mental illness, or has a serious anti-social background, such as a history of criminal activity or prison, their behaviors may be especially challenging.

Another factor exacerbating community members' frustration is the fact that many are interacting frequently with a multitude of private and public agencies to get basic needs met. Consequently, during the process of waiting, answering personal questions and applying for various types of assistance, their frustration level often becomes elevated. By the time that they visit our office, they may be—understandably—in the mood to react negatively towards our requests or instructions.

Although an individual's negative behavior may appear unwarranted, this behavior may be a learned survival technique. Through hard living, some people we serve have found that an aggressive, demanding behavior will get their needs met no matter how inappropriate. Other individuals may react differently by giving up very easily or using passive-aggressive

behaviors—such as walking out—to express frustration. It is important to remember not to take these negative or aggressive behaviors personally. There are reasons for this behavior, and most likely you are not the reason.

Regardless of a person's actions, it is imperative that staff reactions not encourage further negative behaviors or responses. Instead, we can employ simple intervention strategies when a consumer begins to act inappropriately within the work environment.

### **Guidelines**

Here are guidelines to follow in our everyday interactions with people we serve. In order to promote workable relationships, we must address the people we serve with respect and kindness. It is imperative that we do not react to verbal abuse with anger or disrespect. Instead, we should remain calm and in control. Occasionally, people we serve use aggressive and intimidating tactics to get what they want. It is important that we be aware of this type of behavior and learn to respond without being manipulated.

- **Answer questions directly** and assure visitors that their visit is important to us and, if possible, let consumer know approximate wait time.
- **Do not offer lengthy explanations or excuses.** Responding in this manner may increase the community member's frustration.
- Simply **state the facts** and repeat them if necessary. If appropriate, refer the individual to other possible resources.
- **Communicate Quickly when Safety Risks are Possible** – If PTHDC staff/Teams are aware of potential risks, it is required that they inform the Leader on Duty, Program Assistants, Clinical Care Coordinators (CCCs), and others, when applicable.
- **Be Timely in providing Interventions:** Staff members should be flexible to accommodate for people we serve who may need to be seen immediately, upon visiting PTHDC due to recognition of a behavior that is disruptive. If necessary, ACT Teams should have CCC or other staff available to meet with people we serve before 10:00 am.



### III. Assessment

In an effort to maintain a safe working space for staff and the community members we serve, it is important that staff members regularly consider their surroundings and assess potentially dangerous situations, using the following guidelines:

1. Assessment of the type, intent and result of a potential act of violence.
  - a. The type of violence includes the actual act or threat.
  - b. The intent of the violence includes the amount of control the person has over his/ her behavior. For example, is the individual influenced by drugs or alcohol? Is the individual psychotic? Is the threat of aggression intentional or premeditated?
  - c. The results of the violence, including the potential consequences of the threat or action. For example, a person threatening to throw a cup of water presents different consequences when compared to a person threatening to throw hot coffee in someone's face. Consequences, the severity of injury, and, in some cases, intent differ from case to case and must be considered individually.
2. Assessment of the setting where the act or threat of violence occurred.
  - a. Assess the involvement of other people we serve and/or staff. Was there provocation?
  - b. Assess the perceptions of people we serve and/or staff who were present. What did the people we serve and/or staff see and hear?
3. Using information gained from the assessment, staff then uses his or her clinical judgment to address the situation\*, which may include calling on the Leader on Duty for a Crisis Evaluation, should de-escalation attempts prove unsuccessful.

***Assessment can occur over a period of time, during the course of a team meeting, or in a matter of minutes as a situation unfolds.***

\*Any violent act or threat of violence that could result in serious bodily harm should result in an immediate call to the police (911). See section VI: Responding to Emergencies.

## IV. De-Escalation

### **Listening**

The listening and attending skills of therapeutic communication are the most effective tools of averting violent behavior. Even though you may be having a busy, stressful day, remember to clear your mind and pay attention to what the other person is trying to tell you. Don't rehearse your response. Don't defend yourself verbally.

Practice reflective listening. This involves finding out information about what a person is thinking and feeling, and what may be done about a problem. Don't assume that you know. Ask open-ended questions to elicit more informative responses than a simple yes or no answer. Ask **one question** at a time. Listen carefully to what is said. Spending two or three minutes interacting with the consumer may prevent an altercation. After asking questions, it is important to reflect back what you think you are hearing. This summary statement can help ensure that you understand what the person is requesting. The more information you have, the better you will be able to work out a solution.

### **Steps for Effective Listening**

1. Tune in to your personal anxiety level. Assess your feelings and ask yourself if your feelings are interfering with your communication skills.
2. Acknowledge the other person's feelings. Identify the anxiety or anger and acknowledge the potential for violence. You might say, "You seem very upset," "I know how you must feel." or "I'm concerned that you might hurt yourself or others here."
3. Try to elicit the real issue and determine what is behind the anger.
4. Demonstrate appropriate affect. Be sincere and assertive.
5. Convey calmness, control and a willingness to help.

### **Talking**

Being able to talk down an angry, agitated person is a valuable skill for anyone providing services. It is a skill dependent upon having and demonstrating a positive regard and respect for others. While talking, be aware of your voice. The tone of your voice will have an immediate effect upon the other person. It is imperative that your voice remain calm and soft, yet firm. If you become angry or aggressive, or sound angry or aggressive, you will be giving away your control of the situation. Simply state the facts and if necessary, repeat them. Be sure that your tone is not condescending when you repeat any facts. Avoid using your title or authority. Do not offer lengthy explanations or excuses.

### **Do's and Don'ts of Therapeutic, Effective Talking**

#### ***The DON'Ts- verbal***

- Don't threaten the community member or demand obedience
- Don't argue about the facts of the situation. Both of you may be right, but this does not help ease the situation
- Don't tell her/him that they have no reason to be angry

- Don't become defensive and insist you are right
- Don't offer placating responses such as "Everything will be OK" or "You're not the only one."
- Don't make promises you can't keep
- Never challenge the community member or call his or her bluff
- Never criticize the individual
- Never laugh at the person or belittle their concerns (eye rolling, inappropriate side comments to other staff)

### ***The Do's- verbal***

- Do ask, "What can I do to help?"
- Do use simple, direct statements
- Do ask opinions: "In what way do you feel we may be of service to you?" or "How would you like to see the situation resolved?"
- Do offer choices and alternatives: "Can we make another appointment for you at a more convenient time?" Try to leave the community member with options
- Do encourage verbalization of anger rather than acting out
  - Do express your limitation with this verbalization, however, such as expressions or language that are too offensive or threatening. This includes clarifying that certain statements are offensive and not helpful to a successful working relationship (ie: this may include but isn't limited to offensive comments related to race and ethnicity, gender, sexual orientation, gender identity, or nation of origin)
- Do provide reassurance while setting limits and identifying behavioral expectations in a kind manner
- Do assume that the community member has a real concern and that s/he is understandably upset
- Do recognize and acknowledge the individual's right to her/his feelings

## V. Policies for facilities and programs.

Staff are sometimes called upon to respond to situations involving some risk, including threats to self or others, at times, engaging people around specific behavioral concerns. Staff should exercise caution and utilize their best clinical judgement when doing so. In situations where it is unsafe to respond, staff should remove themselves to a safe location and when possible, keep an eye on the situation until the appropriate responder (MPD, DMH) arrives. Each work setting, because of its circumstances and parameters, requires a different response to perceived threats or incidents of violence.

**A. Main offices** Each team has an in/out board near the Program Assistant desk closest to their team space. When each staff member leaves the building, they are to move their magnet from “In” to “Out.” This allows staff on-site to know who is in the building during an emergency or evacuation.

A Leader on Duty is assigned to each week to address crisis situations at the agency. If designated staff person becomes ineffective with an escalating individual, another team member or the Leader on Duty can take over giving the same message. In addition to this, several licensed staff are Officer Agents and capable of determining whether an FD-12 is necessary to admit an individual to CPEP.

**Children & Guests on Property** Access to PTHDC property is limited to those with a legitimate business interest (receiving services, coordinating care, attending meetings or interviews). At this time, Pathways DC does not offer services for children or child care.

**Weapons** Weapons are not permitted on PTHDC property or in vehicles transporting people we serve. We do not store weapons for people we serve. Should a consumer choose to dispose of a weapon, a staff member can assist the consumer with finding ways to dispose of the weapon. Knives can be thrown out. Firearm permits and licenses are not issued in the District of Columbia. If a consumer wishes to turn in a firearm to the police, this can be an opportunity for problem solving ways that the consumer can resolve the issue. Never accept a firearm, or any other weapon, from anyone.

**Work Area Hazards** It's every employee's responsibility to be on the lookout for possible hazards. If you spot one of the conditions on the following list- or any other possible hazardous situation- report it to your supervisor immediately.

- Slippery floors and walkways
- Tripping hazards (cords, food bags, boxes in walkways)
- Missing exit signs
- Stairs with poor lighting
- Dangerously piled supplies or equipment
- Unlocked doors, broken locks
- Leaks
- Blocked aisles
- Blocked fire extinguishers

- Loose handrails or guardrails
- Loose or broken windows
- Blocked fire doors

**Work Area Safety** To ensure your safety and the safety of all individuals on PTHDC property, please observe and obey the following rules and guidelines:

- Fire exits, doors and aisles must be kept clear.
- Keep your work area clean.
- Do not block access to fire extinguishers
- Do not tamper with electric controls or switches
- Do not engage in such other practices as may be inconsistent with ordinary and reasonable common sense safety rules.
- Report any unsafe condition or acts to your supervisor
- Keep vehicles clean and document any repair or maintenance issues in the vehicle log.

**Good Housekeeping** Your work location should be kept clean and orderly. Keep computers, phones, tablets and other machinery away from food and drinks. Clean up spills, drips, and leaks immediately to avoid slips and falls. Place trash in the proper receptacles. Stock shelving units with food bags and other stored items to keep center aisles and walkways clear. Contact your supervisor if more storage space is needed.

**Emergency Evacuations** Exit signs are posted near all exits. They should not be tampered with or removed. Each common area has a floor plan posted on the wall nearest the exit. Floor plans include marked paths for emergency exits. They also map fire extinguishers and alarm systems in the building. Safety training and emergency preparedness procedures are required annually for all staff and quarterly for new employee orientation. Quarterly fire drills are documented in the Emergency Evacuation Drill log.

**Ban from Office** Individuals served at Pathways that have made verbal threats of violence or acted violently should be made aware of PTHDC's Standards of Behavior. These Standards should be hanging in each lobby and designated team area. Additionally, following incidents where violence occurs or is threatened, the acting out individual may be asked to sign a behavior contract during their next visit.

**Behavior Contract:** This contract reviews PTHDC behavior expectations. If a consumer acts out violently, or has a history of violence at PTHDC, the team working with this individual will develop a plan regarding home and office visits which may include sending two staff members for visits, a temporary ban from the office, a review of the behavior contract, or other precautionary measures. This plan should be clearly communicated to the individual involved and appropriate agency staff.

**Staff Communication:** If an individual is banned from the office, an all staff email should be sent out with the individual's photo and the dates of the ban. This information should be included in a google document that is shared with all staff. When the ban is lifted, another email should be sent.

**Documentation:** Staff should document this encounter, file notations in the individual's chart regarding the ban from office, and determine, with the support of the Clinical Director, if our services will be offered to the consumer in the future. If the individual is denied further services, a letter stating this will be handed to him or her at the final encounter. The decision to terminate services must be accompanied by a clear transition plan that includes proper transfer of services and housing. This transition of services occurs ONLY under the most extreme circumstances, as PTHDC seeks to create a reparative experience for all individuals that we serve and is often the last stop for people receiving services.

**B. Consumer Homes** PTHDC has a policy of no violence. While each incident is separately evaluated and a plan of action is determined by the team of clinicians working with the community member in consultation with the Clinical Director, violent acts or attempted violence results in an immediate call to the police. Verbal threats should be taken seriously. Staff should use clinical judgement when threatened verbally, and should wrap up the session and leave the premises, should they feel that their security may be compromised.

***Guidelines for home visits:***

1. Your supervisor needs to know where you will be, and who you will be seeing each day.
2. Before entering the field, identify safety risks based on client history, current living situation, and team member's documentation.
3. Voice any safety concerns to your supervisor during the morning meeting prior to beginning your day's visits.
4. Learn as much as possible about the situation and the community member before setting out to conduct a home visit.
5. Do not visit someone at their home without an in-person introduction from another team member who knows the individual.
6. Always carry business cards or your PTHDC identification card, and a US photo ID
7. Do not remain in a spot where you are privy to a drug deal in process or being set up to "go down." Leave area without drawing attention to yourself.
  - a. If you encounter drug paraphernalia or weapons are visible in the home, this opportunity can prompt a conversation with consumer.
  - b. Never accept or hold any type of controlled substance or weapon. When delivering meds, keep meds concealed and in an unmarked bag/case.
8. Do not escort "unwanted guests" out of a community member's home. If someone

you are serving wants to brainstorm how to escort guests out of the apartment, this can be discussed with team and addressed with individuals that the consumer would like to involve (landlord, police, team, case conference). This planning should be included in the individual's recovery plan (Tx plan).

9. If an individual locks the door behind you, use this as a prompt to ask why they are locking the door and if they feel safe in their apartment. If you do not feel safe, you have the right to request that it be unlocked or to suggest meeting outside of the apartment or somewhere where you both might feel safe.
10. If anything concerning occurs during your day, contact your supervisor and notify them when you have returned back to the office/home safely.

**C. Outreach** When conducting outreach in the evenings, staff should confine themselves to well-lit and/or well-populated areas and refrain from entering alleys or other unsafe locations by themselves.

### ***Safety While Responding to Service Calls in the Community***

1. As normal procedure and best practices, at least two staff will respond to requests for mental health crisis, emergency cases, and/or homeless outreach in the community for reasons of safety, logistics, and clinical decision-making. If two staff members are unable to respond, a sole staff member may respond when partnering with community-based human service staff, law enforcement, or security officers.
2. When receiving a call for a community member who has a history of past or current violence, access to weapons, or other significant safety concerns; staff will discuss the case with a supervisor before responding in the field. During this process, staff will check records for recent updates on the individual's status if their name is known. In addition, a decision will be made whether law enforcement or security officers need to be present to ensure consumer/staff safety during the response.
3. When responding to calls, cell phones will be kept on staff's person—not in purses or backpacks—so staff does not get separated from that equipment and can access them expeditiously.
4. Staff will assess the overall safety of the environment while approaching the site and modify plans accordingly.
  - Staff will not approach areas without law enforcement or security present if they hear loud threatening voices, loud noises, and/or hear/see evidence of a weapon or destruction of property.
  - Upon approaching, staff will survey the area for exits, weapons, items that could be used as weapons, and evidence of drug paraphernalia or alcohol use. Staff will use caution with intoxicated individuals due to the potential for unpredictable and violent behavior.
  - Staff will always keep an eye on the consumer and other individuals

present—never turning their back— and stay as close to an exit point as possible.

- Staff will stay out of confined rooms or rooms that contain potential weapons (i.e., kitchens). If meeting in such a room is necessary staff should stand or sit closest to the exit.

5. Staff will be sensitive to issues of confidentiality (using the community member's name) when working in public areas (e.g., consumer's place of work, store, shelter). Staff will treat all people we serve and other individuals present with respect, calm demeanor and level of voice, and use non-threatening body language and other active listening skills.

6. Unless it is a self referral, staff will refrain from engaging with the referred individual and communicating any details about the purpose of the visit until they are able to speak with the referring agent. Staff will gather as much information about the case/situation including: confirmation of initial concerns, relevant information from various knowledgeable parties, presence of weapons, and safety procedures for the site. Staff will provide the reporting agent with their name(s) and contact information for follow-up communication.

7. Staff will agree upon code words and/or signs to be used in the event of a threatening or violent situation. If such a situation occurs at the site and law enforcement or security officers are not present, staff will immediately communicate to each other the need to leave the site. Using non-violent crisis intervention skills, staff will remove themselves from the scene and call 911 as needed.

If staff cannot leave the site safely, they must avoid becoming separated from each other and may need to secure themselves into a room or private office. Alternatively, if outdoors, staff should interpose natural obstacles between themselves and the threat while reassessing the safety of departing. In either context, staff must call 911 and inform the operator if any weapons are present or have been implied.

8. To confirm safety of staff and consumer in the field, staff will call a supervisor once the intervention is completed and a disposition has been determined. If the responding staff has not contacted the supervisor within an appropriate length of time (depending on the type of intervention) he/she will call the responding staff members to check on safety and status. If he/she is unable to reach staff in the field, and several attempts are made to reach them, 911 will be called and the staff's last known location will be given.

9. Staff experiencing a threatening or violent situation will receive a debriefing and/or counseling by the program director or team leader in a safe place within 24 hours. Staff experiencing these situations will not be required to make another response in the field for the remainder of their current shift.



10. Staff will update the consumer's electronic medical record immediately to indicate critical information regarding history of violence, access and use of weapons, and any other "red-flag" safety-related issues in order to bring these concerns to the immediate attention of staff reviewing the case. If applicable, the staff person will complete a Major Unusual Incident Report and provide it to the supervisor.

#### **D. Vehicles**

1. Before transporting anyone, assess mood and evaluate for safety concerns. If an individual is upset and their behavior is escalating, do not provide transportation.
2. Only transport Pathways consumers and other service providers (home health aids).
3. Do not transport people we serve that are carrying weapons.
4. If a consumer is in your vehicle, or a Pathways vehicle, during the time of an accident (no matter how minor), a Major Unusual Incident (UI) report must be completed. See Appendix D.
5. When transporting people we serve in a car, be mindful of the seat that the individual is sitting in. The safest place for a passenger to sit is behind the passenger seat. The reason for this is that an agitated passenger is least likely to grab control of the steering wheel in this position. If an individual is escalating prior to entering your vehicle, do not enter the vehicle until the individual calms down and you feel safe to operate the vehicle. Use your clinical judgement and speak to your supervisor prior to the visit, if you do not feel comfortable transporting a client that you have been assigned to work with.
6. Always wear a seatbelt and require that people we serve wear a seatbelt.
7. Vehicles must be cleaned out prior to returning the keys. If a vehicle is dirty (interior or exterior) before you begin a trip, it must be noted in the vehicle log.
8. Each vehicle is equipped with an emergency vehicle kit and a mini dustpan and brush for cleaning in the trunk. If these are missing, note this in the log.
9. Each vehicle is equipped with a small first aid kit and hand sanitizer in the glove compartment. If these are missing, note this in the log.

## **VI. Responding to Emergencies**

In the event that an individual's behavior escalates beyond communications becoming threatening, it is important to remind him/her that if they can remain calm and discuss the problem, we will attempt to serve them and work out a solution. At the same time, if the threatening persists, services should be terminated and the individual asked to leave (if at the office). If this occurs in the community, and threats persist after the first warning, the staff member should elect to terminate services for the day.

### **Verbal Interventions**

*Do Not Put Your Hands on Anyone.* Pathways to Housing DC does not support physical interventions. If someone has escalated to a place where they have lost control and are at-risk of being physically aggressive toward others, or have begun to do so, call 911 and explain the gravity of the situation, quickly. (See below: Calling 911).

### **Containment Procedures**

If the individual acting out cannot or will not be contained, it may be necessary to clear the areas of other clients. In this case, the auxiliary leader and support staff should usher other clients quickly and calmly into another waiting room, or outside, if warranted. Make an attempt to separate someone who is disruptive from others as to avoid vicarious trauma, and to attempt to de-escalate them (or remove others from immediate area).

### **Threats and Crisis Events**

In situations where the threat of violence or serious bodily injury occurs, the police should be called to intervene (911). If occurring at the main office, the Leader on Duty should be called on for support, following your call to the police.

#### **Calling 911:**

- Always request a Crisis Intervention Officer (CIO)\*
- Alert the dispatch operator that staff/client is in immediate danger and that we need an immediate response
- If an FD-12 is anticipated or in process, request that the responding police bring "transport" \*
- Provide the location of the building where the emergency is occurring

\*If dispatch operator isn't aware of what you mean by requesting transport and a CIO, request to speak to a Watch Commander

If any staff member notices a consumer is starting to escalate on-site, that staff person can conduct an all page (\*11) and request that a member of the consumer's team and the leader on duty respond immediately. On-site staff and the Leader on Duty may also request additional staff support using the all page function (\*11) stating, "we need immediate staff assistance at \_\_\_\_\_ location."

### **Violent Crises On-site**

When a leader on duty or on-site staff request immediate staff assistance due to violence on-site, the responsibilities of responding staff include:

1. Removing dangerous objects from area.
2. Clearing other staff and people we serve away from situation.
3. Direct or cue the other team members. This may include requesting a staff member to send an all staff email about the FD-12 in process, making an all-staff announcement via the intercom, instructing staff via intercom on directions for staying safe in their area.
4. Calling 911 if it hasn't already occurred, or if additional concerns demand the need for a second call.

### **Post-Crisis Response & Debrief**

The Leader on Duty will immediately:

1. Call for a quick debrief with all those involved,
2. Send an email out to the entire staff stating the crisis has been resolved and what the disposition of the consumer is. (This task may also be done by the auxiliary leader as the crisis leader may still be busy.)
3. Ensure that staff involved complete an Unusual Incident report, within 24 hours.

The acting out individual:

- *May* be immediately escorted (by staff and /or police) from the building.
- *May* meet with their Team, or assigned staff, if they are able.
- **Is** banned from the building for at least the remainder of the day, and maybe longer depending on the level of the behavior (see attached letter re. Ban).
- **Will be** reminded of Pathways to Housing DC's Zero Tolerance policy on violent behaviors, review what they can do differently in the future, and work with their assigned Team/staff on de-escalation techniques.
- *May* be required to participate in a behavioral contract to avoid future problems

### **Staff Debrief**

Staff experiencing a threatening or violent situation will receive a debriefing and/or counseling by the program director or team leader in a safe place (e.g., office, hospital) within 24 hours. Staff experiencing these situations will not be required to make another response in the field for the remainder of their current shift, with necessary adjustments made to their productivity. PTHDC offers access an Employee Assistance Program (EAP). Some of the services offered through EAP include counseling following a violent incident and debriefing crises that occur in the workplace. All staff are encouraged to utilize EAP services, as needed.

### **Consumer Debrief**

Other consumers that were involved in the event or witnesses to the event should be given an opportunity to debrief the experience and the impact it had on them. These individual's names should be included in the Major Unusual Incident report, listed as witnesses. Their team should be notified about their role in the event, so that the team can follow up appropriately.



# Appendices

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## **Appendix A: Crisis Evaluations and Officer Agent FD-12 Procedure**

### **Preparing for an FD-12 and Crisis Evaluation**

It is rare that a consumer's behavior escalates rapidly without the team already being aware of decompensation in days leading up to an incident. Because FD-12 procedures can be highly traumatic for the individuals involved and at times result in little more than a brief stop at CPEP, we must use caution and plan ahead for an FD-12, including the team in the decision whenever possible.

It is advised that teams discuss the individuals that are potentially decompensating and may need a crisis evaluation weekly during the morning meeting.

### **Events leading to 911 call**

When a consumer's behavior has escalated, de-escalation techniques are not proving to be effective, and s/he is choosing to remain on PTHDC property despite requests to leave, the police should be called to help escort the consumer off the property.

If the consumer is acting violently the police should be called immediately (911).

### **Events leading to a Crisis Evaluation/FD-12**

If a consumer's behavior is not immediately violent, but such that they *may escalate quickly* and become dangerous to themselves or others, staff can call for a Leader on Duty or Officer Agent to conduct a crisis evaluation of the consumer's behavior. This includes situations in which the consumer's behavior is impacting their immediate health (medical issues that could lead to rapid decompensation). A Crisis Evaluation *may* include the determination that an FD-12 application be completed.

### **Process for Requesting a Crisis Evaluation**

#### **At the Main Office**

1. The front desk or attending staff member calls the psychiatrist/Leader on Duty requesting a crisis evaluation. If the Leader on Duty is not an Officer Agent, the psychiatrist should be called. A psychiatrist must have seen the individual within the past 72 hours in order to conduct an FD-12. This requirement does not apply to Officer Agents.
2. The front desk or staff member calls the ACT/CM team to identify a team member that will participate in the assessment. If the team is not available then someone else who knows the client should be involved.
3. The front desk or staff calls a member of the safety team to the area, to promote safety of the clients, staff and assess the general milieu.
4. The Officer Agent and team member select a safe place to meet with the client – (outside, training room, a large area where there is the least amount stimulation).
5. Staff who are not involved in the situation should stay with their clients

#### **At the Court Clinic**

Consult with Officer Agent at Court Clinic to establish plan of action.

#### **In the Community/Outreach**

Determine if you are in immediate danger. If so, remove yourself from the situation.

Regardless, call your supervisor to develop plan of action, which may include calling mobile crisis or a PTHDC Officer Agent to respond.

**During Crisis Evaluations**, two staff members should be present (team member, pscyh/leader on duty). Team leader or supervisor should be present or notified by phone.

After FD-12 decision is put into motion the psychiatrist or Officer Agent will

1. Fill out the FD-12 form
2. Call 911 or ask a staff to call 911
3. Staff email is sent – “FD-12 in progress & location”
4. Give FD 12 form to staff to give to police
5. Team is to coordinate who on the team will be going to CPEP to meet the client
6. Psychiatrist/Officer Agent will call CPEP for a heads up
7. Front desk or staff can call psychiatrist/Officer Agent for any support in speaking with police.
8. Staff email to announce FD-12 is over

**The following staff members are Officer Agents:**

Will Doyle, Amanda Harris, Khristine Heflin, Dr. Abby Morris, and Alan Pickett

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## **Appendix B: Leader on Duty**

The Leader On Duty is an integral part of the Agency, providing immediate relief to Staff who require assistance related to the care of clients experiencing crisis, in order to promote wellness, recovery and rehabilitation. Responsibilities are implemented within the framework of agency policy, professional ethics and regulatory guidelines. The Leader On Duty rotates among designated members, and collaborates with Staff to ensure optimal use of time/assignment of duties.

### **RESPONSIBILITIES**

- Respond within reasonable timeframe to requests by staff for assistance, based on assessment of situation (ex. Immediate response may be necessary during an emergency such as a medical/psychiatric/safety situation vs. other situations where someone can/will wait for a meeting).
- Assess all presented situations as individual events and coordinate with staff to develop, and provide direction to address/resolve presented issue/s (ie. Safety emergencies/issues, approving emergency loans/petty cash disbursement, keying into offices for meds, etc., addressing Consumer grievances, liaising with landlords, DMH, DHS, and other Stakeholders, responding to Facilities issues, including partnering with Landlord, taking lead in Disaster Response mobilization).
- Ensure on-site availability during assigned Leader On Duty week, and communicate when needing to leave office and secure alternative Leader On Duty in your absence.
- Act in supervisory capacity, when necessary, to address immediate staff and consumer needs; coordinate with direct supervisors, HR, and Executive Director when warranted.
- Meet directly with people we serve, when necessary.
- Provide crisis-response, following PTHDC safety policies and procedures
- Officer Agent duties are suspended for LOD if FD-12 requires community response.
- Access money from Team safes, and record transactions according to policy/procedures.
- Ensure emotional and physical safety of staff and people we serve during crisis events, drawing from Trauma-Informed Care trainings and model.
- Carry Leader On Duty Keys to ensure access to Doctors' offices, Nurses Offices, Safes, Key Box, and all doors within the Pathways to Housing DC Office.
- Assist with liaising between departments to ensure effective flow of services (ie. Finance Department, Housing Department, Senior Leadership, etc.).



## Appendix C: Ban from Office Letter Template



Date

Re. Ban From Office

Dear \_\_\_\_\_, (Consumer Name)

This letter is to inform you that your behavior/s, while in the Pathways to Housing DC office recently (use dates), evidenced by (provide example), have/has compromised the physical and/or emotional safety of others. It is important for everyone to feel safe when receiving assistance in our offices, and therefore we have made the decision to ban you from the office for the next (\_\_\_days, weeks, months, etc). During this time we will work with you in the community to meet your needs, including supporting your interest in returning to the office, if this is an identified goal.

If you believe this decision is unfair, you may file a formal grievance in writing or request an appointment with the Supervisor of the person/Team you work with. Attached is the form to be used if this circumstance is applicable.

\_\_\_\_\_  
Pathways to Housing DC Staff Signature

\_\_\_\_\_  
Consumer Signature

## Appendix D: Major Unusual Incidents

PTHDC is required to report incidents involving people we serve and staff that resulted in a 911 call, or incidences in which the following occurred:

- Death of a Consumer
- Physical Injury (Consumer or staff)
- Medical Emergencies (emergency hospitalizations)
- Psych Emergencies (FD-12, Mobile Crisis)
- Suicide Attempt
- Missing Consumer
- Physical/Sexual Assault of Consumer
- Fall (on PTHDC property or while staff was present)
- Illegal drug possession/distribution on provider premises
- Vehicle accident (consumer is passenger)

In general, the Major Unusual Incident report should be completed by the staff member who first aware of the incident. The forms for reporting such incidents are located in Credible. Major Unusual Incident reporting guidelines for the Department of Behavioral Health (formerly DMH, now DBH) are also included in Appendix G of this Safety Manual. PTHDC is required to submit MUI reports within 24 hours of the incident, or within 24 hours of the staff member becoming aware of the incident.

ACT and CS staff should complete the DMH Unusual Incident Report visit type, while Case Managers should use the DHS Unusual Incident Report visit type.

Important information the needs to be included in the report includes: the full name and gender of the consumer/s, staff, and any emergency personnel, other individuals, and agencies involved (medical, legal, witnesses), date and time of incident, location of incident, detailed description of incident, current status of consumer, and the planned action to prevent re-occurrence.

Any questions about whether an incident should be reported as a Major Unusual Incident should be directed to your Team Leader, Manager, or a QI staff member.

In some cases DBH requires verbal notification within an hour of the staff member becoming aware of the incident. In these cases, a supervisor must call the Office of Accountability at DBH. The following incidents require an immediate call (within one hour):

- Death of a consumer
- Incidents requiring notification of a law enforcement agency, including US Secret Service for White House cases
- Incidents involving the Office of the Inspector General (OIG) for the District of Columbia
- Incidents requiring notification of Adult Protective Services, when related to performance of services of a DBH Contracted Provider
- Incidents requiring notification of Child Protective Services
- Incidents that result in PTHDC receiving inquiries from the media regarding not yet reported MUIs

- Incidents related to consumer care that raises immediate concerns from the determination of the provider agency regarding the health and safety of any consumer, employee, or visitor.

All verbal notifications should be followed up by an MUI report, sent in to DBH within 24 hours. Supervisors calling DBH for verbal notifications should use the following contact numbers:

- During **normal business hours** (8:30 a.m.-5 p.m. Monday-Friday), call the Division of Quality Improvement at the Office of Accountability (OA) at **(202) 673-2292**
- During **outside** normal business hours (**before 8:30 a.m. or after 5 p.m. Monday-Friday, weekends, and holidays**). Contact the Administrator on Call (AOC) for DBH by calling **Access Helpline** at **1 (888) 793-4357**. Ask to be connected to the AOC. The AOC shall contact the Deputy Director QA/QI designee.

## Appendix E: Fire Drills and Emergency Evacuations

<b>Title:</b> Facilities safety and fire drills	
<b>Procedure #:</b> 008	<b>Category:</b> Administration
<b>Issue/Revise Date(s):</b> 10/15/2013	
<b>Executive Director Approval:</b>	

**Summary of Revisions:** Procedure and Practices were updated to coordinate with the agency's Facility Emergency Response Plan. Operational changes to the Procedure or Practices were made to include the "All Page" function for staff announcing a fire in a separate building (Dialing \*11).

**Purpose:** To ensure the safety of the facility and all of those who utilize the space.

**Scope:** This procedure applies to all Pathways to Housing programs, services, departments, and their staff.

**Procedures:** Fire is one of the most potentially hazardous events that can occur in a facility. In order to assure a high level of preparedness, fire safety training, fire safety inspections, and fire drills will be conducted on a regular basis.

1. All employees are trained on Fire & Life Safety upon hire and annually, thereafter.
2. Fire drills are conducted at all Agency facilities every 3 months.
3. The fire systems and other emergency equipment are maintained according to National Association of Fire Protection standards.
4. The Facility Emergency Response Coordinator (FERC) is responsible to ensure that the practices set forth in this procedure are followed in all facilities for which they are responsible. The FERC must also ensure that the fire safety requirements of the jurisdiction where they are located are followed.

### Definitions:

**System Alarms** are manually operated and can be activated when a fire is discovered. There are three system alarms at the 101 Q St. location, located by the main exit of each building (A, B and C).

**Smoke detectors** are located throughout the facility and activate with smoke

**Fire extinguishers** are portable devices of varying size that smother the fire

**Fire zones** separate a facility into secure areas, and are intended to prevent the spreading of the

fire until the fire department can arrive.

### **Identifying a Fire:**

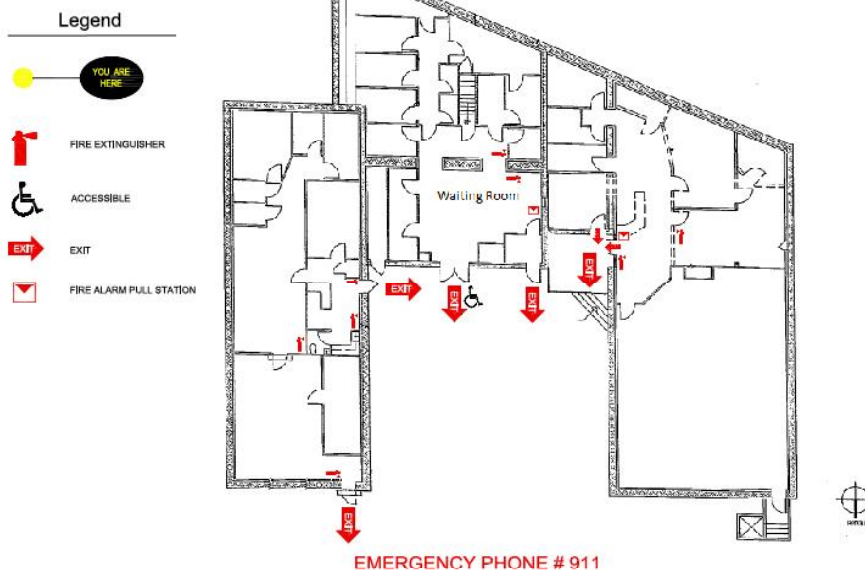
- If you discover, or suspect, a fire, yell "Fire!" with the location and then press the fire button on the nearest system alarm. Call, or have someone else call "911" immediately and make an announcement over the public address system (\*11) stating **"A fire has been reported at location..... evacuate the facility at once through the nearest fire exit and do not return until advised to do so by the fire department."**

### **Location of Exits & Evacuation Routes:**

- In the event of a fire you will be expected to evacuate to an area outside of the facility and assemble at the designated assembly location across the street. Therefore, it is essential that you become familiar with the location of the emergency exits and the evacuation routes.
- Exits are indicated by the lighted EXIT signs hanging from the ceiling or on the wall near the exit.
- The Facility Emergency Response Coordinator (FERC) is responsible for ensuring that Building Diagrams / Evacuation Routes are posted on each floor in all facilities. Below is a sample map showing main exits and fire extinguisher locations for the first floor.

#### **EMERGENCY EVACUATION MAP**

#### **First Floor**



### **Fire Zones:**

- Facilities are typically divided into zones by fire-rated walls and doors. The purpose of

the zone is to contain the fire so an orderly evacuation of the facility can be made, and allow time for the fire department to arrive and put out the fire.

- Fire-rated walls and doors must be maintained and not violated by construction or repair work. Unless fire doors have magnetic holdback devices, they must be kept closed at all times.

### **Location of Fire Alarm Systems:**

- The 101 Q Street facility is equipped with fire alarms systems as well three security system alarms. The fire alarm system may be activated automatically through the smoke/heat detectors. The system alarm can be activated manually by activation at the Master Control Panel(s) near each main entrance.
- Staff working at facilities where an alarm system exists will be trained on how the system works and where the devices are located. This occurs at new staff orientation and annually for all staff.
- The security alarms are not connected across buildings.

### **Activation of the Fire Alarm System:**

The following is a typical system operation; keep in mind that yours may not have all of these devices.

The PTHDC security system alarm is not directly connected to a monitoring company, therefore a staff member must call "911" to report the fire.

### **Silencing & Resetting the Fire Alarm System:**

- The system should not be silenced until authorized by the Fire Department.
- Instructions for silencing the system should be in the facility's Facility Emergency Response Plan (FERP) Binder.
- The system should never be reset without Fire Department authorization.

### **Portable Fire Extinguishers:**

- Portable fire extinguishers are for fighting Class A, B & C fires and are at well marked locations throughout the facility.
  - **Class A (paper, etc.)**
  - **Class B (oil and grease fires)**
  - **Class C (electrical fires)**
- The Class ABC fire extinguisher discharges a white powdery substance.
- All extinguishers operate in a basic four-step process.

1. **Remove extinguisher from the bracket.**
  2. **Pull safety ring out of the handle.**
  3. **Aim nozzle/hose at the base of the burning item (do not aim into the smoke or flames.)**
  4. **Squeeze the handles together.**
- Once an extinguisher has been used, it should not be re-hung in the wall bracket until it has been checked and re-charged.

### **8. Inspection of Fire Alarm Systems and other Emergency Equipment:**

- All Fire Alarm Systems and Fire Safety Equipment will be inspected and serviced by qualified contractors in accordance with applicable fire safety codes and regulations. Additionally all such systems and equipment will be visually inspected by the Administration & Facilities Department during quarterly facility inspections.

### **9. Fire Drills:**

Fire drills are conducted for the purpose of providing occupants of the facility with experience in exiting through approved exits. In order to reduce the hazardous effects of any potential fires, it is essential that all personnel are instructed in and become adept at responding to this type of hazard. For this reason, the facility must conduct fire drills every 3 months.

- The Facility Emergency Response Coordinator (FERC) is responsible for ensuring that fire drills are conducted every 3 months.
- Fire Drills will begin by announcing “FIRE DRILL” and either ringing the manual PULL alarm, activating a smoke alarm, or using a red flashing light. During a drill, all personnel must act as though it were an actual fire, e.g.: enact the R.A.C.E. procedures as indicated below.
- If an electronically connected/monitored Fire Alarm System needs to be activated for drill purposes, both the monitoring company and the Fire Department shall be notified by the person in charge **prior** to performing the drill.
- All occupants of a facility are required to evacuate during a drill.
- All fire drills are to be recorded on the attached Fire Drill Report (or another form that covers the same information) and these will be filed and retained by the FERC at each facility.
- Administrative Services staff will review the Fire Drill records during quarterly inspections and report any discrepancies to the responsible FERC.

### **10. R.A.C.E. Procedures:**

**RESCUE:** Ensure that all occupants safely evacuate the facility using the nearest fire exit and do

not allow them to return to the building without Fire Department authorization. As soon as possible, the Assembly Monitor will do a headcount to assure that all occupants of the facility are accounted for.

**ALARM:** If the alarm has not been activated, either activate it yourself or have someone else do it. Call 911 if the system is not monitored. Make an announcement over the public address system (dial \*11) as follows, or, if one does not exist, yell "**A fire has been reported at location....., evacuate the facility at once through the nearest fire exit and do not return until advised to do so by the Fire Department.**"

**CONTAIN:** If possible, shut off the air conditioning, heating and oxygen. Close doors and windows in the area of the fire, without endangering yourself or the people served. If occupants are unable to evacuate the facility, close the doors to other areas and instruct occupants to remain in their rooms with the doors closed until help arrives.

**EXINGUISH:** Only attempt to fight the fire if you can do so safely and have knowledge of proper fire extinguisher use. To use, pull the pin, squeeze the trigger, aim to the base of the fire and sweep.

### **11. Other Fire Safety Rules & Regulations:**

In addition to drill training and knowledge of the fire systems and their operations, it is also important to understand and practice fire prevention techniques. Observance of basic safety rules and regulations will help to assure facility-wide preparedness.

#### Regulations for Waste Disposal

- All trash or discarded items should be properly disposed of. Do not dispose of items that are hot in the regular trash containers. These items should be allowed to cool before disposal. Directions for disposal marked on any other items should be followed.

#### Safety Rules of the Facility

- Become knowledgeable of all safety policies and rules and adhere to them. Rules, such as those governing the use of oxygen, designation of Smoking Areas, etc. should always be observed. If applicable, the regulations for the storage and handling of Oxygen should be posted in the Oxygen Storage Areas.

**12. Fire and Life Safety Training:** Fire and life safety training shall be held annually for all employees and initially for all new employees.

The Facility Emergency Response Coordinator is

\_\_\_\_\_.



**Pathways to Housing Safety Manual**  
**Staff Acknowledgement of Understanding**

***I have read and understand the PTHDC Safety Manual and its Appendices. In signing this document I agree to follow the guidelines set forth in this manual and direct any questions to my supervisor.***

***Printed Name:*** \_\_\_\_\_

***Signature:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

# Department of Mental Health TRANSMITTAL LETTER

<b>SUBJECT</b> <b>Reporting Major Unusual Incidents (MUIs) and Unusual Incidents (UIs)</b>		
<b>POLICY NUMBER</b> <b>DMH Policy 480.1C</b>	<b>DATE</b> <b>MAY 03 2012</b>	<b>TL#</b> 165

**Purpose.** This policy describes the reporting of Major Unusual Incidents (MUIs) to the Department of Mental Health (DMH) Office of Accountability (OA). It is differentiated from the reporting of unusual incidents (UIs). This policy does not preclude, and is not a substitute, for internal notifications and/or reporting through supervisory levels required by a provider's internal policy.

This update of the DMH Policy 480.1B includes the following: (a) modifications in the MUI and UI form (Exhibit 3); (b) the reference to DMH Policy 662.1 Major Investigations, (c) change in email address for electronic submission of MUI reports ([MUI.OA@dc.gov](mailto:MUI.OA@dc.gov)); (d) incident reporting to OA by the Psychiatric Residential Treatment Facilities (PRTF), and (e) emphases on follow-up reports, major investigations and mortality review timelines.

**Applicability.** Applies to core services agencies (CSAs), Saint Elizabeths Hospital (SEH), DMH contractors providing mental health services or supports (including those out-of-state, e.g., residential treatment facilities), Community Residence Facilities (CRFs), all other providers of mental health (MH) services or supports that are licensed or certified by the DMH, and to the Mental Health Authority (MHA) offices and programs.

**Policy Clearance.** This policy was cleared through the Deputy Director, Office of Accountability.

**Implementation Plans.** A plan of action to implement or adhere to a policy must be developed by designated responsible staff. If materials and/or training are required to implement the policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible to follow through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed within sixty (60) days after the date of this policy.

**Policy Dissemination and Filing Instructions.** Managers/supervisors of DMH and DMH contractors must ensure that staff is informed of this policy. Each staff person who maintains policy manuals must promptly file this policy in Volume I of the DMH Policy and Procedures Manual and contractors must ensure that this policy is maintained in accordance with their internal procedures.

\*If any DMH policies are referenced in this policy, copies may be obtained via DMH Intranet on the dmhweb or the District Internet at [www.dmh.dc.gov](http://www.dmh.dc.gov) Hard copies of DMH policies may be obtained from DMH Policy Support Division by calling (202) 671-4070.

## ACTION

### REMOVE AND DESTROY


DMH Policy 480.1B  
DMH Major and Unusual  
Incident Reporting Procedures  
dated December 22, 2005

### INSERT

DMH Policy 480 1C  
Reporting Major Unusual Incidents (MUIs)  
and Unusual Incidents (UIs)

  
Stephen T. Baron  
Director, DMH

  
Date

GOVERNMENT OF THE DISTRICT OF COLUMBIA  DEPARTMENT OF MENTAL HEALTH	Policy No. 480.1C	Date MAY 03 2012	Page 1
	Supersedes DMH Policy 480.1B, Reporting Major Unusual Incidents (MUIs) and Unusual Incidents (UIs) dated October 21, 2010		

Subject: Reporting Major Unusual Incidents (MUIs) and Unusual Incidents (UIs)

1. **Purpose.** The purpose of this policy is to establish reporting procedures for Major Unusual Incidents (MUIs) and Unusual Incidents (UIs) to the Department of Mental Health (DMH). This policy **does not** preclude, and is not a substitute, for internal notifications and/or reporting through supervisory levels required by a provider's internal protocols.

2. **Applicability.** Applies to core services agencies (CSAs), Saint Elizabeths Hospital (SEH), DMH contractors providing mental health services or mental health supports (including those out-of-state, e.g., residential treatment facilities), Community Residence Facilities (CRFs), all other providers of mental health (MH) services or mental health supports that are licensed or certified by the DMH; and to the Mental Health Authority (MHA) offices.

3. **Authority.** Department of Mental Health Establishment Amendment Act of 2001 and 22A DCMR Chapter 34 Mental Health Rehabilitation Services (MHRS) Provider Certification Standards.

4. **Policy.** The DMH requires timely reporting and investigation of all major unusual incidents, identifying the underlying causes toward immediate and/or systemic quality improvements, as applicable. Reporting abuse or neglect under this MUI policy does not exempt mandatory reporters pursuant to D.C. Official Codes Section 4-1321.02 (child abuse and neglect) and Section 7 – 1903 (adult abuse and neglect) from their mandatory reporting requirements.

5. **Definitions.**

5a. **Consumers.** Individuals receiving community mental health services from the DMH. For purposes of this policy, also, mean "individuals in care", the term used for those receiving in-patient services at Saint Elizabeths Hospital (SEH).

5b. **Employee.** The term "employee" when used in this policy, applies to all DMH staff, including employed consumers, volunteers, students and interns; and employees of mental health providers/contractors.

5c. **Major Unusual Incidents [(MUIs) - see Exhibit 1].** Adverse events that can compromise the health, safety, and welfare of persons, employee misconduct, fraud and actions that are violations of law or policy.

5d. **Psychiatric Residential Treatment Facility (PRTF).** A psychiatric facility that (1) is not a hospital and (2) is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the state in which it is located and (3) provides inpatient psychiatric services for individuals under the age of twenty-two (22) and meets the requirements set forth in §§ 441.151 through 441.182 of Title 42 of the Code of Federal Regulations, and is enrolled by the District of Columbia Department of Health Care Finance (DHCF) to participate in the Medicaid program.

5e. Unusual Incidents [(UI) – see Exhibit 2]. Any significant occurrence or extraordinary event, different from the regular routine or established procedure that does not rise to a MUI.

5f. MUI Categories and Codes (see Exhibit 1)

5g. UI Categories and Codes (see Exhibit 2)

**6. Responsibilities in Reporting MUIs.**

6a. Managers/Supervisors (MH providers and MHA program) shall:

(1) **verbally notify** the DQI of MUI incidents (see Exhibit 1) listed in Section 8 (see Section 9 for specific instructions).

(2) **submit** required written MUI report (Exhibit 3 with Glossary in Exhibit 4) within twenty-four (24) hours or the next business day from discovery or learning or witnessing of the MUI (see Section 9h).

(3) **ensure** that a follow-up report (Exhibit 5), as needed, and/or an internal investigation is conducted and the written report is submitted to DQI **within ten (10) business days** following internal procedures for investigations (see DMH Policy 662.1 Major Investigations).

(4) **ensure** that verbal notifications within the provider level or MHA division are followed per their internal policies and procedures.

6b. DMH Executive Officers and Providers of Mental Health Services **shall ensure** that:

(1) Program Managers/supervisors or designee and DMH employees understand their direct responsibility for following the MUI reporting from verbal and written notifications, to submission of a follow-up, as requested by the DQI, and/or investigation report;

(2) Employees are required to cooperate in the incident investigations, as warranted (e.g., providing testimony and/or written statements, any other evidence relevant to an incident investigation in a timely manner; and

(3) Written internal operating procedures on MUI reporting adhere to this policy.

**7. Procedures in Reporting MUIs.**

7a. **DMH OA receives, investigates** as needed, **tracks, trends, and monitors** the implementation of remedial actions to prevent re-occurrence and quality improvement.

**7b. MUIs THAT REQUIRE IMMEDIATE VERBAL NOTIFICATION TO OA.**

**WHAT TO VERBALLY REPORT:** Call the OA to verbally report MUIs involving:

(1) Death of a consumer or DMH employee while on duty.

(2) Incidents requiring notification to a law enforcement agency (including U.S. Secret Service for White House cases).

(3) Incidents involving the Office of Inspector General (OIG) for the District of Columbia.

- (4) Incidents requiring notification to Adult Protective Services (APS) when related to performance of services by a DMH contracted provider.
- (5) Incidents requiring notification to Child Protective Services (CPS) of the Child and Family Services Agency (CFSA) or Metropolitan Police Department (MPD) when related to performance of services by a DMH contracted provider.
- (6) Incidents that result in a mental health provider receiving inquiries from the media regarding any MUI that is not yet reported to DMH.
- (7) Incidents related to consumer care that raises immediate concerns from the determination of the provider agency regarding the health and safety of any consumer, employee, or visitor.

**7c. WHO INITIATES VERBAL REPORTING OF AN MUI TO INTERNAL IMMEDIATE SUPERVISOR.**

The provider or DMH employee who is first aware of the incident shall immediately verbally notify the designated supervisor.

**7d. WHO VERBALLY NOTIFIES OA OF AN MUI.**

- (1) At the mental health services provider level. The designated provider supervisor shall verbally notify OA through the Division of Quality Improvement (DQI) among other notifications at the internal level per established reporting lines.
- (2) At the Mental Health Authority Level Offices. Program managers at each component of the Authority (or office directors/designees where there are no subordinate levels) shall notify OA directly of MUIs and make internal notifications based on their established reporting lines.
- (3) General Public. Anyone in the general public who becomes aware of an MUI may also call OA directly.

**7e. WHEN TO VERBALLY NOTIFY OA OF AN MUI.** Verbal notifications shall be done **immediately** (or no later than one hour after discovery/learning of the incident) followed up by **written report no later than twenty four (24) hours** after discovery/learning of the incident.

**7f. WHOM TO CALL ON MUIs.**

- (1) During **normal business hours (8:30 a.m. – 5 p.m. Monday through Friday)**, call the **Division of Quality Improvement at the OA at (202) 673-2292.**
- (2) During **outside of normal business hours (Before 8:30 a.m. or After – 5 p.m. Monday through Friday), Weekends, and Holidays.** Contact the Administrator-On-Call (AOC) for DMH by calling **Access Helpline at 1 (888) 793-4357.** Ask to be connected to the AOC. The AOC shall contact the Deputy Director, OA/QI/designee.

**7g. HOW TO REPORT DEATH OF A CONSUMER.**

- (1) Any loss of life of a consumer must be verbally reported as an MUI to DMH OA immediately (or no later than one hour after learning of death).

(2) Within the written MUI report (see Exhibit 3, MUI/UI Report Form, section B and C), list the last date of service, type of service (e.g. community support, medication/somatic, etc), and outcome of services (e.g. what happened as result of the intervention).

**7h. Written MUI Reports.**

(1) The MUI Report Form (see Exhibit 3, with Glossary in Exhibit 4) must be completed by the person who first became aware of the incident. If a provider or DMH employee, he/she must complete the written report by the end of his/her tour of duty.

(2) Designated provider supervisor or MHA Program Manager shall submit the completed MUI Report to DQI within twenty-four (24) hours of verbal notification and/or discovery the incident. MUI can be submitted with actual signature using a PDF document or electronic signature attached to an email to [MUI.OA@dc.gov](mailto:MUI.OA@dc.gov) . Fax to (202) 673-2191 as an option or when signatures cannot be attached electronically.

(3) Internal written reporting procedures shall be followed by providers and MHA programs.

**7i. Out of State Facilities.** MUIs (including unauthorized leave) involving DMH consumers in out-of-state facilities shall be reported to DQI in accordance with this policy. This is in addition to other requirements by the District of Columbia or the state in which the facility is located, or that are mandated by contract or other types of arrangements with DMH or other District agencies.

The Deputy Director, DMH Office of Programs and Policy, shall ensure that all out-of-state facilities are aware of this requirement and have copies of this policy. The OA shall coordinate with the DMH Office of Programs and Policy, as necessary, to determine the appropriate response to such incidents.

**7j. PRTFs.** All MUIs in PRTFs shall be reported directly to OA. The DC social worker/case manager, referring agency, and the DMH PRTF monitor, if any, shall be indicated by the PRTF on the MUI Report Form (see #15 of Exhibit 3).

**7k. Actions by DMH OA.** After review of MUI report (verbal and written) received, the DQI shall:

- (1) **Make contact** with provider CEO or designee, as needed, for further verification.
- (2) **Ensure** appropriate actions are being taken.
- (3) As applicable, **notify** DMH Director, DMH Office of the General Counsel, Office of Consumer and Family Affairs, DMH Compliance Officer, DMH Chief Clinical Officer, and/or other appropriate offices.
- (4) **Maintain** copies of MUI reports and conduct analysis as described in Section 11.
- (5) **Ensure** that the provider completes a written follow-up report (DMH Form 1243A) on the disposition of MUIs when all details and/or the final disposition about the incident have not been provided as determined by Director of DQI.
- (6) **Ensure** that the provider completes and submits a Mortality Review report for all

consumer deaths within forty five (45) days from death or notification of death to DMH.

(7) **Conduct** an investigation, as needed. Review the provider's internal investigation report to determine further actions. The DMH Director or DMH Deputy Director for OA shall initiate an investigation of a MUI at his/her discretion (refer to DMH Policy 662.1 Major Investigations).

(8) **Track and trend.** DQI will collect, identify issues and concerns, both systemically and per individual service provider and analyze detect patterns and trend.

(9) **Monitor.** DQI closes the loop of a MUI with action steps to be taken by the provider addressing immediate and/or systemic quality improvements, as applicable.

7I. **School-based Mental Health Program (SMHP).** The SMHP program level Managers shall ensure that a MUI report is submitted to DMH OA for any reports to the CPS of CFSA or MPD.

#### **8. Reporting Unusual Incidents (UIs).**

(1) **Only MUIs shall be reported to OA.** All incidents categorized under UI (Categories of UI, Exhibit 2) shall be reported to designated persons at the provider level according to their policy and procedures. At the MHA program, UIs shall be reported to the designated program manager (e. g., UIs at the Residential Treatment Center (RTC) shall be reported to the RTC Program Manager).

(2) The MUI/UI Report Form (Exhibit 3) **shall be used to document all events that fit the definition of a UI.** The incident code entered will distinguish whether it is a MUI or UI.

(3) Based on contract requirements, certain providers will **also** be required to provide copies of incident logs on a monthly basis to the DMH Office of Programs and Policy. The Office of Programs and Policy will ensure that the contract clearly describes the reporting requirements (how, when, etc.) and procedures.

#### **9. Documentation of MUIs and UIs.**

(1) **Log of Incidents.** Provider level program managers/designees shall maintain a log of all MUIs and UIs. These logs and other records relevant to incidents must be made available to DMH upon request. The log shall include: (a) consumer identifying number, (b) date of incident, (c) date incident was reported at the provider level, (d) type of incident, (e) date the MUI was reported to OA, (f) immediate administrative actions taken and (7) outcome/final result.

(2) **Consumer's Clinical Record.** Appropriate documentation about the incident must be included in the progress notes section of each consumer's clinical record. The MUI reports and follow-up forms **shall not** be filed in the consumer's record unless otherwise required by law or regulation.

#### **10. Follow-up Reports, Major Investigations and Mortality Reviews and Timelines.**

(1) **Follow-up reports.** A follow-up report (see Exhibit 5) shall be submitted by the provider **within ten (10) business days** from the date of the initial submission of the written MUI

report to DMH. This is required by the DQI Director when more information is needed in the MUI report.

(2) The DQI Director/designee shall be notified when more time is needed. The follow-up report may serve as the investigation summary, as applicable, and may contain information such as final disposition, summation of corrective actions by management, and systemic changes toward quality improvement. Internal policy and procedures on provider investigations shall be followed.

In some cases, OA may require providers to submit an expedited follow-up report and/or the disposition of the incident **within five (5) business days** from the date of the initial verbal notification or written MUI.

(3) **Major investigations.** The DMH OA may elect to independently investigate MUIs (refer to DMH Policy 662.1 Major Investigations, for types of incidents investigated). The major investigation shall be completed by OA and submitted to the Deputy Director, OA/designee within sixty (60) business days, as feasible. This investigation serves as one of the major analytical tools in the Critical Incidents and Mortality Review.

A timely investigation has to be conducted for any suspected or allegation of employee misconduct that rise to the level of MUI. The employee has to be placed on administrative leave pending the results of the investigation. In the case of DMH employees, appropriate actions are to be taken in accordance with D.C. Personnel Manual in consultation with the DMH Division of Human Resources.

(4) **Mortality Reviews by Providers.** Mortality Review Reports by providers shall be submitted to DMH DQI within forty five (45) days of consumer death or notification of a death (or sooner if expected review is warranted).

#### **11. Reports and Analysis of Incidents.**

(1) The DQI shall maintain a computerized database on MUIs and submit the summary analysis on MUI tracking and trending to the DMH Internal Quality Committee (IQC) and DMH Quality Council (QC) on a quarterly basis.

(2) The IQC shall review the summary analysis submitted by DQI and provide written recommendations to the DMH Director and QC to address any issues and concerns, if needed.

**12. Other Requirements for Providers.** Mental health providers shall establish internal policies and procedures consistent with this DMH policy.

**13. Sanction for Non-Compliance.** Non-compliance of this policy shall result in appropriate action in accordance with DMH policies and rules (See Title 22A DCMR Chapter 34, Mental Health Rehabilitation Services Provider Certification Standards and Chapter 38, Community Residence Facilities for Mentally Ill Persons).

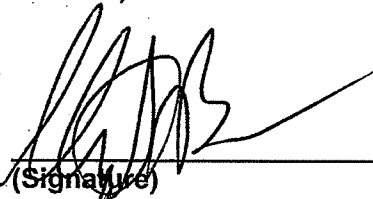

#### **14. Related DMH Policies and Exhibits.**

DMH Policy 115.1, Mortality Review  
DMH Policy 482.1A, DMH Policy on Protecting Consumers From Abuse, Neglect or Exploitation  
DMH Policy 662.1 Major Investigations  
Chap. 5, Title 22A 52 DCR 7229 - DMH Use of Restraints and Seclusion Rule



**Exhibits**

- 1 MUI Categories and Codes
- 2 UI Categories and Codes
- 3 MUI/UI Report Form (DMH 1243)
- 4 MUI Form Glossary (DMH 1243)
- 5 MUI/UI Follow-up Report (DMH Form 1243A)

**Approved by:****Stephen T. Baron**  
**Director, DMH**  
(Signature)  
(Date)

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DEPARTMENT OF MENTAL HEALTH



MAJOR UNUSUAL INCIDENT CATEGORIES

MUI Code	Categories and Description
1a	<b>Death of a currently enrolled DMH consumer.</b> Check classification of cause of death.
1b	<b>Death of a DMH employee while on duty.</b>
2a	<b>Physical injury (consumer).</b> Bodily harm, pain, or impairment experienced by a consumer which requires medical or dental treatment beyond facility-based first aid.
2b	<b>Physical injury (staff).</b> Bodily harm, pain, or impairment experienced by a DMH staff while on duty which requires medical or dental treatment beyond facility-based first aid.
2c	<b>Physical injury (Other).</b> Bodily harm, pain, or impairment experienced by those other than (1) and (2) (e.g. visitors, student interns, volunteers, etc. while at DMH service location).
3	<b>Medical emergency.</b> Any unplanned or unanticipated medical event requiring calling "911", emergency room intervention or hospitalization.
4	<b>Psychiatric emergency (community residential facility).</b> Any unplanned or unanticipated psychiatric event experienced by a consumer who resides in a community residential facility.
5	<b>Physical Assault.</b> A physical attack using force or violence upon a consumer, consumer to staff, or DMH staff while on duty.
6	<b>Sexual Assault.</b> Any sexual or attempted sexual activity, when one party has not given or cannot give consent (e.g., staff as perpetrator).
7a	<b>Physical Abuse.</b> Any physical contact with, or handling of a consumer with more force than is reasonably necessary in order to ensure his/her safety or the safety of others.
7b	<b>Psychological or verbal abuse.</b> The use of verbal or nonverbal expression or other actions in the presence of a consumer that subjects him/her to humiliation, contempt, harassment, threats of punishment, wrongful manipulation or social stigma.
8	<b>Neglect.</b> The failure of an employee to act responsibly which could compromise the safety and well-being of consumers and others (e.g., driving a government owned or leased vehicle recklessly or under the influence of drugs or alcohol).
9	<b>Exploitation.</b> Misuse or misappropriation of the consumer's assets (includes the use of a position of authority to extract personal gain from a consumer).
10	<b>Sexual harassment.</b> Events which involve any sexual or attempted sexual activity between an employee and a current or former contract worker/consumer regardless of whether or not the consumer consents. Also, when privileged information or direct therapeutic relationship about a former consumer is used by staff against him/her to gain sexual favors.
11	<b>Crime.</b> Any police involvement or event which is or appears to be a crime under District of Columbia or Federal law involving a consumer or staff, either as the victim or the perpetrator (e.g., arson, assault, homicide, possession of a deadly weapon, possession or sale of narcotics, theft, sexual offense).
12a	<b>Restraint.</b> Any manual or physical method, use of drugs as a restraint, mechanical device, material, equipment that immobilizes or reduces the ability of a consumer to move his or her arms, legs, body, or head freely.
12b	<b>Seclusion.</b> The involuntary confinement of a consumer in a room or area where he/ she is prevented from leaving, or believes that he or she cannot leave at will.
13	<b>Suicide Attempt.</b> Actions of a consumer that are self-inflicted towards the goal of ending one's life; may or may not have resulted in an injury.

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14	<b>Fall.</b> The unintended and sudden loss of an upright or erect position resulting in a person coming to rest on the ground, floor, or other lower level.
15	<b>Reportable Disease.</b> A disease or condition that must be reported to public health authorities at the time of diagnosis due to mandatory reporting law.
16a	<b>Severe adverse reactions due to medication error.</b> Any medication error that has potential of resulting to prolonged hospitalization, significant or permanent disability or death. Any unplanned or unanticipated medical event requiring calling "911", emergency room intervention or hospitalization that has been found to be related to a medication error.
16b	<b>Missed Medication.</b> Any medication orders that are not followed according to schedule when the consumer is present in a community residential facility (e.g., CRF).
17a	<b>Unauthorized Leave/Elopement (SEH, RTC, PRTF).</b> A situation in which a consumer is found missing from the expected location and time.
17b	<b>Missing Consumer .</b> A situation in which a consumer is first identified as missing in the community.
18a	<b>Illegal drugs and weapons.</b> Any event where illegal drugs or weapons are found in DMH or provider premises and a community residential facility (CRF).
18b	<b>Illegal possession and distribution of goods.</b> Situations where a consumer (s) possess or distribute goods illicitly (e.g. goods that may normally be owned but are liable to be seized because they were used in committing an unlawful act and hence begot illegally, such as smuggled goods, stolen goods).
19	<b>Fire.</b> Fire occurring in any DMH occupied, licensed, certified, or contracted residential, treatment, or office facility that results in serious injuries or is of a suspicious nature or causes property damage rendering the facility or part thereof unusable.
20a	<b>Vehicle accident (consumer is passenger).</b> Any vehicle accident (minor or major) that occurs when a DMH consumer is a passenger.
20b	<b>Vehicle accident (Injury).</b> Any vehicle accident that occurs while a DMH staff is on duty resulting in serious injury.
20c	<b>Vehicle accident (Government vehicle).</b> Any vehicle accident (minor or major) that involves a District of Columbia Government vehicle.
21a	<b>Security (Facility).</b> Any facility, required to be locked, that has faulty locks or security equipment, or any lost government issued keys or security badge.
21b	<b>Security (PHI).</b> Any unauthorized release of a consumer's protected health information.
21c	<b>Theft .</b> Any theft of DMH property, occurring on DMH property or service location.
22	<b>Environmental.</b> Any loss of utilities or structure impacting the health, safety or welfare of consumers which may or may not require evacuation or transfer to another location. This includes any violation of federal or District laws regarding building occupancy.

----- END OF MUI CODES -----

**CATEGORIES OF UNUSUAL INCIDENTS (UIs)**  
(Not included in Major Unusual Incident (MUI) Report Categories)

**UI CATEGORIES ARE NOT REPORTED TO THE DMH OFFICE OF ACCOUNTABILITY (OA).  
UIs ARE ONLY REPORTED AT THE PROVIDER LEVEL or MHA PROGRAM LEVEL.**

UI Code	UI Categories	Descriptions
<b>A</b>	Consumer criminal activity with no police involvement	Alleged/suspected/actual criminal activity by consumer <u>not</u> resulting in police involvement.
<b>B</b>	Non-consumer criminal activity with no police involvement	Alleged/suspected/actual criminal activity by employee or any other person (non consumer) <u>not</u> resulting in police involvement.
<b>C</b>	Operational Breakdown	Operational breakdown that may lead to but is not yet causing direct threats to life and safety of consumers (e.g. an electrical blackout, telephone outage, natural disaster that requires the residential relocation of consumers).
<b>D</b>	Self-Injurious behavior	Alleged, suspected, or actual physical injury of a consumer intentionally brought about by the consumer and does not require medical or dental treatment attention beyond first aid, and which does not have as a goal to end one's life (e.g. punching a wall, biting oneself).
<b>E</b>	Minor physical injury of a staff member (e.g. RTC, MHA Staff)	Physical injury of a staff member resulting from participating in crisis intervention (e.g., at a facility or during transport) with a consumer which does not require treatment beyond first aid.
<b>F</b>	Property damage	Damage of any property that the facility is or can be accountable for (e.g. vehicle, other people's belongings, etc.) or at the facility (e.g. furniture, appliance, etc.) or structure of the facility (e.g. walls, doors, etc.) that relates to cost as a result of behavioral issues.
<b>G</b>	Verbal threats	Verbal threats made by a consumer towards another consumer or by a consumer towards a staff or by a staff to another staff (DMH Supervisor of staff to be notified, Sec. 17, Policy 480.1B)
<b>H</b>	Staff Shortage	Significant, unexpected staff shortage causing threat to life and safety of others.
<b>I</b>	OTHER	Incidents that clearly do not fit under any other UI code.

End of UI Categories

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## MAJOR AND UNUSUAL INCIDENT (MUI/UI) REPORT FORM

**GENERAL INSTRUCTIONS:** To be completed and submitted by the first person who learned/witnessed/discovered an MUI / UI to the appropriate authority per policy. Add pages as necessary. Refer to DMH Policy 480.1C Exhibit 1 for MUI and Exhibit 2 for UI for full descriptions. **For electronic submission, the supervisor should email this report directly to the Office of Accountability (MUI.OA@dc.gov).**

## A. Incident Information

1) First Name:	2) Last Name:	3) ID/eCura Number:
4) Legal Status: Voluntary <input type="checkbox"/> Involuntary <input type="checkbox"/> NA <input type="checkbox"/> 5) Person Involved: Staff <input type="checkbox"/> Visitor <input type="checkbox"/> Consumer <input type="checkbox"/>		
6) Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other: <input type="checkbox"/> N/A <input type="checkbox"/> 7) Date of Birth:		
8) Ethnicity		
9) Date of Incident:		10) Time of Incident: <input type="checkbox"/> AM/ <input type="checkbox"/> PM
11) Name of Agency Submitting Report:		12) Incident Location:
13) Type of Program: <input type="checkbox"/> CSA <input type="checkbox"/> CRF <input type="checkbox"/> CBI <input type="checkbox"/> Crisis <input type="checkbox"/> PRTF <input type="checkbox"/> SMHP <input type="checkbox"/> SEH <input type="checkbox"/> ACT <input type="checkbox"/> CPEP		
For PRTF use only 14) Referral Agency <input type="checkbox"/> CFSA <input type="checkbox"/> DYRS <input type="checkbox"/> DCPS <input type="checkbox"/> CSOSA <input type="checkbox"/> HSCSN <input type="checkbox"/> Other		
15) DC Social Worker/Case Manager: <input type="checkbox"/> Other		
If there is a PRFT DMH Monitor involved with this case, please ID:		

## Administrative Use Only

☐ DMH Risk Manager  
☐ DMH QI Director

Date Received:

Date Mortality/Follow up  
is Due:

16) Clinical Home: 17) Address of Clinical Home:

18) Please check the category below (check all that apply) - Major Unusual Incident Category  
(Please refer to Policy 480.1C Exhibit 1 for specific MUI Descriptions):

- |  |  |
|--|--|
| <input type="checkbox"/> 1a Death (DMH Consumer)               | <input type="checkbox"/> 13 Suicide Attempt                                  |
| <input type="checkbox"/> Suicide                               | <input type="checkbox"/> 14 Fall   |
| <input type="checkbox"/> Homicide                              | <input type="checkbox"/> 15 Reportable Disease                               |
| <input type="checkbox"/> Natural causes                        | <input type="checkbox"/> 16a Severe Adverse Reaction due to Medication Error |
| <input type="checkbox"/> Accident                              | <input type="checkbox"/> 16b Missed Medication                               |
| <input type="checkbox"/> Unknown                               | <input type="checkbox"/> 17a Unauthorized Leave/Elopement                    |
|  | <input type="checkbox"/> 17b Missing Consumer                                |
| <input type="checkbox"/> 1b Death (DMH Employee)               | <input type="checkbox"/> 18a Illegal drugs/weapons on DMH/provider premises  |
| <input type="checkbox"/> 2a Physical Injury (Consumer)         | <input type="checkbox"/> 18b Illegal Possession and Distribution of Goods    |
| <input type="checkbox"/> 2b Physical Injury (Staff)            | <input type="checkbox"/> 19 Fire   |
| <input type="checkbox"/> 2c Physical Injury (Other)            | <input type="checkbox"/> 20a Vehicle Accident (Consumer is passenger)        |
| <input type="checkbox"/> 3 Medical Emergency                   | <input type="checkbox"/> 20b Vehicle Accident (Injury)                       |
| <input type="checkbox"/> 4 Psych emergency (community - MHCRF) | <input type="checkbox"/> 20c Vehicle Accident (Government Vehicle)           |
| <input type="checkbox"/> 5 Physical Assault                    | <input type="checkbox"/> 21a Security (Facility)                             |
| <input type="checkbox"/> 6 Sexual Assault                      | <input type="checkbox"/> 21b Security (PHI)                                  |
| <input type="checkbox"/> 7a Physical abuse                     | <input type="checkbox"/> 21c Theft   |
| <input type="checkbox"/> 7b Psychological /Verbal Abuse        | <input type="checkbox"/> 22 Environmental                                    |
| <input type="checkbox"/> 8 Neglect                             |  |
| <input type="checkbox"/> 9 Exploitation                        |  |
| <input type="checkbox"/> 10 Sexual Harassment                  |  |
| <input type="checkbox"/> 11 Crime                              |  |
| <input type="checkbox"/> 12a Restraint                         |  |
| <input type="checkbox"/> 12b Seclusion                         |  |

## Unusual Incident Categories: (Internal Reporting or MHA Program Use Only)

- ☐
- A Consumer criminal activity with no police involvement
- 
- ☐
- B Non-consumer criminal activity with no police involvement
- 
- ☐
- C Operational Breakdown
- 
- ☐
- D Self-Injurious behavior
- 
- ☐
- E Minor physical injury of a staff member (e.g. RTC Staff)
- 
- ☐
- F Property damage
- 
- ☐
- G Verbal threats
- 
- ☐
- H Staff Shortage
- 
- ☐
- I OTHER

## Severity

☐ High  
☐ Medium  
☐ Low

## Initial Investigation Findings

☐ Substantiated  
☐ Unsubstantiated  
☐ Inconclusive  
☐ N/A

## Follow-up Activities:

☐ Consumer connected to Primary Care Provider  
☐ Consumer's diagnosis & Prognosis  
☐ Consumer's Current Status

☐ Investigation Complete as of \_\_\_\_\_

Note:

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH**B. Description of Incident:** Describe exactly what happened: Who, What, Where, When, Why, and How? (Use additional paper as needed)**C. Consumer(s) Involved in the Incident\*\***

No	Name	Ecura No	Provider	Legal Status	DOB	Gender	Role in Incident*
1						<input type="checkbox"/> F <input type="checkbox"/> M	
2						<input type="checkbox"/> F <input type="checkbox"/> M	
3						<input type="checkbox"/> F <input type="checkbox"/> M	
4						<input type="checkbox"/> F <input type="checkbox"/> M	

**D. Provider Employee(s) Involved in the Incident**

No	Name	Unit/Office	Position	Gender	Role in Incident*
1				<input type="checkbox"/> F <input type="checkbox"/> M	
2				<input type="checkbox"/> F <input type="checkbox"/> M	
3				<input type="checkbox"/> F <input type="checkbox"/> M	
4				<input type="checkbox"/> F <input type="checkbox"/> M	

**E. Other Person(s) Involved in the Incident**

No	Name	Organization	Relation to Individual	Gender	Role in Incident*
1				<input type="checkbox"/> F <input type="checkbox"/> M	
2				<input type="checkbox"/> F <input type="checkbox"/> M	
3				<input type="checkbox"/> F <input type="checkbox"/> M	

\* Identify 'Role in Incident' by number as follows: 1) Aggressor 2) Victim 3) Involved 4) Witness 5) Other (Specify)

\*\* If more than four individuals are involved in the incident, use the 'Other Persons Involved' table below to list the remaining individuals.

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH**F. Current Status and Planned Actions for Prevention**

Person Involved	Clinical Treatment Provided (by whom)	Administrative Action Taken (by whom)	Current Status	As of (Date)	Planned Actions to Prevent Re-occurrence

Other Comments:

**G. Parties Notified (as needed)**

Affiliation	Person Notified + Title	Notified by + Title	Date	Telephone	Note
<input type="checkbox"/> DMH, Office of Accountability					
<input type="checkbox"/> Family/Guardian					
<input type="checkbox"/> Metro Police Dept.					
<input type="checkbox"/> Adult Protective Serv (APS)					
<input type="checkbox"/> Child Protective Serv (CPS)					
<input type="checkbox"/> Other: _____					

**H. Preparer of Incident Report: Employee Who First Witnessed Incident**

Name:	Title:	Office/Unit:
Telephone:	Fax:	Email:
Signature ( <input type="checkbox"/> Electronic Submission):		Date Prepared:

**I. Supervisor of Preparer**

Name:	Title:	Office/Unit:
Telephone:	Fax:	Email:

Additional Information regarding Incident:

Signature (☐ Electronic Approval): Date Reviewed/Approved:If follow-up, is needed DMH should please contact: (Name)  
Phone Number: Email:**FORWARD A COPY OF THIS FORM TO: OFFICE OF ACCOUNTABILITY, DMH,  
64 NEW YORK AVE., 4<sup>th</sup> fl., NE, WASH., DC, 20002**

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH



TEL. (202) 673-2292 and FAX (202)-673-2191

Electronic version of this form is available

**MAJOR UNUSUAL INCIDENT REPORT – CONTINUATION SHEET**

**J. Describe exactly what happened: Who, What, Where, When, Why, and How? (Use) additional paper as needed).**  
(Please use this sheet for any additional information, and indicate the corresponding item number from the form)



## **MAJOR UNUSUAL AND UNUSUAL INCIDENT (MUI/UI) REPORT FORM GLOSSARY**

### **A. Incident Information**

**1 – 2) Write First and Last Name:** Name of primary person involved in the incident (separate MUI report should be filed for each consumer substantially involved in an incident).

**3) ID/eCura #:** The ID should be the ECura number, unless the consumer is not registered in eCura, in which case this ID will be calculated from the consumers initials and birthdate, as follows: **Mike Smith** born **01/01/1993** would have the ID: **MS010193**. In other words, the consumers first initial of the first name, first initial of the last name, two-digit month, two-digit day, and two-digit year of birth would be combined to form the ID.

**4) Legal Status:** Write whether named individual is a voluntary consumer, an involuntary consumer, or if the category is not applicable.

**5) Person involved in incident:** This describes the classification of person named at the top of the MUI/UI form. Choices are consumer, visitor, Staff, or Agency. Most MUI/UIs are reported for Consumers, but in some instances the named individual will be in a different classification.

**6) Gender:** The gender of the named individual: Male or Female or Other (N/A when the incident refers to an agency)

**7) Date of Birth:** Write month, day, and year. **8) Ethnicity:** The ethnicity of the named individual in #1

**9) Date of Incident:** Month, day and year **10) Time of Incident:** The date and time at which the reported incident occurred. Always indicate whether AM or PM in time.

**11) Name of Agency Submitting Report:** The actual agency/organization that is submitting the MUI/UI report.

**12) Incident Location:** The address where the incident occurred (e.g. Saint Elizabeths Hospital, parking lot at 64 NY Ave., NE).

**13) Type of Program:** The type of program where the incident report came from [e.g. Core Services Agency (CSA), Community Residential Facility (CRF), Comprehensive Psychiatric Emergency Program (CPEP), Psychiatric Residential Treatment Facility (PRTF), School Mental Health Program (SMHP), Crisis Bed Placement (Crisis), Saint Elizabeths Hospital (SEH), Community Based Intervention (CBI) or Assertive Community Treatment Team (ACT)].

**14) Referral Agency:** *If the reporting program is a PRTF, then specify the Referral Agency and the name of DC Social Worker/Case Manager in item 15. Then, specify the PRTF DMH Monitor for the child or youth, where applicable.*

**16) Clinical Home:** The name of the agency where the consumer involved in the incident is enrolled (e.g. Green Door, Community Connections, MHSD, etc.) and **17) address**

**18) Check the Category of the Major Unusual Incident/Unusual Incident (MUI/UI):** Check all of the categories which best describe this MUI/UI (see Policy 480.1C, Exhibit 1 and 2).

### **B. Description of Incident:**

Describe exactly what happened (Who, what, where, when, why, and how?) Use additional paper, as needed.

## **MAJOR UNUSUAL AND UNUSUAL INCIDENT (MUI/UI) REPORT FORM GLOSSARY**

### **C. Consumer (s ) Involved in the Incident**

Write details about all the consumers involved in this incident. Consumer #1 should be the individual named at the top of the MUI/UI form. Identify the "Role in Incident" using the following codes: 1=Aggressor, 2=Victim, 3=Involved, 4=Witness, 5=Other (please specify further).

### **D. Provider Employee(s) involved in the incident.**

Write names of all staff involved in this incident. Describe their position, as well as the Unit or Office for which they work. Identify the "Role in Incident" using the following codes: 1=Aggressor, 2=Victim, 3=Involved, 4=Witness, 5=Other (please specify further).

### **E. Other Person(s) involved in the incident.**

Write names other people involved in the incident. Use this space to list involved consumers who did not fit into the space provided in Sec. B. Identify the "Role in Incident" using the following codes: 1=Aggressor, 2=Victim, 3=Involved, 4=Witness, 5=Other (specify further).

### **F. Current Status and Planned Actions for Prevention.**

Describe the provider's response to the MUI/UI, and the disposition of the consumer. Not all sections will be completed for every MUI/UI.

Clinical Treatment Provided: Describe any clinical treatment provided to the consumer, and the person by whom it was provided.

Administrative Action Taken: Describe any administrative action taken by the provider, and the person by whom it was taken.

Current Status: Describe the current disposition of the consumer.

As of (Date): Use this field to note the date for which the "Current Status" is current.

Planned Actions to Prevent Re-occurrences: Describe clinical, administrative, or policy changes that will be made in order to prevent a re-occurrence of this incident, or incidents of this type.

### **G. Parties Notified.**

List person(s) notified their affiliations and titles, write who performed the notification, the date, the number at which they were contact, and any relevant notes. While all incidents must be reported to DMH OA, other necessary notifications will depend on the incident described.

### **H. Preparer of Incident Report.**

Provide all requested information for the preparer of this MUI/UI form. The preparer should be the employee who first became aware of the incident.

### **I. Supervisor of Preparer.**

Provide all requested information regarding the Agency Supervisor who signed off on this MUI/UI report.

### **J. Describe exactly what happened – continuation page**

**Important: All signature fields/lines must be filled out completely.**

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH



**MAJOR AND UNUSUAL INCIDENT FOLLOW-UP REPORT FORM**

**GENERAL INSTRUCTIONS:**

Complete and return to the DMH OA within 10 days from the date the incident was reported to DMH OA only if full details, final disposition, etc. were not initially provided. Please include full details of the incident and of the final disposition, a summary of actions taken by management officials, and any additional corrective actions taken.

Name: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Date of Follow-Up Report: \_\_\_\_\_

Name of Person Providing Information: \_\_\_\_\_ Title: \_\_\_\_\_

Phone # of Person Providing Information: \_\_\_\_\_ Investigation Conducted: ☐ Yes ☐ No

Investigation Report sent to DMH? ☐ Yes ☐ No When sent to OA: \_\_\_\_\_

(1) Findings/complete details:

(2) Final disposition:

(3) Summary of Management/Corrective Actions

Preparer's Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact email \_\_\_\_\_ Tel. #: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Title: \_\_\_\_\_

Risk Manager/Designee Reviewed, Date: \_\_\_\_\_ Initial: \_\_\_\_\_

**FORWARD A COPY OF THIS FORM TO: DMH OFFICE OF ACCOUNTABILITY**  
**TEL. (202)673-2292** (during normal business hours 8:30am to 5pm) and **1(888)793-4357** (non-business hours)  
**FAX (202)-673-2191, email: MUI.OA@dc.gov**  
Electronic version of this form is available

In addition to reporting MRIs to the DMH Office of Accountability, based on specific contract requirements, certain contractors are to provide copies of incident logs, on a monthly basis, to: DMH Office of Programs and Policy. Tel. (202)-671-2900 and (Fax) 671-2971