

## **DDSO/Agency**

### **INCIDENT MANAGEMENT TREND ANALYSIS**

#### **INTRODUCTION**

The Developmental Disabilities Services Office (DDSO) Director has delegated the day-to-day responsibility for incident management to the Quality Services Unit. The Quality Services Unit Incident Management Treatment Team Leader, functioning in the role of Special Review Committee Chairperson, in conjunction with the Special Review Committee, evaluated available information for the Part 624 annual trend analysis report. This report covers the period of January 1, 2009 – December 31, 2009. The trend analysis report contains statistically relevant information related to incidents (allegations of abuse, serious reportable and reportable incidents) that were filed in DDSO sponsored programs including the Developmental Center, Individualized Residential Alternatives, Family Care Homes, Day Habilitation Programs, Recreational Programs, Respite Programs, Home and Community Based Waiver Programs, and Care at Home Programs.

#### **SPECIAL REVIEW COMMITTEE**

##### **Membership**

Membership for the DDSO Special Review Committee included:

- Chairperson
- Psychologist
- Nurse
- Ombudsman
- House Leader
- Residential Manager
- Treatment Team Leader
- Physician Consultant

##### **Meetings**

The Special Review Committee met to review all serious reportable incidents and allegations of abuse within one month of occurrence. Meetings were held once every two weeks and more frequently when required. On a rotating basis, members of the committee met in small groups with the Chairperson to review all reportable incidents following the conclusion of the scheduled committee meeting. It was the subcommittee's responsibility to ensure that any recommendation made or action taken was brought to the attention of the full committee and documented in the full committee's meeting minutes. All incidents were reviewed in order to:

- Assure that incidents were reported, managed, investigated and documented consistent with provisions of 624 regulations and agency policies and procedures. When necessary recommendations are made to correct, improve or eliminate inconsistencies in investigations.
- Assure that necessary and appropriate corrective, preventive, and/or disciplinary action

has been taken to protect consumers from further harm and to safeguard against recurrence of similar incidents.

- Ascertain if further investigation or if additional corrective, preventive and/or disciplinary action is necessary and if so, make appropriate recommendations.
- Identify trends and to recommend appropriate corrective, preventive, and/or disciplinary action to safeguard against such recurring situations.
- Ascertain and ensure the adequacy of the agency's reporting and review practices including monitoring and the implementation of recommendation for corrective and preventive action.

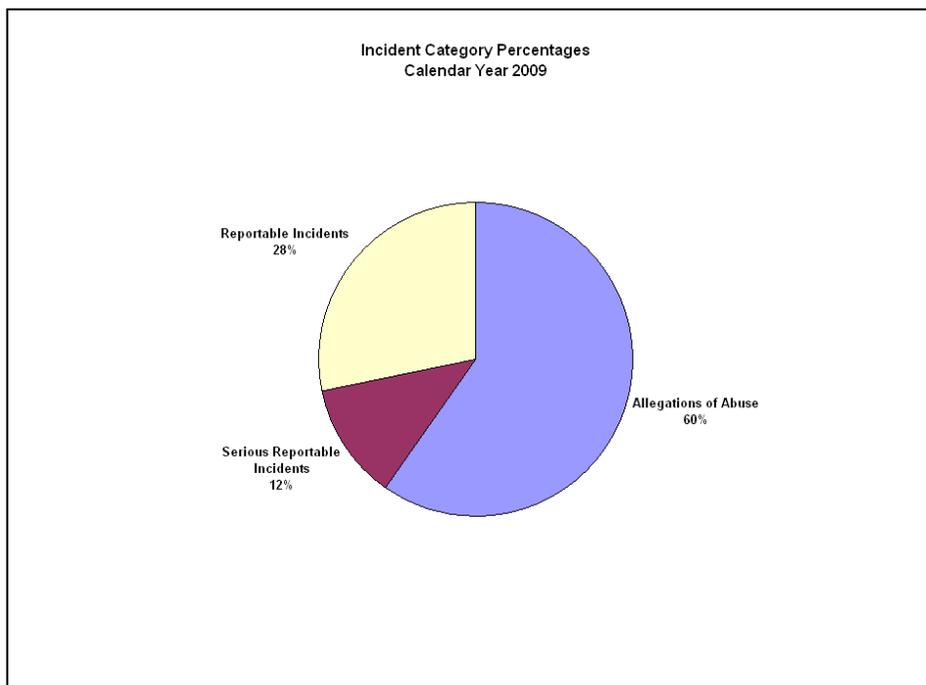
### **Additional Review**

Following Special Review, the Board of Visitors conducts a monthly review of incidents and investigations to maintain their regulatory authority and due to the absence of a parent advocate Special Review Committee member.

## **STATISTICS, COMPARISONS, AND TRENDS FOR CALENDAR YEAR (2009)**

### **General Summary of Incident Categories**

During calendar year 2009, there were a total of three hundred and five (305) consumer incident reports filed. Of this total, one hundred and eighty two (182) incidents were categorized as allegations of abuse, thirty seven (37) incidents were categorized as serious reportable and eighty six (86) incidents were categorized as reportable. The breakdown of incidents by incident category is depicted below. A comparison of incident categories indicates that the majority of incidents filed during calendar year 2009 were categorized as allegations of abuse, which is consistent with calendar year 2008 data. There was a minor decrease of 21% in serious reportable incidents during calendar year 2009. Historically, the majority of incidents filed were categorized as reportable. Changes in reporting requirements for this incident category have served to dramatically decrease the number of reportable incidents filed, although there was noted to be a moderate increase of 34% in reportable incidents this year. Trends relative to each incident category will be discussed later in this report.

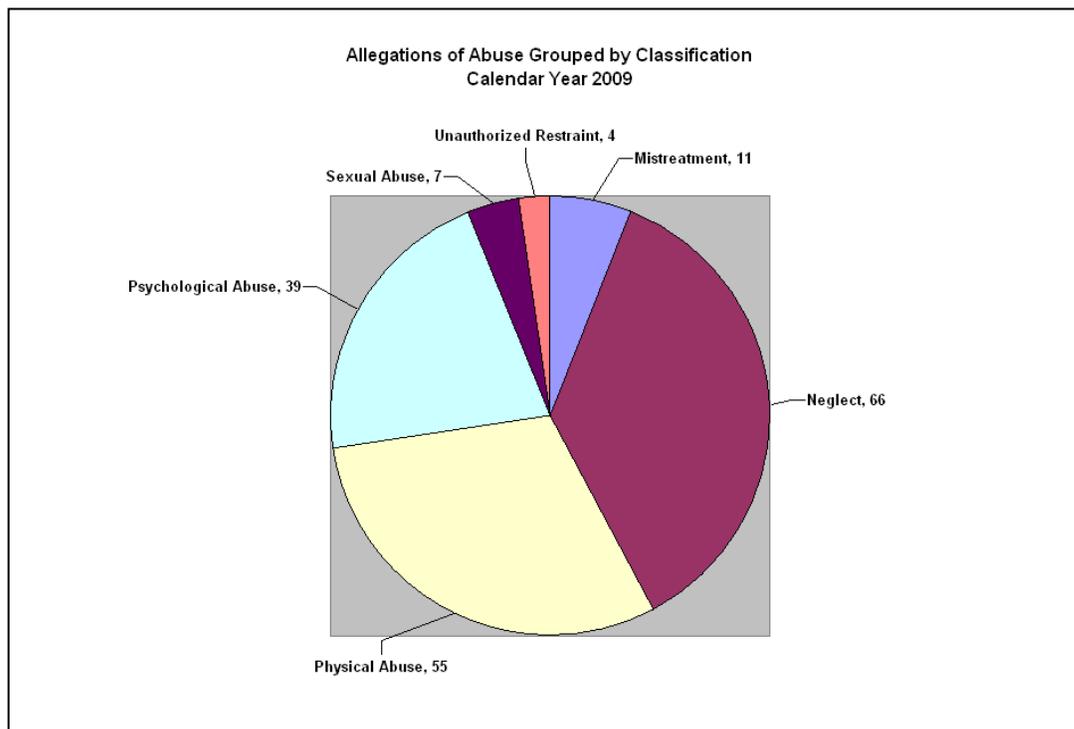


## Allegations of Abuse

As mentioned previously, one hundred and eighty two (182) incidents were categorized as allegations of abuse during calendar year 2009. Compared to calendar year 2008 data this number represents an increase of only 1%. Relevant trends related to allegations of abuse will be discussed according to classification, county, location, circumstances, and findings.

### Allegations of Abuse by Classification:

As depicted below, allegations of neglect were filed more frequently than any other classification. Historically, allegations of neglect have occupied the first or second highest number of allegations filed. Allegations of physical abuse and psychological abuse were the second and third most frequent type of allegation filed, respectively. Allegations of sexual abuse and mistreatment were reported at moderately low levels during the calendar year, which is a positive finding. Allegations of Unauthorized or Inappropriate Use of Restraint were reported at the lowest level. This information is statistically similar to calendar year 2008 data. In terms of historical relevance the data depicted below is statistically similar to previous trend analysis. Trends related to allegation circumstances will be discussed later in this report.

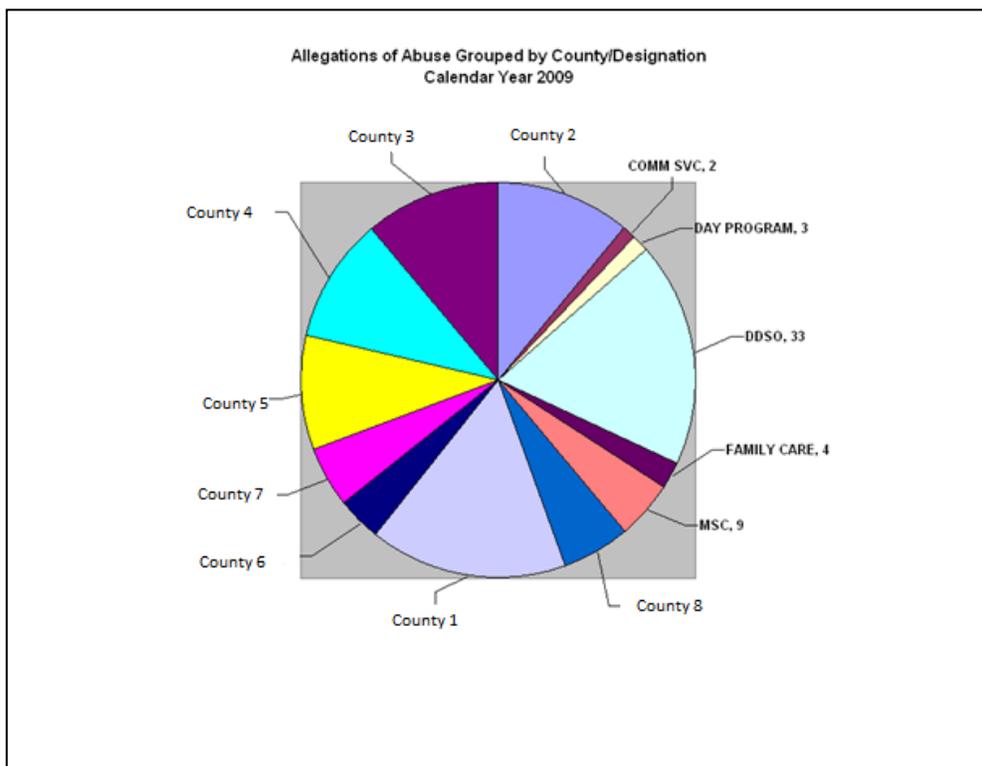


**Allegations of Abuse by County/Designation:**

It should be noted that day programs are currently under the auspice of the County Teams, and that while the teams are now recognized by number rather than county name, for the purpose of this report and in order to lend clarity to approximate geographic location, the old county designations were used.

As depicted below, during calendar year 2009, the DDSO filed the largest number of allegations of any state operated program. This designation captures all consumers that require an ICF level of care. County 1 IRAs filed the second highest number of allegations of abuse, followed closely by County 2, County 3, County 4, and County 5. It was noted that County 6, County 7 and County 8 filed allegations of abuse at a low level during calendar year 2009, as did Family Care, MSC and Community Services. County 6 had the greatest decrease in reporting of allegations of abuse during between calendar year 2008 and 2009. A separate count of allegations of abuse occurring in day programs revealed a total of twelve (12) allegations which represents 7% of the total number of allegations of abuse filed during calendar year 2009.

Counties/Designations that have not reported allegations of abuse at statistically normal levels should provide increased monitoring and education to staff, to improve recognition of actions/inactions that may be considered abusive.



**Allegations of Abuse by County/Designation - cont:**

In terms of allegation classification, as depicted in the pivot table report below, the DDSO and County 3 filed the largest number of allegations of neglect, followed by County 1 and County 8. County 2 filed the largest number of allegations of physical abuse, followed by County 1, County 4 and the DDSO. The DDSO and County 1 filed the largest number of allegations of psychological abuse, followed by County 4 and County 2. The DDSO filed the largest number of unauthorized or inappropriate use of restraints. All other allegation categories were equally dispersed among counties/designations. In terms of prevention, it is recommended that Treatment Team Leaders focus on the identified areas of weakness to provide increased education to staff to increase recognition of actions or inactions that may be considered abusive.

**County Data**

Count of Incident Type	Incident Class						
County	Mistreatment	Neglect	Physical Abuse	Psychological Abuse	Sexual Abuse	Unauthorized Restraint	Grand Total
County 2	2	4	12	5			23
COMM SVC		1		1			2
DDSO		13	7	8	1	4	33
FAMILY CARE	1		2	1			4
MSC	1		5	2	1		9
County 8		7	2	1			10
County 1	2	11	7	8	1		29
County 6	1	4	2				7
County 7		3	4	2			9
County 5	1	8	5		3		17
County 4	3	2	7	7			19
County 3		13	2	4	1		20
Grand Total	11	66	55	39	7	4	182

**Allegations of Abuse by Location/Classification:**

Within each County/Designation there are a number of sites. Data is depicted below by site and location

**County 3 Data**

Location	Neglect	Physical Abuse	Psychological Abuse	Sexual Abuse	Grand Total
IRA 1	3				3
IRA 2	2	1			3
IRA 3	3	1		3	7
IRA 4	5			1	6
IRA 5				1	1
Grand Total	13	2		4	20

The County 3 Treatment Team supervises twelve IRAs. Seven (7) of twelve (12) IRAs did not report abuse allegations.

**Allegations of Abuse by Location/Classification: - cont.**

**County 3 Data – cont.**

With regard to County 3 data, as depicted above, allegations of neglect were filed more frequently than any other classification. The number of allegations of abuse filed by the County 3 Team is numerically similar to 2008 data. IRA 3 filed the greatest number of allegations of abuse during calendar year 2009, followed closely by IRA 4. IRA 4 filed the greatest number of allegations of neglect and IRA 3 filed the greatest number of allegations of psychological abuse. During calendar year 2008, IRA 4 reported six (6) allegations of abuse as well.

**County 5 Data**

Location	Mistreatment	Neglect	Physical Abuse	Sexual Abuse	Grand Total
IRA 1	1	3			4
IRA 2		1			1
IRA 3			1		1
IRA 4			1		1
IRA 5		3	1	3	7
IRA 6		1	1		2
DH			1		1
Grand Total	1	8	5	3	17

The County 5 Treatment Team supervises twelve IRAs and one Day Habilitation Program. Six (6) of twelve (12) IRAs did not report abuse allegations. With regard to County 5 data, allegations of neglect were filed more frequently than any other classification. The number of allegations of abuse filed by the County 5 Team is statistically similar to 2008 data. As depicted above, IRA 5 filed the greatest number of allegations of abuse followed by IRA 1 during calendar year 2009. Both IRA 1 and IRAs 5 also filed the largest number of allegations of neglect in this county, while IRA 5 filed the largest number of allegations of sexual abuse.

## Allegations of Abuse by Location/Classification: - cont.

### County 1 Data

Location	Mistreatment	Neglect	Physical Abuse	Psychological Abuse	Sexual Abuse	Grand Total
IRA 1			1	1		2
IRA 2		1	2	2		5
DH 3	1	1				2
IRA 4				1		1
IRA 5	1	5	4	3	1	14
IRA 6		3		1		4
DH 7		1				1
Grand Total	2	11	7	8	1	29

The County 1 Treatment Team supervises seven IRAs and two Day Habilitation Programs. With regard to County 1 Data, allegations of neglect were filed more frequently than any other classification. The number of allegations of abuse filed by the County 1 Team, increased by 17% between the 2008 and 2009 calendar years. Two (2) of nine (9) sites did not report abuse allegations during calendar year 2009. As depicted on page 6, IRA 4 filed the greatest number of allegations of physical abuse, neglect and psychological abuse. IRA 6 filed the second greatest number of allegations of neglect. None of the other sites had statistically significant numbers.

### County 6 Data

Location	Mistreatment	Neglect	Physical Abuse	Grand Total
IRA 1			1	1
IRA 2	1			1
IRA 3			2	2
IRA 4			1	1
IRA 5			1	1
IRA 6			1	1
Grand Total	1		4	7

The County 6 Treatment Team supervises eight IRAs and one respite home. Three (3) of nine (9) sites did not report abuse allegations. With regard to County 6 data, allegations of neglect were filed more frequently than any other classification. The number of allegations of abuse filed by the County 6 Team decreased by 65% between the 2008 and 2009 calendar years. As depicted above, none of the other sites had statistically significant numbers for other classifications.

**Allegations of Abuse by Location/Classification: - cont.**

**County 2 Data**

Location	Mistreatment	Neglect	Physical Abuse	Psychological Abuse	Grand Total
IRA 1			1		1
IRA 2				1	1
IRA 3	1				1
IRA 4		1	1		2
IRA 5	1		3	1	5
IRA 6		1			1
IRA 7			1	1	2
IRA 8		1	3	1	5
DH 9		1	3	1	5
Grand Total	2	4	12	5	23

The County 2 Treatment Team supervises nine IRAs and one Day Habilitation Program. With regard to County 2 Data, allegations of physical abuse were filed more frequently than any other classification. The number of allegations of abuse filed by the County 2 Team during calendar year 2009, is statistically similar to 2008 data. One (1) of ten (10) sites did not report abuse allegations during calendar year 2009 as depicted above. With regard to County 2 data, IRAs 5 and 8 and DH 9 filed the greatest number of allegations of physical abuse during calendar year 2009. None of the other sites had statistically significant numbers for other classifications.

**County 4 Data**

Location	Mistreatment	Neglect	Physical Abuse	Psychological Abuse	Grand Total
IRA	1	1	1	2	5
IRA			2	2	4
IRA	2		1	1	4
IRA		1			1
RESPITE				1	1
IRA			1		1
IRA			2	1	3
Grand Total	3	2	7	7	19

The County 4 Treatment Team supervises seven IRAs and two (2) respite homes. With regard to County 4 Data, two (2) of nine (9) sites did not report abuse allegations during calendar year 2009. The number of allegations of abuse filed by the County 4 Team, during calendar year 2009 remained statistically similar to 2008 data. As depicted above IRA 1 filed the greatest number of allegations of abuse followed by IRAs 2 and 3 during calendar year 2009.

### **Allegations of Abuse by Location/Classification: - cont.**

#### **DDSO/ICF Data**

Unit	Neglect	Physical Abuse	Psychological Abuse	Sexual Abuse	Unauthorized Restraint	Grand Total
1		2	3			5
2	4	1				5
3	4			1		5
4		1	2			3
5	2	1	1		1	5
6	2					2
7		2	1		1	4
8			1		2	3
Day Program	1					1
Grand Total	13	7	8	1	4	33

The DDSO/ICF Treatment Teams supervised nine residential apartments and one day program. One residential apartment was closed during calendar year 2009. With regard to ICF data, one (1) of ten (10) sites did not report abuse allegations. The site was identified as Apartment 10. Apartment 10 has filed zero (0) allegations of abuse for two consecutive calendar years. The number of allegations of abuse filed by the DDSO/ICF Teams has decreased by 15% between the 2008 and 2009 calendar years. As depicted above, Apartments 2 and 3 filed the greatest number of allegations of neglect. Apartment 1 filed the greatest number of allegations of psychological abuse. All other allegation classifications were dispersed equally among sites.

Allegations of Abuse data, by location/classification, for the remaining sites were not queried due to the statistical insignificance of the data. It is recommended that Treatment Teams focus efforts toward reduction of allegations of abuse at the identified sites.

### **Allegations of Abuse By Circumstances and Classification:**

With regard to allegations of neglect, the most prevalent trend related to direct circumstances for filing this allegation category was identified as failure of staff to provide the identified level of supervision specified by a consumer's plan of care. Inadequate supervision, failure to ensure the transfer of supervision of a consumer to another staff member, and sleeping on duty were identified as the most prevalent causes. Transition times, such as change of shift, and change of activity were most common times for lapses in supervision to occur. Most often the consumer(s) involved suffered no ill effects as a result of inadequate supervision, however, in some cases lack of supervision was cited as the cause of other consumer incidents/allegations. An emergent nuance to the issue of inadequate supervision, was identified as staff leaving a consumer in the bathroom unattended, resulting in a fall that required medical treatment beyond first aid. A trend was also identified for consumers that require G-tube or J-tube feedings, not receiving their feedings.

### **Allegations of Abuse By Circumstances and Classification: - cont.**

The most prevalent trend related to direct circumstance for filing allegations of psychological abuse was staff arguing and using inappropriate language in the presence of consumers, which is consistent with calendar year 2008 data. The most prevalent trend related to direct circumstance for filing allegations of sexual abuse was identified as accusation of touching or fondling of intimate parts between consumers not capable of consenting to sexual activity.

The most prevalent trend related to direct circumstance for filing allegations of unauthorized or inappropriate use of restraint was identified as exceeding the allowable time-frame for protective gear removal. There were no prevalent trends related to direct circumstances for any other allegation category.

### **Allegations of Abuse By Indirect Circumstances:**

During a review of the calendar year 2009 data and investigations that have been presented to Special Review Committee, the following trends were identified related to incident circumstances/ancillary issues.

Trends for providing inaccurate information to an investigator and instances of late reporting of allegations of abuse have continued to occur. Late reporting amongst direct care staff has decreased dramatically; however late reporting or reporting incorrectly amongst supervisory staff has increased. Re-training for supervisory staff is recommended. It is recommended that Administration consider additional preventative training or additional penalties for failure to meet employee responsibilities.

Trends for staff not following consumers' Behavior Support Plans and documentation issues were noted. Trends were also identified for not providing staff with consistent/clear guidelines related to supervision and behavior, based on the information having been reflected differently across guiding documents such as the individual protective oversight plans, ISPs, and Behavior Support Plans. In terms of incident circumstances, the most prevalent pre-setting event to many of the allegations, regardless of the investigative findings, was poor communication among staff or between staff and consumers which includes misuse of contingencies and redirection.

With regard to the investigative process, early in calendar year 2009 a positive trend was identified for an improvement in investigative reports in terms of quality and timeliness. Towards the middle to the end of the year it was noted that investigative reports were not as comprehensive as they should have been and are not being completed in a timely manner. In some cases not all possible witnesses (staff and consumers) were interviewed as to their knowledge of the event being investigated. In most cases this did not affect the investigative outcome; however the potential for a negative outcome does exist. Another issue pertains to the investigative interview process. Investigators were asking leading questions of the witnesses, which had a direct impact on the investigative process. Witnesses were given too much information regarding what issues were being investigated, which lead them to providing predictable answers to the questions.

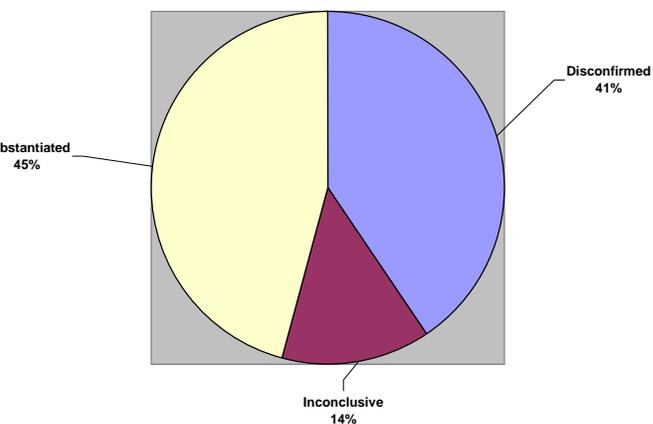
**Allegations of Abuse By Indirect Circumstances: -cont.**

Another trend relates to supportive documentation. In many cases the investigator was not summarizing pertinent documentation. In some cases the investigator made conclusions and recommendations that were not supported by the factual findings of the investigation. Investigators were not always identifying and making recommendations regarding late reporting.

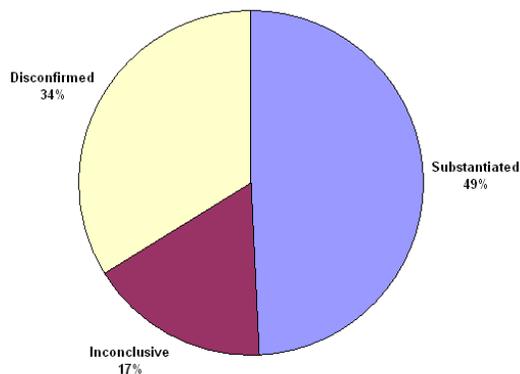
**Allegations of Abuse by Findings:**

Depicted below are Investigative/Special Review Committee findings for the total number of abuse allegations that have been reviewed. As the chart illustrates, the majority of allegations of abuse filed during calendar year 2009 were substantiated, which is consistent with calendar year 2008 data, indicating that slightly less than half of all allegations filed, were verified to have occurred, by a preponderance of the investigative evidence. A positive trend noted for calendar years 2008 and 2009, was identified as a low number of allegations of abuse with an inconclusive finding. The increase in substantiated and disconfirmed allegations of abuse can be attributed in part to an overall improvement in the quality and scope of investigative process. It was noted that the calendar year 2009 chart only reflects investigative conclusions for allegations of abuse that have been submitted for Special Review. A total of seventy five (75) cases have not been submitted. At the end of the calendar year, meetings and discussions were held with DDSO Administration which has resulted in a new administrative approval process to ensure more timely submission of investigative reports.

Allegations of Abuse Grouped by Findings  
Calendar Year 2008



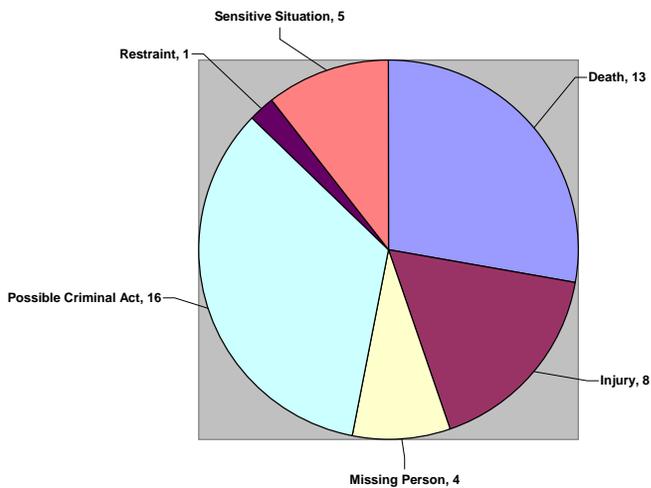
Allegations of Abuse Grouped by Findings  
Calendar Year 2009



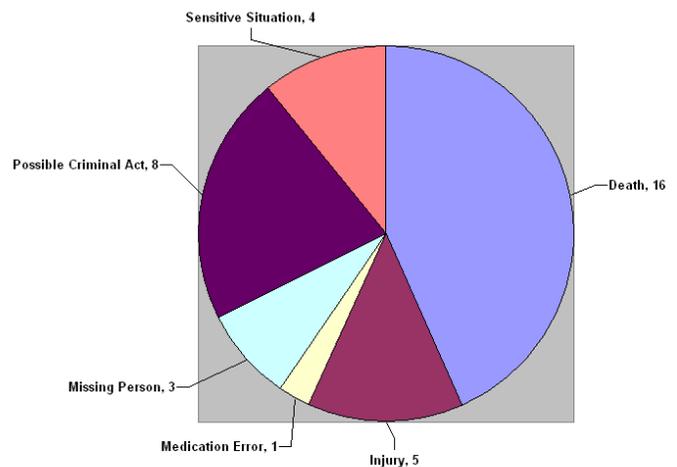
## Serious Reportable Incidents

Thirty Seven (37) consumer incidents filed during calendar year 2009 were classified as serious reportable, as mentioned previously in this report. Compared to historical data this number is below the statistical norm. Relevant trends related to serious reportable incidents will be discussed according to classification, circumstance, and county/designation.

Serious Reportable Incidents Grouped by Classification  
Calendar Year 2008



Serious Reportable Incidents Grouped by Classification  
Calendar Year 2009



### Serious Reportable Incidents by Classification and Circumstance:

There was one (1) serious reportable medication error filed during calendar year 2009 and zero (0) serious reportable restraints filed during the year. As illustrated above, during calendar year 2009, a positive trend was identified as a continuing reduction in the total number of serious reportable sensitive situations.

A potentially problematic trend was noted for the serious reportable incident category, injury, for calendar year 2009. The majority of serious reportable injuries were of unknown cause at the time of filing. Etiology was discovered during the investigative process in the majority of cases. During calendar year 2008 an emergent trend was noted for fractures as a result of severe osteoporosis. This trend has continued during calendar year 2009. Serious reportable injuries have been maintained at a low level for the past three calendar years.

The serious reportable incident category, possible criminal act, comprised the second highest number of serious reportable incidents filed during calendar year 2009, which represents a significant reduction, of 50%, in possible criminal acts between the two calendar years. The majority of possible criminal acts filed involved a consumer being arrested or spoken to by the police for such offenses as assault of staff, a peer or police. The majority of consumers that were involved in these incidents reside in supervised settings and are dually diagnosed with psychiatric issues. Other possible criminal acts filed involved, allegations of inappropriate touching of a peer.

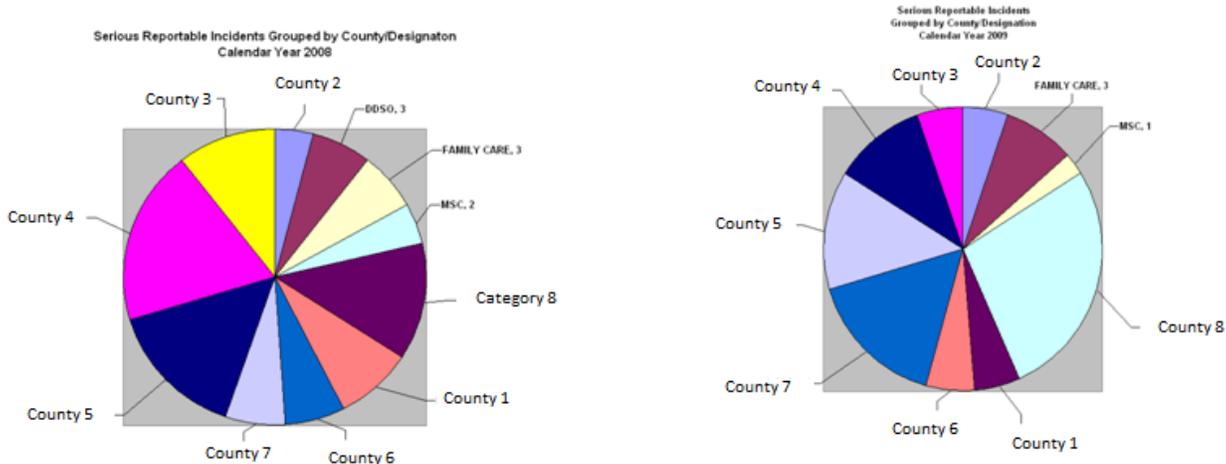
**Serious Reportable Incidents by Classification and Circumstance- cont.:**

Although Part 624 regulations allows agencies the latitude to file some consumer deaths as reportable incidents, since it is OMRDD policy to require the same level of inquiry, the DDSO files all deaths as serious reportable. The serious reportable classification, death, comprised the highest serious reportable incident category during calendar year 2009. The number of consumer deaths is statistically similar to previous years. The breakdown of deaths by gender included five (5) women and eleven (11) men. During calendar year 2009, nine (9) of sixteen (16) consumer deaths were expected. These individuals were elderly, in most cases or exceedingly frail. All had documented medical conditions that were not responding to treatment. Some of these individuals developed associated infections. Others were diagnosed with terminal cancers. Seven (7) of sixteen (16) consumer deaths were unexpected. Consumers did not display symptoms prior to the day of their deaths and were responding to their medication regimes. Four (4) of seven (7) unexpected deaths were due to sudden cardiac arrest. One (1) of seven (7) unexpected deaths was due to cerebral vascular accident. One (1) of seven (7) unexpected deaths was caused by septic bowel. The remaining one (1) of seven (7) unexpected deaths was due to an arterial bleed, caused by a hidden lung tumor. The number of consumer deaths is statistically appropriate.

Serious reportable incidents for the categories missing persons, restraints, and medication errors were maintained at a low level during calendar years 2008 and 2009, as depicted on page 12 of this report.

**Serious Reportable Incidents by County/Designation:**

The chart below provides a breakdown of serious reportable incidents by county/designation. As mentioned previously in this report the designation “DDSO” pertains to consumers that receive an ICF level of care. County 8 filed the greatest number of serious reportable incidents, followed by County 4. As is shown, serious reportable incidents were dispersed equitably among the remainder of the grouping. All counties/designations experienced minor to moderate decreases in serious reportable incidents, with the exception of County 8. A further breakdown of data will be discussed by county/designation and classification.



**Serious Reportable Incidents by Classification and County/Designation:**

As depicted below, County 8 reported the greatest number of consumer deaths, which is consistent with calendar year 2008 data. It has been identified that there is a significant number of medically frail consumers residing in County 8 IRAs. County 7 reported the second greatest number of consumer deaths. The incident classifications serious reportable injury and sensitive situation were more or less equally distributed among counties/designations. Although the incident classification, missing person, was maintained at a low level, it was noted that two (2) of three (3) incidents filed were filed as missing persons in County 4, which is also consistent with calendar year 2008 data. County 5 filed the greatest number of incidents classified as possible criminal acts, which is anomalous. It was noted that County 1 has a greater percentage of individuals with forensic issues than any other county/designation. County 1 and County 3 filed the second highest number of incidents classified as possible criminal acts during calendar year 2009.

County	Death	Injury	Medication Error	Missing Person	Possible Criminal Act	Sensitive Situation	Grand Total
County 2	1		1				2
FAMILY CARE	2					1	3
MSC						1	1
County 8	9	1					10
County 1					2		2
County 6	1	1					2
County 7	3	2			1		6
County 5		1		1	3		5
County 4				2		2	4
County 3					2		2
Grand Total	16	5	1	3	8	4	37

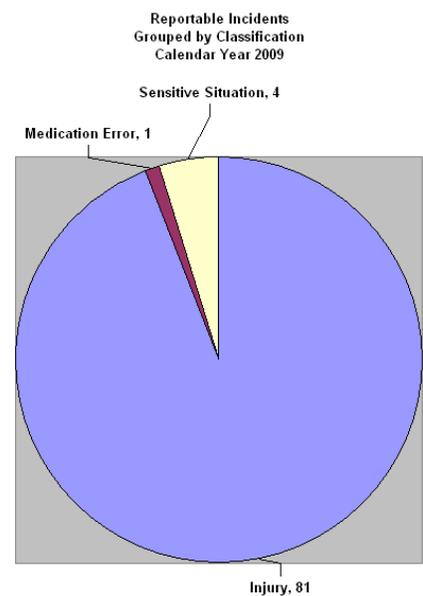
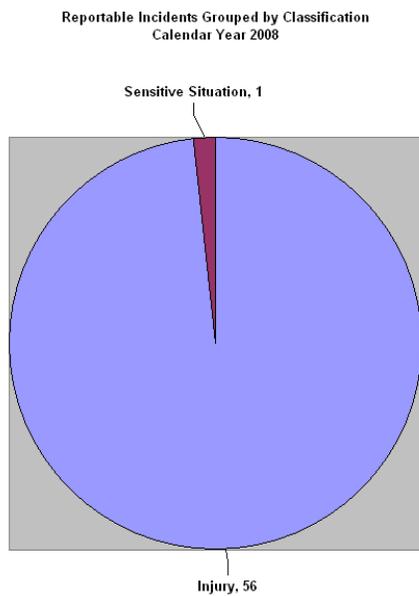
**Reportable Incidents**

Eighty six (86) consumer incidents filed, were classified as reportable, during calendar year 2009. Relevant trends pertaining to reportable incidents will be discussed according to classification, county/designation, origin/cause, medical treatment, affected body part, and ancillary circumstances.

**Reportable Incidents by Classification:**

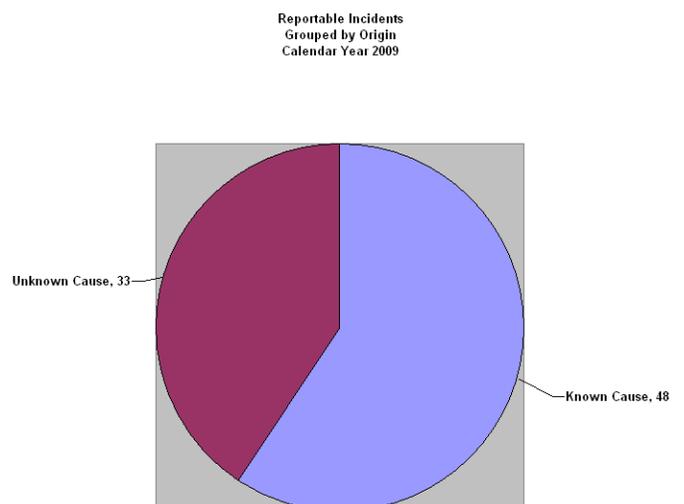
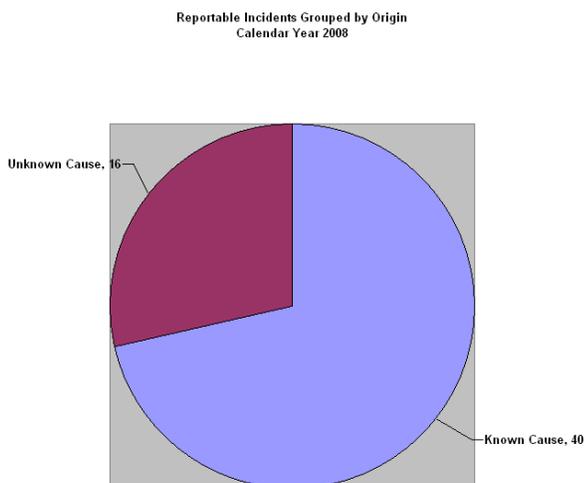
As depicted on page 15 of this report, eighty one (81) of eighty six (86) reportable incidents were classified as injuries. Four (4) reportable incidents were classified as sensitive situations and the remaining one (1) reportable incident was classified as a medication error. These incidents will not be discussed further due to the statistical insignificance of the events. It was identified that there has been an increase of thirty (30) reportable injuries, or 35% between calendar years 2008 and 2009. This increase is significant.

**Reportable Incidents by Classification –cont.:**



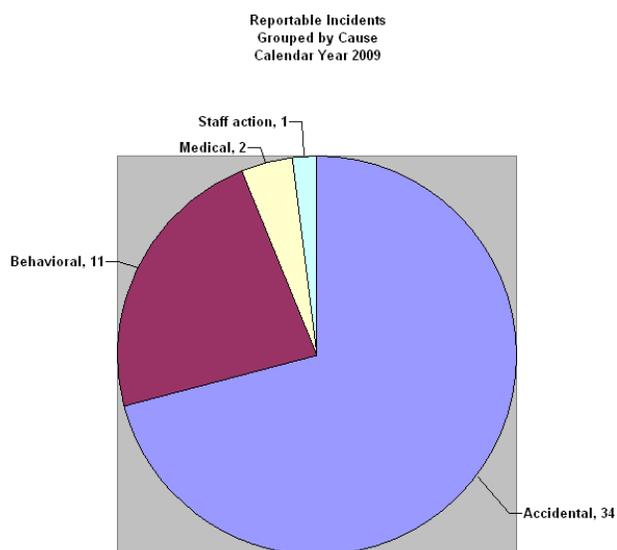
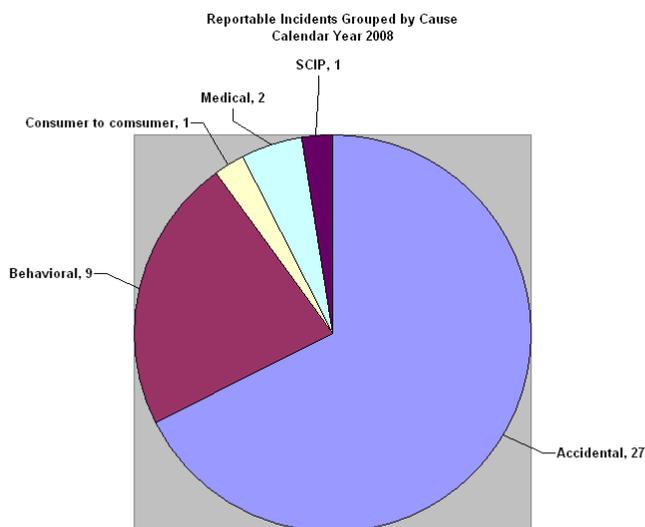
**Reportable Injuries by Origin/Cause/Circumstance:**

As depicted below, during calendar year 2009, forty eight (48) reportable injuries were of known cause/origin at the time of filing. The remaining thirty three (33) reportable injuries were of unknown cause/origin at the time of filing. In many cases the origin of these injuries was not discovered during investigation, although in most cases a plausible explanation was hypothesized. In all but a very few cases there was no suspicion of possible abuse. The Special Review Committee recommended in each case that when a consumer sustains an injury of unknown origin, every effort should be made to discover the actual cause of the injury, in accordance with Part 624 Regulations. The investigative reports should include medical opinion as to how the injury may have occurred or the possible date of injury. Other shift and day program staff should be interviewed, and documentation prior to the discovery of the incident should be reviewed to ascertain the possible cause of the injury, as well as an evaluation of possible environmental hazards. A problematic trend was noted for prevalence only, related to the increase in injuries of unknown origin by 51% between the two calendar years 2009.



### Origin/Cause/Circumstance: - cont.

As mentioned previously, forty eight (48) reportable injuries were of known cause/origin at the time of filing. As depicted below, the majority of consumer injuries that required treatment beyond first aid were sustained through accidental causes. Eleven (11) of forty eight (48) injuries of known cause/origin were sustained during a behavioral outburst. All other causal factors were maintained at a low level. It is recommended that the Treatment Teams discuss efforts toward positive reduction of accidental injuries. During the next calendar year, the accidental category will be further broken down into additional categories to capture the types of accidents that have produced injuries that require treatment beyond first aid.

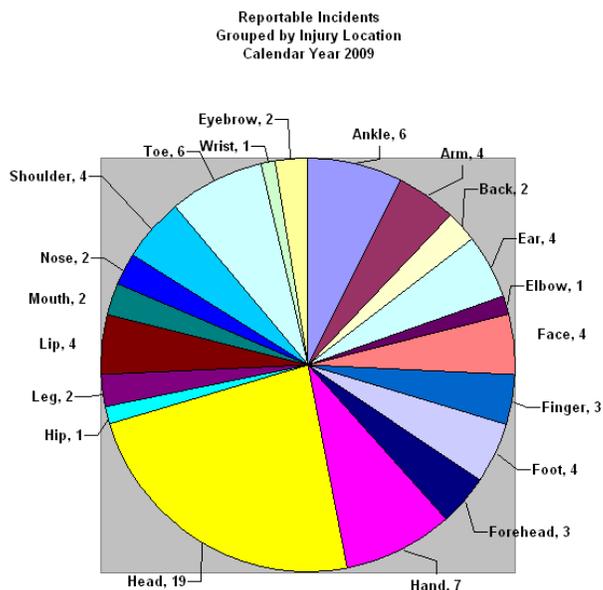
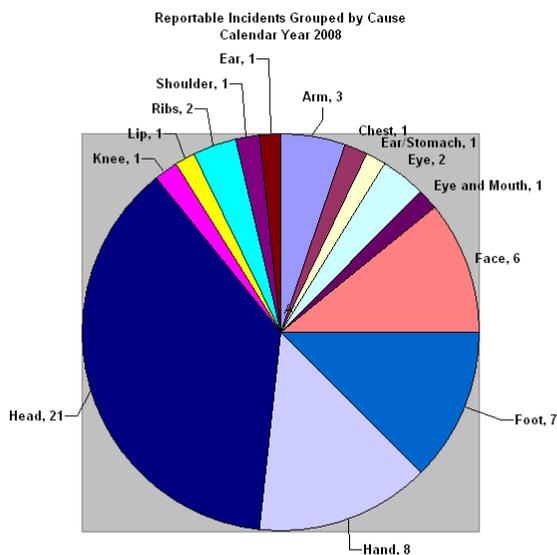


### Reportable Incidents by Injury Location:

In terms of injury location/affected body part, during calendar year 2009, injuries to the head, neck and facial outnumbered injuries to the upper extremities, and lower extremities. This finding is consistent with calendar year 2008 data. The most frequent injury site was listed as the consumer's head. Injuries to the upper extremities have continued to outnumber injuries to the lower extremities. It is recommended that the Treatment Teams discuss efforts toward positive reduction of head neck and facial injuries. A systemic trend was identified related to initial care and treatment of an injury. In many cases the staff moved the consumer without knowing the extent of their injury or receiving a direction from medical personnel that it was okay to move the person. In most of the cases reviewed, this action did not worsen the consumer's injury or cause any other harm; however the potential for causing harm did exist. Another identified trend relates more directly to the injury sustained, and was identified as, the individual having sustained a seemingly innocuous injury, with initial minor symptoms that become more pronounced over a day or two.

### Reportable Incidents by Injury Location: - cont.

In all of these cases the individuals have a diagnosis of osteoporosis, and the x-ray taken on day 2 or 3 following the initial injury, is positive for fracture. Recommendations were made to DDSO Administration and the Medical Director to address these issues with staff when the trends were initially identified.

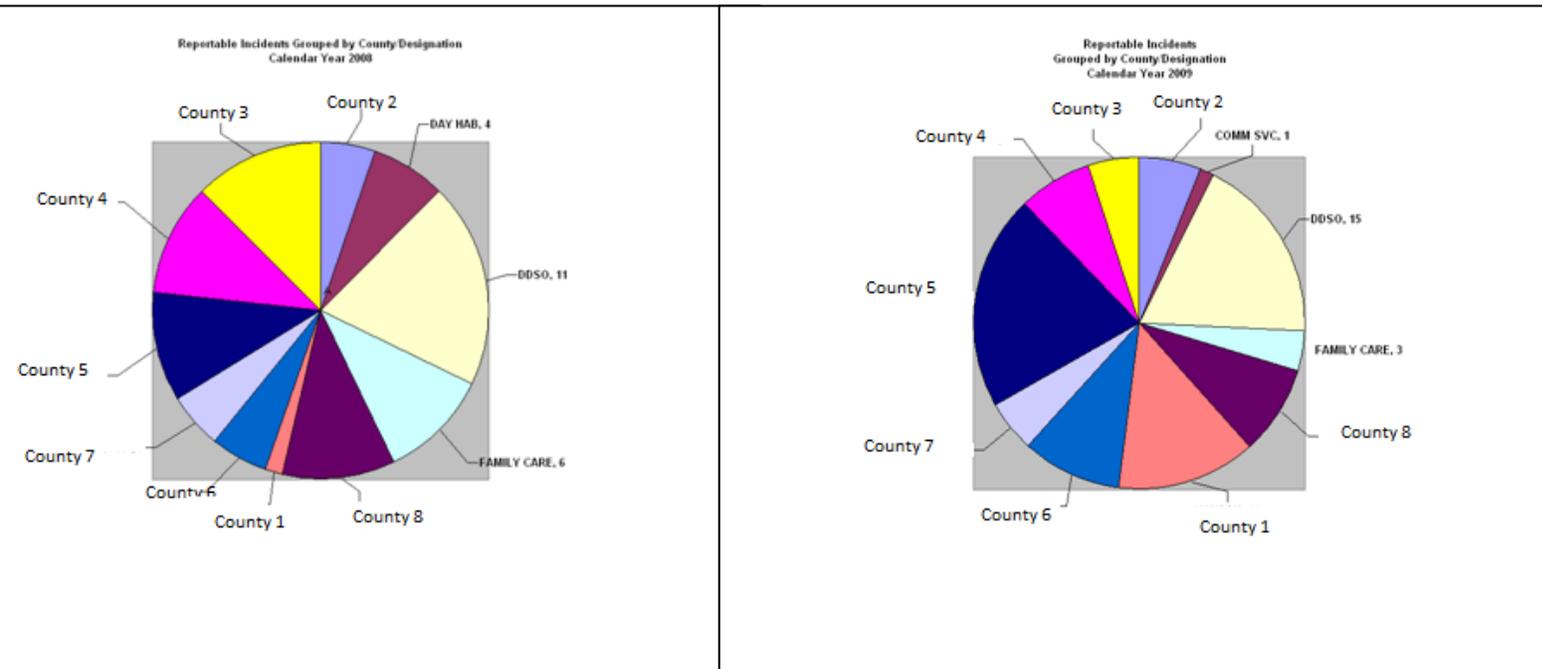


### Reportable Incidents by County/Designation and Location:

Individuals residing in County 5 sites sustained more injuries to their head, than any other county/designation. Individuals that reside at the DDSO/ICF sustained the second greatest number of injuries to the head. There were no other trends related to County/Designation or location regarding affected body part. Injury types were distributed equally among sites. In terms of injuries of known/unknown origin, it was noted that County 5 reported the greatest number of injuries of unknown origin, followed by the DDSO/ICF program. These findings are relatively anomalous. It also should be noted that these two sites reported the greatest numbers of injuries of any kind during calendar year 2009, as depicted on page 18. All other sites maintained injuries that require treatment beyond first aid at a moderately low level, with minor increases or decreases between the two calendar years.

With regard to location data, specific to community based sites, IRA1 and IRA 2 reported the greatest number of injuries of any kind during fiscal year 2009, followed closely by IRA 2, IRA 4 and IRA 5, with four (4) and three (3), reportable injuries per site, respectively. All other sites maintained reportable injuries at a low level. It was noted that the make up of these homes varies with regard to size, and type of developmental disability; however most individuals residing in these homes have significant cognitive and communication deficits.

**Reportable Incidents by County/Designation and Location: -cont.**



**Jonathan’s Law Statistical Information**

During calendar year 2009, the DDSO made three hundred ninety nine (399) Jonathan’s Law notifications. Three hundred ninety two (392) OMR 148 Action Reports were sent to qualified persons. Twenty five (25) qualified persons requested to have a meeting with the DDSO Director’s designee. Fourteen (14) allegation of abuse investigations were redacted and sent to qualified persons after receiving a written request for that information. This year there were no invalid requests for information.

**Commentary and Recommendations**

1. The total number of incidents has increased moderately between calendar years 2008 and 2009, due to the increase in the reportable injury category. It is recommended that efforts continue in the area of positive reduction.
2. Geographic distribution of incidents according to residence type has remained equitably disbursed between according to historic groupings. With regard to site-specific data, it is recommended that high incident concentrations for identified sites be viewed as emergent trends, and that these sites be monitored more closely to determine whether the high incident numbers are anomalous or indicative of a breakdown in systems.
3. Although the Special Review Committee has identified areas that need improvement in incident investigations, the quality and scope of investigations and summary reports has continued to improve, resulting in fewer process errors and more effective recommendations.
4. Head injuries have continued comprise the highest number of reportable injuries. It is again recommended that the administration alert treatment teams of this trend as a first

step toward positive reduction of this injury category.

5. The increased number of reportable and serious reportable injuries of unknown cause during calendar year 2009 is anomalous. However; to prevent the prevalence of injuries of unknown cause from becoming a trend, it is recommended that Treatment Teams take additional measures toward reduction of injuries of unknown cause by encouraging staff vigilance and thorough documentation.
6. While the number of open cases does not represent the majority of incidents filed during calendar year 2009, DDSO Administration should continue to address the timely submission of incident investigations, due to the possibility that unresolved cases or issues could pose a potential breach in protection for persons receiving services and to ensure compliance with Part 624 regulations.

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