REPORTING, RECORDING, REVIEWING, AND MONITORING – INTERNAL EVENTS, REPORTABLE SIGNIFICANT INCIDENTS, AND ABUSE

POLICY:
It is the policy of Racker that people receiving services do so in a safe, caring, and supportive environment. All interaction with recipients and their families, as well as with other staff, should be characterized by respect for the worth and dignity of the individual.

EXPECTATIONS:
Whenever a student has an event that causes or has the potential to cause harm or the risk of harm to their (or to others) physical or emotional well-being, it is the responsibility of each staff person to intervene and provide what help and support they can. An event may include actions by a student or others, which creates adverse effects or the potential thereof, to the student's (or other's) well-being. The setting of the event (in program, or external) may impact the type of report and follow-up warranted; however, whenever an event is identified it is the responsibility of each staff member to:

a. Intervene, provide support and obtain assistance as needed;
b. Notify Program Director/designee immediately for assistance with ensuring immediate and continued safety & well-being of the student;
c. Notify Justice Center and/or OMH Office of reportable incidents as required within 24 hours of discovery - use the attached NIMRS grid for specific reporting requirements;
d. Complete a program incident/injury form.

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DEFINITIONS:

* Significant Incident: a Reportable Incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety or welfare of a patient.

* Reportable Incident: Significant Incidents including death, and allegations of abuse and neglect that must be reported to the Justice Center for the Protection of Persons with Special Needs and the office.

***** See NIMRS Attachment **Definitions for Incident Types (allegations of abuse/neglect or Significant Incidents, & deaths)** or by visiting**:**
https://www.omh.ny.gov/omhweb/dqm/bqi/nimrs/regulations/omh_nimrs_reportability_card.pdf

***** Custodian:
(1) a director, operator, employee, security personnel, or volunteer of a mental health provider; or
(2) a contractor that performs services pursuant to a contract that permits regular and substantial contact with patients of a mental health provider.

* Qualified Person (Q.P.): any person who may request access to a patient's clinical record in accordance with section 33.16 of the Mental Hygiene Law.

* Discovery: the time a mandated reporter witnesses an activity which appears to be a Reportable Incident or when any other person comes before the Mandated Reporter in their professional or official capacity and provides information that gives the mandated reporter reasonable cause to suspect that a Reportable Incident has occurred.

* Serious injury or harm:
  (1) physical harm requiring medical treatment or intervention beyond first aid, including the use of an opioid antagonist (i.e. Narcan/Naloxone) when used to counter the effects of a suspected opioid overdose (excluding routine diagnostic tests such as laboratory work, X-rays, or scans if no medical treatment is indicated);
  (2) psychological harm evidenced by negative changes in affect, behavior, cognition, or which necessitate a significant change in psychotropic or psychotherapeutic intervention; or
  (3) a risk for life threatening physical injury or for psychiatric emergency or trauma

* Human trafficking, also known as trafficking in persons: a crime under the penal law that involves compelling or coercing a person to provide labor or services, or to engage in commercial sex acts. The coercion can be subtle or overt, physical, or psychological. Exploitation of a minor for commercial sex is human trafficking, regardless of whether any form of force, fraud, or coercion was used.

*** For definitions of Incident Types, see NIMRS Attachment or visit:**
https://www.omh.ny.gov/omhweb/dqm/bqi/nimrs/regulations/omh_nimrs_reportability_card.pdf

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GENERAL REPORTING:

Allegations of Abuse or Neglect are reported to:
- Justice Center (JC) and OMH, *if involving a custodian*;
- CPS, if the student is under the age of 18 and the allegation is against a parent;
- State Ed. Dept., if allegation involves a school staff member.

Significant Incidents are reported to the Justice Center (JC) and OMH *with the following exceptions which are only reported to OMH*:

- Crime in the community or suicide attempt occurring off the premises of the facility or program and when the patient was not under the intended or actual supervision of a custodian:

- ***Deaths*** are reported to OMH *only*, *unless* it is believed that the death may be related to abuse by a *custodian.* If it is believed that the death is related to alleged abuse *by a custodian*, a report must be made to the JC as well.

[Note: Programs must assess various situations prior to reporting to determine if they rise to the level of a 'Significant Incident'. Examples include: crimes; child missing; attempted suicide. Seriousness, potential for harm, how the situation was discovered, and where the situation occurred are some of the factors that the program needs to take into consideration when determining:

(1) the need to report; and
(2) to whom to report.

Consultation with QS and/or the OMH Incident Management liaison is ***strongly recommended*** to assist with make final determinations for filing.]

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PROCEDURE FOR REPORTING INCIDENT and FOLLOW-UP:

The Staff Member observing or discovering any event involving a student who may cause harm to self or others, will:

1. Respond to the student involved;
2. Assist with calming the student/deescalating the situation, or other support as possible and necessary;
   - ❖ [If abuse, take **immediate** action to stop the abuse];
3. Ensure First Aid treatment, emotional crisis support, and secure assistance from others.
4. Inform School Nurse ***and*** Racker Program Director/designee **immediately** so that any further prompt and necessary supports may be provided, to ensure the continued safety & well-being of the individual.
   a. If program director is not available, contact a senior clinician.

NOTE! All situations involving suicidal ideation with or without a suicidal gesture or attempt are to be brought to a program director's *immediate* attention. Further, all staff should reference and utilize *Risk and Assessment Response Plan* [section 1400 of P&P manual]

5. Contact the New York State Justice Center ***immediately***, if it is believed that the event rose to the level of a 'reportable incident', as defined by the NIMRS chart.
   a. When reporting - provide the name, title, and contact information of every person known to the mandated reporter to have the same information as the mandated reporter concerning the incident.
   b. In cases where multiple mandated reporters have direct knowledge of the same reportable incident or have reasonable cause to suspect such incident has occurred, each mandated reporter is required to report such incident, unless they know that the report has already been made by another mandated reporter and that this person has been named in that report as a person with knowledge of such incident.
   c. After reporting to the JC, immediately notify the director or designee that report has been made.
   d. In circumstances where a patient reports an allegation of abuse or neglect to a provider which appears to be impossible or incredible, such provider shall promptly review the matter and must determine, within 24 hours of such report, whether there is

reasonable cause to suspect that a reportable incident has occurred. Discovery of the incident shall be deemed to be when the provider determined that such reasonable cause exists. If it is determined that reasonable cause does not exist and a report is not made to the Justice Center, such decision shall be documented.

6. Initiate and complete an internal Incident/Injury form – regardless of if the incident rises to the level of 'reportable' or not.
7. Submit incident/injury form to program director or senior clinician *by end of day*.

School Nurse will:

1. Ensure health assessment is completed, as possible and necessary;
2. If not already done, notify Program Director/designee.

The Program Director/Senior Clinician (as designee) will:

1. Ensure arrangements are made for physical exam and further medical treatment, as necessary;
2. Make arrangements or recommendations for mental health evaluation, as necessary;
3. Secure/preserve the immediate vicinity of the incident as necessary.
    a. If area must be used, preservation of area may be done by taking photos.
4. Review information provided on incident/injury report and from the notifying staff member;
5. Notify partner program (e.g., BOCES), if applicable and appropriate. [If school personnel is a target of an allegation, it is the school district's responsibility to investigate and report to State Ed. Dept.]
6. Determine type of incident/injury and appropriateness of reporting to OMH; JC; CPS; Executive Director; Medical Director; and/or Qualified Person (Q.P.) – i.e., parents/guardians, if report has not already been made by staff to such parties.
    a. Consultation with QS and /or the OMH incident management liaison if available.
    b. See attached notification schedule & 24-hour contact to reference mandated time frames of notifications.
    c. If it is initially deemed 'not reportable' to the JC or OMH and more information comes to light at a later point that would warrant filing, place a call to the JC and/or OMH and provide updates.
    d. Notify OMH of all deaths within five business days of incident or discovery of incident – whether or not they occur in program.
        i. Notify the JC, *if the death is related to alleged abuse **by a custodian***.
7. Notify Racker's Quality Standards Department (QS) to assign a Quality Enhancement Reviewer, as warranted.
    a. At times either the JC or OMH may take over the investigation.
8. Notify all potential witnesses of their responsibilities to be interviewed and cooperative with the review process, emphasizing confidentiality of all information about the individual and circumstance.
9. Complete NIMRS Report and/or Justice Center Import and enter full incident report details. Submit electronically to OMH and other offices, as necessary.
    a. Notify QS Dept. if report is filed with OMH or JC – as they can assist with filing.

   b. *If there is any difficulty with completing the report in NIMRS contact the liaison for assistance and document all attempts and communications with the liaison until resolution of NIMRS issue or incident, if NIMRS cannot be resolved.*
10. Forward *copies* of internal report forms (including any physical intervention reports) to QS Dept. for review and trending.
11. When an incident affects a patient's health or safety, or a reportable incident occurs involving an allegation of abuse or neglect, wrongful conduct, missing patient, or death, the agency must provide telephone notice to a qualified person within 24 hours of the initial reporting of an incident.

The Quality Enhancement Reviewer will:
1. Obtain NIMRS report from Program Director/designee
2. Go to the site of the incident and conduct a comprehensive QE Review.
3. Submit final written & signed QE Review report (with applicable statements) to QS.

The Program Director will:
1. Develop a Corrective Action Plan (CAP) to address all recommendations made by all parties.
2. Ensure follow up is completed to recommendations, per CAP.
3. Submit follow up to QS for verification, within 2 weeks.

Throughout the process for identifying, reporting, documenting, reviewing & monitoring incidents, **The QS Department will**:
1. Review all reporting to the Justice Center and OMH and assist program with ensuring thoroughness.
2. Organize and facilitate Review Panels and Special Review Committee meetings to review and monitor reporting and review requirements. Minutes will:
   a. Be recorded to reflect panel and committee discussions; reviews; recommendations; and monitoring and verification of follow-up to recommendations;
   b. Include explanations for any late reporting and plan on how to avoid late reporting in the future;
   c. Be maintained in QS.
3. Submit review records (packets) to OMH via their electronic system, within 45 days. This includes:
   a. Finalized and signed reports for all allegations of abuse;
   b. Review findings for all Significant Incidents.
   c. [OMH is responsible for forwarding any reports and/or findings to the JC.]
4. Ensure CAPs (for substantiated allegations of abuse) are submitted to the JC via their electronic system.
5. Track and verify follow up to CAPs, and monitor for efficacy.
6. Provide any other assistance to the program that is necessary to ensure program standards and regulatory requirements are satisfied.

The Program Director will:

1. Provide final follow up with Q.P. after the Review Panel.
    a. For allegations of abuse (involving Racker Staff as a target) this will only involve informing the Q.P. that Racker review is completed and forwarded to OMH – and the JC will provide them with final outcome.
2. Use information from review of incidents, trends and recommendations to inform program practices.

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COMMITTEE ROLE

A Special Review Committee holds the responsibility to review all incidents and provide timely review of allegations of abuse and Significant Incidents.

Special Review Committee (SRC)

Membership

- Board members
- A licensed health care practitioner
- Persons identified by the director, to include some members of the following:
    - Direct Support Staff
    - Licensed Health Care Practitioners
    - Service Recipients
    - Representatives of family, consumer, or advocacy organizations
    - RoundTable (RT) Members (when requested)

As incidents mainly involve students under the age of 18, it is deemed inappropriate for another student to serve as a committee member.

Also in attendance:
Specific professional staff may be asked to attend to offer information in their area of expertise.

Duties: The Committee will review CSS incidents on a quarterly basis and review all Allegations of Abuse & Significant Incidents within 45 days.

PROCEDURE FOR THE SPECIAL REVIEW COMMITTEE:

The Special Review Committee will:

1. Convene at least semi-monthly with minutes taken to reflect meeting proceedings;
2. Convene within 45 days or sooner following the report of an Allegation of Abuse or Significant Incident to review QE report regarding any incident.
3. Review incidents/injuries reported, handled, reviewed and documented to ensure thoroughness and quality of the process;
4. Recommend to the Program Director:

   a. corrective/preventive actions to minimize or eliminate recurrence of incidents/injuries;
   b. changes in agency and program policy and procedures, which will improve conditions contributing to the incidents/injuries;
   c. Other items, as warranted.
5. Monitor actions taken on all recommendations made;
6. Identify, review, document, and monitor patterns of other events or situations attributed to a person receiving services, which may potentially harm an individual.
7. Analyze trend reports focusing on types of incidents, individuals involved, staff members involved and sites, time, date and circumstances.
8. Provide final review and closure of all incidents in the CSS program with any applicable recommendations for corrective and preventive action.
9. Forward findings and recommendations (i.e., minutes) to the Executive Director or designee and the Board President, in two (2) weeks or less, of the meeting.
10. The chair will draft and maintain minutes and subsequent documentation that all reports of allegation or incident have been reviewed by the committee and results and recommendations have been conveyed to the Executive Director.

The QS Department will:

1. Draft and maintain minutes of all meetings. Minutes will provide a brief summary of the situation (including date), what caused the report to be generated, committee findings and recommendations, and actions taken on the part of the agency/program as a result of such recommendations.
2. Provide trainings to all staff on this P&P and their responsibilities.

Note: No committee members may participate in the panel or committee review of any Allegation of Abuse/Significant Incident in which they were directly involved.

These procedures are based on:
Racker Best Practices
14NYCRR section 524 (amended 10/29/2025)

OMH NIMRS DEFINITIONS FOR INCIDENT TYPES AND REPORTABILITY

NEW YORK STATE | Office of Mental Health

Incident Type – Sub Type		Definition	Required Reporting
Abuse and Neglect Report to JC & OMH	**Allegation of Abuse and Neglect:** Abuse and neglect involve actions or a lack of actions by a custodian.		
	Physical Abuse	**Intentional or reckless contact with a client which causes or has the likelihood of causing physical pain or harm.**	**Report to JC & OMH** 1. **Report to the JC:** Call 1-855-373-2122 or submit the web form which can be accessed at: https://vpcr.justicecenter.ny.gov/WI/ 2. **Report to OMH:** After the report is made to the JC, the VPCR report will appear in your JC Import Tracker in NIMRS. The report must be imported as a NIMRS incident, enter required information into NIMRS and then sent to OMH. 3. Investigate, document findings and submit the investigation via WSIR within 45 days.
	Psychological Abuse	**Verbal or nonverbal conduct that intentionally or recklessly causes a patient emotional distress.**	
	Sexual Abuse	**Any sexual contact involving a custodian and a patient, or any legal sexual contact involving a patient that is encouraged or allowed by a custodian.**	
	Neglect	**Any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a patient.**	
	Deliberate Inappropriate Use of Restraint	**Use of restraint for any reason other than as an emergency safety intervention.**	
	Obstruction of reports of Reportable Incidents	**Conduct by a custodian intended to impede the reporting or investigation of a reportable incident.**	
	Unlawful use/ administration of a controlled substance	**Any illegal administration, use, or distribution by a custodian of a controlled substance (e.g. codeine, OxyContin, Ambien, cocaine) while in the workplace or on duty.**	
	Aversive Conditioning	**The use of unpleasant physical stimulus to modify behavior. ANY use of aversive conditioning is prohibited in facilities under the jurisdiction of OMH.**	
OMH & JC Death Report to JC & OMH	**OMH licensed or operated Inpatient Units, Residential Programs, or CPEP**	**Clients in OMH licensed or operated Inpatient Units, Residential Programs, or CPEP. Additionally, deaths of clients who had received services from such programs in the 30-day period preceding death. These "Death of Client" incidents are reported to the Justice Center.**	**Report to JC & OMH** 1. **Report to the JC:** Call JC Death Reporting Line at 1-855-373-2124 to make initial report. The VPCR report will appear in your JC Import Tracker in NIMRS. 2. **Report to OMH:** Import the VPCR report into a NIMRS Incident, enter required information on each NIMRS screen and then send to OMH. 3. Submit ***Report of Death to the Justice Center*** by clicking "Submit Death" within 5 days of the initial report to the JC.
OMH Only Death Report to OMH	**OMH licensed or operated OUTPATIENT programs**	**Death of patients receiving services only from an OMH licensed or operated OUTPATIENT program, must be reported to OMH via NIMRS. Additionally, deaths of clients who had received services from such programs in the 30-day period preceding death. These "Death of Client" incidents are entered directly into NIMRS click "Create Event" on the NIMRS Home Page and create an incident.**	**Report ONLY to OMH** 1. Log into NIMRS & select "Create Event" from the home screen. 2. Enter required information on each NIMRS screen and click "Email OMH".

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OMH NIMRS DEFINITIONS FOR INCIDENT TYPES AND REPORTABILITY

NEW YORK STATE | Office of Mental Health

Incident Type – Sub Type		Definition	Required Reporting
Significant Incident Regardless of Harm	**Significant Incident:** The following incidents are **Significant Incidents**, reportable to the Justice Center and OMH, when they **occur on program premises** or when the patient was **under the actual or intended supervision** of a custodian:		
	Crime	**An event which is or appears to be a crime under New York State or Federal law, which involves a patient as a victim, or which affects or has the potential to affect the health or safety of one or more patients of the program or has the potential to have a significant adverse impact on the property or operation of the program. It also includes acts committed by persons less than 18 years of age which, if committed by an adult, would constitute a crime.**	**Report to JC & OMH** 1. **Report to the JC:** Call 1-855-373-2122 or submit the web form which can be accessed at: https://vpcr.justicecenter.ny.gov/WI/ 2. **Report to OMH:** After the report is made to the JC, the VPCR report will appear in your JC Import Tracker in NIMRS. The report must be imported as a NIMRS incident, enter required information into NIMRS and then sent to OMH. 3. Investigate, document findings and "close" report in NIMRS within 45 days.
	Financial Exploitation	**Use, appropriation, or misappropriation by a custodian of a patient's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the patient of those resources. Examples include the deliberate misplacement, theft, or wrongful, temporary, or permanent use of a patient's belongings or money.**	
	Fire Setting	**Action by a patient, either deliberate or accidental, that results in fire on program premises.**	
	Injury of Unknown Origin*	**Any suspicious injury to a patient for which a cause cannot be immediately determined.**	
	Inappropriate Use of Restraint or Seclusion	**Unauthorized use of restraint or seclusion that is inappropriate because it was implemented without a valid physician's order or in a manner that was otherwise not compliant with applicable regulations, but which does not rise to the level of abuse (i.e. physical abuse or Deliberate Inappropriate Use of Restraint.)**	
	Missing Patient	**A patient of an inpatient or residential program: who has not been accounted for when expected to be present (in accordance with facility or program practice or policies) and who has not been found on the facility grounds or other expected location, or who is known to have left the facility grounds without the permission of an employee, when such permission is otherwise required and who is considered dangerous to others or unable to care for themselves, or who has not been accounted for when expected to be present and while missing was a victim of human trafficking.**	
	Sexual Assault	**Nonconsensual sexual conduct including the deliberate touching of a patient's intimate body parts, or clothing covering those body parts, or using force to cause self-touching by another patient of intimate body parts, or contact, that results in vaginal, anal, or oral penetration, i.e., rape or attempted rape and sodomy or attempted sodomy; or any sexual conduct between a person who is 18 years old or more and a person who is less than 15 years old, or between a person who is 21 years of age or older and a person who is less than 17 years old; or any sexual conduct which involves a patient who is deemed incapable of consent.**	
	Sexual Contact Between Children	**Vaginal, anal, or oral penetration by patients under age 18.**	
	Suicide Attempt	**An act committed by a patient of a mental health provider in an effort to cause their own death.**	
	Wrongful Conduct*	**Actions or inactions on the part of the custodian that are contrary to sound judgment or training, and which are related to the provision of services, the safeguarding of patient health, safety or welfare, or patient rights, but which do not meet the definition of abuse or neglect. This includes activity of a sexual nature involving a patient and a custodian' or activity of a sexual nature involving a patient that is encouraged by a custodian.**	

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OMH NIMRS DEFINITIONS FOR INCIDENT TYPES AND REPORTABILITY

NEW YORK STATE | Office of Mental Health

Incident Type – Sub type		Definition	Required Reporting
Significant Incidents Only with Serious Injury or Harm	**Significant Incident Only with Serious Injury or Harm:** The following incidents are **Significant Incidents**, reportable to the Justice Center and OMH, when they **occur on program premises** or when the patient was **under the actual or intended supervision** of a custodian with **serious injury or harm involved**:		
	Assault	**A violent or forceful physical attack by a person other than a custodian, in which a patient is either the victim or aggressor, and which results in serious injury or harm.**	**Report to JC & OMH** 1. **Report to the JC:** Call 1-855-373-2122 or submit the web form which can be accessed at: https://vpcr.justicecenter.ny.gov/WI/ 2. **Report to OMH:** After the report is made to the JC, the VPCR report will appear in your JC Import Queue in NIMRS. The report must be imported as a NIMRS incident and then "emailed" to OMH. 3. Investigate, document findings and "close" report in NIMRS within 45 days.
	Choking	**An event where a patient is unable to breathe as a result of ingestion of food or other foreign object, resulting in serious injury or harm or admission to a hospital, or where there is a written directive for such patient concerning risk of choking in place at the time of the event.**	
	Falls by Patients	**Events where patients trip, slip or otherwise fall in an inpatient or residential setting, resulting in serious injury or harm.**	
	Fights	**A physical altercation between two or more patients, in which there is no clear aggressor and no clear victim, resulting in serious injury or harm.**	
	Medication Error	**An error in prescribing, dispensing, or administering a drug which results in serious injury or harm.**	
	Other Incident	**An event, other than one identified in this section, which has or creates a risk of serious injury or harm.**	
	Overdose	**When a patient consumes an amount of a substance (e.g., prescription, over-the-counter, legal, or illegal) which is not intended to cause their own death, but results in serious injury or harm.**	
	Severe Adverse Drug Reaction*	**Unintended, unexpected, or excessive response to a medication given at normal doses, which results in transfer to ER or serious injury or harm.**	
	Self-Abuse	**Self-inflicted injury not intended to result in death that results in serious injury or harm.**	
	Verbal Aggression by Patients	**A sustained, repetitive action or pattern by a patient or patients of ridiculing, bullying, demeaning, making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on another patient or patients, which causes serious injury or harm.**	

OMH NIMRS DEFINITIONS FOR INCIDENT TYPES AND REPORTABILITY

NEW YORK STATE | Office of Mental Health

Incident Type – Sub type		Definition	Required Reporting
OMH Only Incidents **Report Only to OMH**	**OMH INCIDENTS: The following off-site incidents are reportable ONLY to OMH**		**Report ONLY to OMH** 1. Log into NIMRS & select "Create Event" from the home screen. 2. Enter required information on each NIMRS screen and click "Email OMH".
	Crime in the Community	**An event which is, or appears to be, a crime under New York State or Federal law, and which is perceived to be a significant danger to the community, or which involves a patient whose behavior poses an imminent concern to the community.**	
	Missing Subject of AOT Court Order	**A client who is subject to an AOT court order who fails to keep a scheduled appointment and/or who cannot be located within a 24-hour period (Outpatient Only) Inpatient and residential programs should report missing AOT persons under "Missing Client".**	
	Suicide Attempt, Off-site	**An act committed by a patient of a mental health provider in an effort to cause their own death that occurs off program premises, when the patient was not under the actual or intended supervision of a custodian.**	
	Human Trafficking, Off-site	**A patient of an inpatient or residential youth program, while on authorized leave or pass from the program, is the victim of human trafficking. Human Trafficking means a crime under the penal law that involves compelling or coercing a person to provide labor or services, or to engage in commercial sex acts. The coercion can be subtle or overt, physical, or psychological. Exploitation of a minor for commercial sex is human trafficking, regardless of whether any form of force, fraud, or coercion was used.**	

* In some cases, definitions are abbreviated. The revised 14 NYCRR Part 524 contains the full incident definitions and additional information is available in the Incident Management Field Guide.

Part 524 regulations: https://omh.ny.gov/omhweb/policy_and_regulations/adoption/part-501.pdf
Incident Management Field Guide: https://omh.ny.gov/omhweb/dqm/bqi/nimrs/regulations/inciden_management_field_guide.pdf

Definition of Custodian: A director, operator, employee, security personnel, or volunteer of a mental health provider, or a contractor that performs services pursuant to a contract that permits regular and substantial contact with patients of a mental health provider.

Definition of Serious Injury or Harm: physical harm requiring medical treatment or intervention beyond first aid, including the use of an opioid antagonist (i.e. Narcan/Naloxone) when used to counter the effects of a suspected opioid overdose (excluding routine diagnostic tests such as laboratory work, X-rays, or scans if no medical treatment is indicated; or psychological harm evidenced by negative changes in affect, behavior, cognition, or which necessitate a significant change in psychotropic or psychotherapeutic intervention; or a risk for life threatening physical injury or for psychiatric emergency or trauma

PLEASE CALL NIMRS HELPDESK at (518) 474-3619 OR EMAIL NIMRShelp@OMH.NY.GOV FOR ANY INQUIRIES RELATING TO REPORTING AN INCIDENT or IN NIMRS, CLICK THE "Ask A Question" TAB ON THE HOME PAGE.

Incident/Injury Reporting and Follow-up Guidelines

		Reportable Incidents (occurring ***on premises/under intended supervision*** – unless otherwise noted)	
Type of Incident	**Incident/Injury[1]**	**Significant Incident[2]** Note: refer to NIMRS definitions for threshold definitions	**Allegation of Abuse/Neglect/ Wrongful Conduct**
Form	Incident/Injury report (Agency form); Physical Intervention notification to site director	Internal incident/injury report; NIMRS	Internal incident/injury report; NIMRS
Notify immediately or ASAP	School Nurse (if injury involved); Director/designee & Parent &/or Guardian	Director; School Nurse (if injury involved) Executive Director; Q.P.; JC & OMH (via NIMRS) ▪ Report off-site instances of crime in community; suicide attempt; death to OMH *only* ▪ **If death is related to abuse by a custodian, report to JC**	Director; School nurse (if injury involved) Executive Director; Q.P.; ▪ *If Racker staff accused* - JC & OMH (via NIMRS); ▪ *If school personnel accused* school district (principal/superintendent), as appropriate; ▪ *If external to program/school* – NYS Central Registry (Child Abuse hotline)
Within 24 hours of incident reporting	XXXXXXX	Telephone notification of Qualified Person if an incident affects child's health or safety (see below re: Jonathan's Law)	Telephone notification of Qualified Person (see below re: Jonathan's Law)

Racker – **Director of Counseling for School Success** – Sarah Tarrow – 607-257-1555 ext. 5052; cell: 607-233-2029
Racker – **Director of Quality Standards** – Jessie Janssen – 607-272-5891 ext. 249; cell: 315-730-4634
Racker – **Executive Director** – Cris Donovan – office: 607-272-5891 ext. 277; cell: 607-273-5734
Q.P. – **Qualified Person** - Parents or other legal guardians of minor patients; students over 18 if own guardian.
OMH: *For information/clarification/assistance with incident management*:
Central and Western NY-Deborah Feldman (Deborah.Feldman@omh.ny.gov)
For after-hours and on weekends, call the OMH Main Number and ask for 'administrator on call': 1-800-474-3619
JC (Justice Center)/VPCR (Vulnerable Persons Central Registry): 1-855-373-2122
JC for deaths: 1-855-373-2124
Child Registry (for allegations of abuse or neglect occurring outside of program): 1-800-635-1522 for people *younger than age 18*

[1] Includes injuries of known origin & no more than basic first aid; physical interventions; other as determined by Director.
[2] Includes crime; financial exploitation; fire setting; injury unknown origin; inappropriate use of restraint or seclusion; sexual assault; sexual contact between children; suicide attempt; wrongful conduct; adverse drug reaction; assault; choking; fights; medication error; overdose; severe adverse drug reaction; self-abuse; verbal aggression by student; other - as deemed 'serious.'
Note: refer to NIMRS definitions for threshold definitions.

Jonathan's Law/Mental Hygiene Law sections 33.23 and 33.25

(1) Upon admission patients and qualified persons shall be informed in writing of their rights to receive information pursuant to Mental Hygiene Law sections 33.23 and 33.25.

(i) When an incident affects a patient's health or safety, or a reportable incident occurs involving an allegation of abuse or neglect, wrongful conduct, missing patient, or death, the agency must provide telephone notice to a qualified person, as defined in paragraph six of subdivision (a) of section 33.16 of the Mental Hygiene Law, within 24 hours of the initial reporting of an incident.

(ii)The agency must not provide such notice to a qualified person in the following situations:

(a) if the qualified person is the alleged abuser;

(b) if there is written advice from the qualified person that they object to receiving such notification. The notice must then be provided to another qualified person if one exists; or

(c) if the person receiving services is a capable adult who objects to such notification being made.

(*1)* If the capable adult objects to notification of a qualified person, the capable adult must be provided the notice described in this clause.

(iii) At the qualified person's request, the following must be completed:

(a) provide the qualified person with a copy of the written incident report, provided that the names and other personally identifiable information of patients and employees are redacted unless patients and employees authorize such disclosure;

(b) meet with the qualified person to discuss the incident; and

(c) within 10 days send the qualified person a written report on the actions taken to address the incident (Actions Taken Report).

(iv) In accordance with Mental Hygiene Law 33.25, upon written request to the provider, qualified persons may obtain records and documents related to reportable incidents including the results of the investigation within 21 days of either the conclusion of the investigation or the written request, whichever is later, provided that the names and other personally identifiable information of patients and employees are redacted unless patients and employees authorize such disclosure.

(v) In accordance with Mental Hygiene Law section 33.25, incidents or allegations reported to the Justice Center, shall not be deemed to be serving a quality assurance function as defined pursuant to Social Services Law section 490(b). As such, the only information that may be redacted are names and other personally identifying information of other patients and employees unless such patients and employees authorize disclosure.

(2) The following documentation must be maintained by the provider:

(i) the telephone notice and responses received, including the identity and position of the person providing the notice, the name of the person receiving the notice, the time of the

original call or attempted call, the time of subsequent attempted calls if the initial call was not successful and the time of follow up calls if the notice occurred in more than one call;

(ii) any requests for a meeting or the initial incident/occurrence report;

(iii) meetings held in response to the request, and those present;

(iv) a copy of the Actions Taken Report and any initial incident/occurrence report (with redaction) that was given to the qualified person; and

(v) advice that a particular qualified person does not want to receive notifications or that the capable adult receiving services objects to notice or objects to the provision of documents/information;

(vi) a copy of the full investigative report with identifying names of employees.

(3) Administrative appeal process—denial of requested records/documents.

(i) A qualified person denied access to the records and documents requested pursuant to this section may appeal such denial, in writing, to the Office of Mental Health's Office of Quality Improvement.

(ii) Upon receipt of the appeal, the agency issuing the denial will be notified of the appeal and given an opportunity to submit relevant information to the Office of Quality Improvement, including the reasons for denial, within 10 business days of the receipt of such appeal. The Office of Quality Improvement may also request additional information from the qualified person as may be necessary to resolve the appeal.

(iii) Within 10 business days of the receipt of complete information, the Office of Quality Improvement will make a determination about whether the requested records and/or documents should be released. The Office of Quality
Improvement will issue their determination with an explanation of the reasons for the determination to the qualified person and the agency. If so, directed by the Office of Quality Improvement, the agency must provide the requested records and/or documents to the requestor.

(iv) Note that records maintained by the agency may also be available under section 496 of the Social Services Law to *other persons named in the report* as defined in section 488 of the Social Services Law.