



**Johnson County Auditor**  
Johnson County, Kansas  
**PERFORMANCE AUDIT**

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**January 18, 2007**

**Management of Incident Reporting Systems**  
**Departments of Mental Health, Public Health and Med-Act**

*“Trend analysis would enhance departmental incident reporting systems”*



## Johnson County Audit Services

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January 18, 2007

To: The Johnson County Board of County Commissioners  
Michael Press, County Manager  
David Wiebe, Executive Director, Department of Mental Health  
Leon Vinci, Director, Department of Health  
Ted McFarlane, Director, Med-Act

In accordance with the approved audit plan, we performed an audit of incident reporting systems at the Departments of Mental Health, Public Health, and Med-Act. Our objective was to determine if incidents that could cause harm to consumers and staff are reported accurately and timely to effect meaningful intervention. A similar review was done at the Department of Developmental Supports and results are included in report number 2006-03, dated July 27, 2006.

We concluded the departments implemented incident reporting systems, trained staff to report incidents, and staff generally complied with departmental procedures. The audit recommended management use trend analysis techniques to enhance their quality control. Such analysis would allow managers to identify broader issues such as problems with staff, consumers, programs or providers. Additionally, the audit recommended managers develop procedures to minimize errors in incident reporting and ensure timeliness in conducting and completing investigations.

The audit was conducted according to applicable standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, except that Peer Review has not been performed, and included such tests of the procedures and records as considered appropriate.

I appreciate the cooperation received from the Department Directors and their staff during this audit.

William D. Miller, CIA, CGFM  
County Auditor

The following auditors contributed to this report:

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**MANAGEMENT OF INCIDENT REPORTING SYSTEMS  
DEPARTMENTS OF PUBLIC HEALTH, MENTAL HEALTH AND MED-ACT**

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## **RESULTS AND RECOMMENDATIONS**

### **1. Managing Incident Reporting Systems**

Quality assurance in the departments of Public Health, Med-Act, and Mental Health could be enhanced by including trend analysis techniques in their incident<sup>1</sup> reporting systems and ensuring reported data is accurate and subsequent reviews are timely. These departments use the incident reporting systems to record inappropriate activities including medication and clinical errors, consumer behaviors, accidents and, in some cases, equipment malfunctions. All of the departments effectively trained staff to prepare incident reports, and staff awareness and compliance was high. However, the incident reporting systems have been used primarily as diaries for documentation purposes rather than a management tool for proactive review and problem solving. While individual incidents may be resolved, trend analysis may disclose broader issues such as problems with staff, consumers, programs, or providers.

#### **Recommendations**

We recommend the Directors of Mental Health, Public Health and Med-Act:

- 1.1 Develop a systematic process for tracking and trending incidents to assist in identifying potential problems with specific consumers, staff, facilities, programs, or providers.
- 1.2 Develop guidelines and accountability procedures to address:
  - Accurate identification and documentation of an incident
  - Criteria for initiating and timelines for completing investigations
  - Criteria for implementing corrective action plans and timelines for completion
  - Requirements for documenting final disposition and closure of the incident in the incident reporting system
- 1.3 Establish a grading system for assigning risk levels to reported incidents when warranted.

We recommend the Director, Public Health:

- 1.4 Develop a centralized process for tracking all reported incidents from the five divisions.

We recommend the Directors, Mental Health and Public Health:

- 1.5 Evaluate the utility of, and implement if warranted, a first-reporter, point-of-entry electronic incident reporting system similar to Med-Act's.

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<sup>1</sup> Basic definition of an incident is an event (or evidence suggesting an event ) which seriously or adversely affects the health or safety of a consumer or employee or has the potential to do so.

## Management Comments

The Department Directors of Med-Act, Public Health and the Executive Director of Mental Health agreed with the recommendations. Detailed comments are included in Appendix II, page 11.

### Discussion

Incident reporting systems are an important resource county departments have available for identifying and measuring unique or ongoing consumer incidents, program weaknesses, common trends and exposures to unnecessary risks. These reporting systems provide management tools to pro-act versus react to risk situations.

We reviewed the incident reporting systems at Public Health, Med-Act, and Mental Health. This audit evaluated each department's definition of a reportable incident, criteria for reporting and investigating incidents, responsibility for oversight, and use of the captured information.

#### **Each department has a unique incident reporting system**

All three departments developed incident reporting systems with documentation requirements for staff to implement. The methods of reporting vary between standardized forms developed for the department to letters and memos. Some of the departments have automated systems or use quasi-automated systems while one maintains manual records. Table 1.1 shows these types of incident record systems.

**Table 1.1: Organizational Structure of Incident Record Systems**

Department	Decentralized	Centralized	Manual Records	Automated Records
Public Health	X		X <sup>1</sup>	
Mental Health		X	X	X <sup>2</sup>
Med-Act		X		X <sup>3</sup>

Source: Organizational documentation and results of interviews

<sup>1</sup>Incidents are recorded manually and retained in each division

<sup>2</sup>Incidents are recorded manually and re-entered into a centralized automated database

<sup>3</sup>Incidents are directly recorded into the automated database by the first reporter

The types of incidents reported are typically:

Inappropriate actions between clients  
Medication errors  
Equipment malfunctions

Accidental injuries  
Threatening behavior toward staff  
Clinical errors

The departments immediately respond to incidents upon occurrence, document the incidents for their files and initiate an investigation if warranted.

## Incident reporting is influenced by the definition of a reportable incident.

Mental Health and Med-Act staffs use a broad definition of an incident to ensure visibility by the departments over all incidents that occur—major or minor. Any occurrence or practice out of the ordinary is reportable.

Public Health policy does not clearly define a reportable incident. The department’s reporting guidelines limit reporting to six criteria involving consumer occurrences within clinic settings. There is no reporting system for staff encounters while in the field. Table 1.2 shows the total number of reportable incidents by each department over various selected review periods.

**Table 1.2: Total Incidents**

<b>Department</b>	<b>Number of Months</b>	<b>Total Reported Incidents</b>	<b>Average Incidents Per Month.<sup>1</sup></b>
Public Health	24	40	2
Med-Act	18	697	39
Mental Health	6	312	52
Total		1049	

Source County Auditor Audit Analysis

<sup>1</sup>Rounded

We used the average number of incidents per month for comparison because of the different review periods. As shown, the average per month varies significantly among the departments. Public Health’s low average could be due to the limited criteria used for reporting incidents.

## Reported incidents can be used to monitor safety and performance

None of the departments routinely track and trend consumer incidents. Although not required, departments can benefit by developing a tracking and trending system to determine if, and when, to take proactive corrective measures on specific issues or problems.

Mental Health and Med-Act databases offer many options for tracking and trending incident reports. Management can sort and compile data in meaningful ways to identify a baseline of consumer incidents, programs, locations, or a variety of other areas of potential concern. Management could use trend analysis techniques to measure incident occurrences against baseline data and take corrective action as required.

Two departments have the tools to trend data

For example, an increase in number of incidents by a consumer could trigger closer monitoring or adjustment of activity. Repetitive incidents from different consumers associated with a common facility or program could indicate staffing or program operational issues that need further review.

As an illustration, we tracked the incidents reported by Mental Health between January and June 2006. A sort of the report database by “ClientID” showed 239 consumers accounted for 312 incidents.

**Table 1.3: Mental Health Tracking Incidents by Consumer**

Number of Consumers	Incidents Per Consumer	Total Incidents	Percentage of Total Incidents
188	1	188	60.2
36	2	72	23.1
9	3	27	8.7
5	4	20	6.4
1	5	5	1.6
239		312	

Source: County Auditor Audit Analysis

The table shows 15 consumers had 3 or more documented incidents accounting for 52 (16.7%) of the total reported incidents. At this stage, there is no indication whether this is a good or bad outcome. Rhetorically, is this outcome a good target to base future measurements for success? Or, should the department expect a higher percentage of 2 or less incidents per consumer? Management could set benchmarks and acceptable tolerance levels for incidents and use trend analysis to measure against them. If the number of incidents exceeds the benchmarks and tolerance levels, management could take action to determine if common underlying issues need to be addressed.

In another illustration, we randomly selected 8 Med-Act “Units” from their incident reporting database and compared the total number of reported incidents by unit and trends between January and March 2006. Table 1.4 demonstrates the management follow-up that could be done by tracking and trending report data.

**Table 1.4: Med-Act’s Incidents by Selected Units**

Unit	Month			Total
	Jan.	Feb.	March	
A	7	9	6	22
B	0	0	3	3
C	1	2	6	9
D	1	2	3	6
E	2	3	2	7
F	4	0	2	6
G	0	3	0	3
H	3	4	3	10
Total	18	23	25	66

\* Includes only a partial list of total units.

Source: County Auditor Audit Analysis

As shown, Unit A has documented over 100 percent more incidents than any of the other units in this comparison. Is there something unique about Unit A? Or, are there problems that need to be addressed?

We are not suggesting these illustrations represent problems or that these are even the elements the departments would choose to trend. These illustrations show how managers could approach

examinations of data that could lead to questions about incidents or to set baselines. Officials from Mental Health and Med-Act told us they conduct some limited reviews but they are not documented or done routinely. Public Health does not have the capability to generate these types of analytical processes efficiently due to their manual tracking process.

**Documentation must be accurate to have effective trend analyses**

There was a significant volume of incident reporting errors. The incident reporting systems are based on each department’s definition of a reportable incident, the ability to recognize an incident, and documenting the incident. We randomly selected a sample of 203 incident documents from the 3 departments and compared them to the respective reporting databases to evaluate data reliability. Examples of errors found include:

- Use of incorrect or outdated forms
- Missing or only partial critical information
- Errors or omission in time and date postings
- Misclassifications
- Failure to identify the location of the incident
- Failure to identify all consumers or staff involved
- Duplicate postings
- Failure to document a supervisory review process

Comparative error rates are shown in Table 1.5. Multiple errors were found on individual incident reports and the databases.

**Table 1.5: Comparison of Documentation Errors**

<b>Department</b>	<b>Total Documented Incidents</b>	<b>Sampled Incidents</b>	<b>Total Errors</b>	<b>Percentage of Error<sup>1</sup></b>
Med-Act	697	114	35	31
Mental Health	312	49	46	94
Public Health	40	40	40	100

<sup>1</sup>The error rate was computed based on a single error on an incident report regardless of multiple errors  
 Source: County Auditor Audit Analysis

The percentages shown between Mental Health and Public Health are similar while Med-Act’s are significantly less. Med-Act’s direct input electronic incident reporting system may have contributed to a lower percentage of errors.

According to department officials from each department, all employees are trained on incident reporting procedures. These officials said documentation errors occurred because the information was not deemed critical, information was unknown or staff made errors.

## **Improved timeliness of reporting and management review was needed**

Staff must prepare incident reports the same day of the occurrence or as soon as possible thereafter. Prompt review and followup by managers is imperative to ensure appropriate decisions are made and to maintain the integrity of the incident reporting system. Med-Act<sup>2</sup> and Mental Health<sup>3</sup> require incidents to be reported within 24 hours. Although department policies have been established, audit tests showed the policies are not always followed. Public Health has not established any department or division specific policies that define timelines for review and tracking incident reports.

Compliance with timelines could be improved

At Med-Act, 83 of 114 (72.8%) incidents reported between January and March 2006 were not reviewed by the battalion or division chiefs within their specified 24-hour timeline. A Med-Act official told us their electronic reporting system does not allow for automatic notification to the battalion or division chiefs. Med-Act policy places this responsibility on the employees. These employees are not always alerting their supervisors. Therefore, management staff is often not aware an incident report has been documented.

Mental Health established a 24-hour timeline to document and review incident reports. Our review of the original incident report documents shows incidents are being reported between 2 to 15 days after the incident. Division officials told us they review but do not document investigations resulting from incident reports due to concerns with peer review protection status and confidentiality issues. Consequently, neither we nor Mental Health officials could determine or calculate timelines to provide assurance their system was functioning as intended.

Delays in reporting and managing incidents can increase the risk for consumers and employees especially in those instances where an investigation is warranted.

## **Incident cases are sometimes not closed within required timelines**

Med-Act expects closure of an incident within 72 hours and is the only department that has established defined timelines to close an incident. Mental Health and Public Health do not document timelines beyond the incident report date. We could not determine if incident cases were being closed, especially those that might have involved an investigation process.

Med-Act personnel were not always following procedures. Table 1.6 shows the percent of time that incidents were not closed within 72 hours.

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<sup>2</sup> Med-Act Incident Report Policy #809

<sup>3</sup> Mental Health Occurrence Reporting Policy #435

**Table 1.6: Analysis of Days Med-Act Management Took To Close Incidents**

Number of Days to Close	Number of Incidents	Total Sampled Incidents	Percentage Over Policy Timelines
4-9 days	16	114	14.0
10-19 days	16	114	14.0
20 – 49 days	10	114	8.8
50 – 99 days	5	114	4.4
100 – 200 days	17	114	14.9
Over 200 days	4	114	3.5
Total:	68		59.6

Source: County Auditor Audit Analysis

As shown above, 68 incidents (59.6% of 114 incidents) were not closed within the prescribed time period of 3 days. Department officials were unaware of the status of these incidents at the time of this review.

**A risk based assessment of incidents could aid managers**

Depending on the volume of incidents, departments may need to distinguish the severity of risk to establish priority for management attention. Levels of severity help distinguish major from minor incidents. None of the three departments use this technique.<sup>4</sup> A risk based system could include assignment of standard risk level codes such as level 1 (very serious), level 2, and level 3 (minor), or assignment of points to specific types of incidents.

**Departments lack criteria for determining need for investigations**

Not all incidents require investigations. However, investigations could be warranted when incidents cause harm, occur repetitively, or have a questionable cause. None of the departments documented criteria for determining when an incident should generate an investigation and guidance for conducting the investigation. We could not determine if investigations were conducted or their outcomes in the cases we reviewed. For example:

Investigations cannot be tracked

One department documented a case involving a consumer medication error, “the medication sheet and medication box reflected proper dosages for twice daily but the medication orders say to take once daily.” Documentation showed that a supervisor was notified of the discrepancy immediately. There was no additional documentation to show that an investigation was conducted to determine the cause of the error, or final disposition of the incident.

Without reasonable assurance that incidents warranting further investigations are investigated and resolved, the reporting process becomes a documentation process with unknown outcomes.

<sup>4</sup> Med-Act has such a system for their Quality Assurance reviews; a separate process from the incident reporting system.

Public Health does not maintain a centralized database to track incidents. Instead, completed incident reports are filed separately within each Division. Based on our review, we noted immediate action was taken to resolve individual incidents. However, we did not find an investigation process used to determine systemic problems. As a result, we could not evaluate the process.

Mental Health and Med-Act's incident report databases show the facts of the incident but do not identify an investigative process. Department officials told us any further information captured on the incident reporting system could possibly puncture the integrity of the "peer review" process. Department officials told us they conduct oversight and investigations on incidents when warranted but do not have defined timelines to measure these processes.

### **Med-Act's integrated electronic incident reporting system is more efficient**

Med-Act developed a unique incident reporting system that could be considered by the other departments. Med-Act's first reporter can directly enter the information into an automated system. The database is generated directly from the source data. The other departments use manual reporting systems that either require re-entry into an automated system or do not require any entry into an automated system.

Med-Act's system frees up resources and offers additional advantages such as:

- Fewer documentation errors
- Eliminates duplicate postings
- Standardizes report postings by offering only specific "drop-down" menu options
- Ensures required information is input to the system before the user can move to the next posting category
- Limits subjectivity of staff

This system is more efficient, cost-effective, and can offer more reliable results.

### **Each department is improving their systems**

Mental Health is taking significant steps to improve their incident reporting and quality assurance processes. During the first part of 2006, they employed a quality improvement manager who has taken an active role in modifying and enhancing the department's incident reporting system processes and procedures. Throughout the audit, we were consulted regarding some actual and some planned incident reporting process changes. Based on the documentation provided, we believe these changes are positive enhancements for Mental Health's incident reporting process.

Public Health and Med-Act officials told us they are currently reviewing and evaluating their reporting process(s), policies, and procedures for reporting incidents.

## **Summary**

The departments we reviewed recognized the need for and implemented incident reporting systems. These systems were effective in reporting and achieving corrective action for the incidents involved. The audit results offer an opportunity to provide top management with effective tools to monitor incidents in their departments. Trend analysis techniques give management the ability to observe incidents from a broader perspective, identify common patterns, trends or other issues, and potentially detect underlying causes.

**OBJECTIVES, SCOPE AND METHODOLOGY**

**Objectives**

The objectives were to determine if:

- Reporting and tracking systems are in place to provide management response to situations which may put Johnson County employees at risk of assault while in the course of performing their duties, or consumers at risk for injury, abuse, neglect, or exploitation
- These systems are functioning as designed in accordance with appropriate laws, regulations, county and departmental policies, and to what extent the systems are effective

**Scope and Methodology**

Our period of audit included transactions from calendar year 2004 through the first 6-months 2006.

We interviewed management and staff members to obtain an understanding of management and internal controls. We reviewed 203 incident reports to determine if they were accurate, properly processed, reviewed by management, and timely resolved.

We identified common facets of the departments' incident reporting systems and focused our review on reports processed. Issues identified were discussed with responsible personnel to obtain agreement and corrective action.

The scope of the audit was impaired by the denial of access to some records. As a result, we could not review them and arrive at conclusions on the effectiveness of decisions made. These records were protected under Peer Review provisions of KSA 65-4925 and we obtained legal advice which resulted in the denial of access.

**DETAILED DEPARTMENT RESPONSES****Director, MED-ACT:**

*Thank you for the opportunity you have presented through this audit. Med-Act has already taken steps to improve our incident reporting processes, based on the interactions we have had with your staff. We generally agree with your findings and recommendations, and we will be working towards an improved system in 2007. Your hard work is appreciated.*

**Suggestion 1.1**

*Develop a systematic process for tracking and trending incidents to assist in identifying potential problems with specific consumers, staff, facilities, programs, or providers.*

*We appreciate the statements acknowledging our incident tracking mechanisms, and we concur with the recommendation to implement a trending process. The Division Chief of Quality Management will be responsible for such tracking on a biannual basis, beginning in 2007. Trend analysis will consider incident frequency within each category, by unit, and by risk level. For high-risk incidents, outcomes and their timeliness will be evaluated during the analysis. Identifying negative trends will allow us to enhance our systems in a proactive manner.*

*Additionally, the Division Chief of Quality Management will be responsible for an annual assessment as to whether our incident reports are complete, appropriately categorized for subject and risk level, and processed in a timely manner. Summary reports will be presented to the Management Team, with follow-up education provided as necessary.*

**Suggestion 1.2**

*Develop guidelines and accountability procedures to address:*

- *Accurate identification and documentation of an incident*

*We concur with the recommendation. We believe that our definition of what constitutes an "incident" is reasonable, and that our personnel apply it in an appropriate manner. However, we do recognize challenges in the consistent, accurate documentation of incidents. By January 1, 2007, we plan to modify our practices so that the initial reviewer, rather than the author, selects the most appropriate category for each incident. The list of categories will be reviewed and modified to provide a clear, unambiguous list of topics relevant to our industry.*

- *Criteria for initiating and timelines for completing investigations*
- *Criteria for implementing corrective action plans and timelines for completion*

*Criteria for initiating investigations and corrective actions will be built into the system by way of the risk-level grading system. (See suggestion 1.3 below). The initial reviewer will be responsible for identifying high-risk incidents and initiating an investigation and/or corrective action within 0-7 days. Medium risk incidents will require action at the Deputy Chief level, within 45 days. The Division Chief of Quality Management will coordinate low risk responses,*

*within the ordinary channels Med-Act uses for organizational change. These changes will occur by June 30<sup>th</sup>, 2007, after the implementation of the risk-level grading system.*

*Investigations and corrective actions within our department vary significantly in their scope. Some require simple interviews and are completed within hours. Others use peer review boards, the solicitation of expert opinion, and other methods that require different time commitments. As a result, setting specific timelines for their completion would not be reasonable in this setting.*

- *Requirements for documenting final disposition and closure of the incident in the incident reporting system*

*We concur with this recommendation. In fact, participating in this audit process has brought certain problems to light, and we have already taken action to make improvements in this area. Changes in practice and policy will mandate the addition of specific comments regarding the final disposition of each incident.*

*Also, we recognize the challenges our personnel have faced in the timely closing of incidents. The deadlines established in our current practice have been difficult to achieve, and perhaps are not reasonable, given our environment. We believe the irregular nature of our work shifts has contributed to this. Policy revisions will include more reasonable deadlines, giving the initial reviewer seven calendar days (instead of 24 hours) to forward the report to the Deputy Chief, and the Deputy Chief will be required to close the incident within thirty days (instead of 72 hours.) The new policy will be effective January 1, 2007.*

**Suggestion 1.3**

*Establish a grading system for assigning risk levels to reported incidents when warranted.*

*We concur with this recommendation. We already use a similar method when classifying clinical issues, and plan to implement a risk-level system for use on non-clinical incidents as well, by June 30<sup>th</sup>, 2007. This change will be added to the electronic database, and choosing an appropriate risk level will be the responsibility of the initial reviewer. As mentioned, high-risk incidents will warrant more expeditious action than others.*

**Director, Public Health**

*This opportunity to respond to the draft report concerning recent audit findings for the Department of Public Health is appreciated. On balance, we are in agreement with these findings which underscore our department's ongoing track record of high quality services with little or no incidents. Further, most of our incidents have to do with human error and facility situations, usually associated with our building's structure.*

**Recommendation 1.1-1.3**

Agree. As noted in our earlier correspondence, we have clarified the definition of an incident as well as re-worked our report form. These items are attached for your file; and, by design our form addresses the four elements in this section.

**Recommendation 1.4**

In an effort to attain a higher level of excellence for our departmental operations, we are incorporating several of the suggestions from the audit into our operations. Some of the modifications we are employing include:

Incident Report Form - The existing Incident Report Form that we utilize is being reviewed and modified and is currently near completion.

Definition of Incident - Our current definition of incident is being clarified in order to achieve clarification and consistency across our department.

Training - Ongoing departmental training is being updated to include the modifications noted above. All supervisory staff will be informed and familiarized with these amended procedures.

Centralized System - Centralized in the Director's office, a system which catalogs and provides ongoing assessments of potential trends in incidents has been developed. All reports will reside in this central registry and will be available for supervisory staff and monitoring.

**Recommendation 1.5**

Agree. Our evaluation for this item is underway.

The improvements listed above correlate with the issues raised in the Audit Report. We anticipate that these improvements can further enhance our operations and efficiencies.

**Executive Director, Mental Health**

1.1 Develop a systematic process for tracking and trending incidents to assist in identifying potential problems with specific consumers, staff, facilities, programs, or providers.

Mental Health agrees with this recommendation and has already implemented an updated occurrence reporting database that contains these functions.

1.2 Develop guidelines and accountability procedures to address:

- Accurate identification and documentation of an incident
- Criteria for initiating and timelines for completing investigations
- Criteria for implementing corrective action plans and timelines for completion

- *Requirements for documenting final disposition and closure of the incident in the incident reporting system*

*Mental Health agrees with these recommendations and has already implemented these actions with the exception of the fourth bullet. Details regarding the final disposition of incidents will be maintained in a separate reporting system in order to protect the integrity of the peer review process. This action has already been implemented.*

*Mental Health strongly concurs with the need to ensure “accurate identification and documentation of an incident” (see first bullet above), and believe centralizing responsibility with the recently hired Quality Manager will further our objective of accurate identification and documentation of incidents.*

*We disagree, however, with the auditor’s approach to identifying errors (page 5), and therefore we disagree with the message conveyed in the percentage of errors reported in Table 1.6. Showing a 94% error rate in documentation, without further explanation, conveys a message of a dysfunctional incident reporting system, when the opposite is true. The MHC maintains a highly effective, high volume, incident reporting process with regard to the following: (a) Every significant incident is captured and documented; (b) Every incident report is reviewed by a higher authority; (c) In every case where additional information is needed to fully understand the incident, it is obtained; and (d) In every situation where follow-up is indicated, it occurs.*

*With response to specific errors which were included in the 94% error rate in the audit findings: (1) Mental Health allows staff to submit incident reports with missing data such as the time that an incident occurred (which may be unknown when a client reports an incident that occurred in their home), and we do not consider the absence of non-critical data to be an error; (2) Mental Health knowingly allowed more than one incident report form to be utilized; specifically, a draft form being utilized in our substance abuse programs as a pilot test of this form. Reports based on these forms should not be considered errors; and, (3) Staff are encouraged to categorize the nature of the event, but the specialist “Quality Manager” subsequently reviews the events and re-categorizes them when appropriate. The auditor agreed that this was an appropriate function and Mental Health does not believe that it is appropriate to categorize these reports as errors when they were correctly entered into the database by the Quality Manager.*

### **Auditor’s Comment**

The Mental Health response defines an “acceptable level” of noncompliance to a quality control system which we do not agree with since it breaks down the discipline of the department procedure. Our audit tested incident reporting practices against Department procedures. The types of errors we found were: failure to identify category of incident, location of incident, lack of required client information, incorrect information on the aforementioned categories, and lack of documentation of an incident. Since our sample came from the database referred to by Mental Health in their response, we found no evidence that the incidents we examined were corrected in the database as stated by Mental Health officials.

We are satisfied that the overall response to the recommendations indicates a desire to improve their incident reporting system.

- 1.3 Establish a grading system for assigning risk levels to reported incidents when warranted.

*Mental Health agrees with this recommendation and had previously implemented this recommendation with a “standard of care” designation for all incidents which resulted in a peer review. This has now been expanded to document the “standard of care” determination for all incidents for which the Quality Manager determines that a review should be conducted.*

- 1.5 Evaluate the utility of, and implement if warranted, a first-reporter, point-of-entry electronic incident reporting system similar to Med-Act’s.

*Mental Health agrees with the concept of developing a point-of-entry electronic incident reporting system. As Mental Health has just upgraded our incident report database to enhance our ability to track and trend incidents as recommended in 1.1 above, and because Mental Health is in the midst of developing and implementing an electronic medical records system to address other risk management issues, evaluation of this recommendation will be delayed until the fourth quarter of 2007.*