The West Virginia Department of Health and Human Resources (WVDHHR) requires that all Behavioral Health Providers and Opioid Treatment Programs licensed by the Office of Health Facility Licensure and Certification (OHFLAC) maximize the health and safety of all individuals served by completely and fully investigating all incidents involving potential rights violations or hazards to consumers/patients. The Provider is responsible for tracking incidents and taking appropriate action on both an individual and systemic basis in order to prevent harm to the health and safety of all individuals served. These requirements are described in the West Virginia Legislative Rules for Behavioral Health Centers Licensure (§64-11-8.2.b., §64-11-7.7.a., §64-11-7.8.a.3., §64-11-5.5.h., §64-11-6.1.c. and §64-11-5.9.a.4.) and the Regulation of Opioid Treatment Programs (§64-90-23.1. through §64-90-23.6.). All of these sections of the rules imply or state that incidents shall be investigated thoroughly, tracked and used for quality improvement purposes.

These guidelines were the result of a cooperative effort of the OHFLAC, Bureau for Behavioral Health and Health Facilities, Bureau for Children and Families, Behavioral Health Ombudsman, West Virginia Advocates, EMS/TSN Hartley/Medley Advocates and the West Virginia Association for Behavioral HealthCare Providers.

**Instruction:**

Each Provider shall be responsible for developing a policy and procedures for staff to follow in the identification, investigation and remediation of incidents which have produced or have the potential to produce harm or risk to the safety or civil rights of persons served. Incidents shall be sorted by the Provider and generally classified as one of the following:

1. an allegation of abuse and/or neglect;
2. a critical incident; or
3. an incident requiring service provider monitoring and follow-up.

The Provider shall have in place procedures requiring investigation and monitoring of each level of incident in a manner consistent with minimum guidelines set forth by OHFLAC. The Provider may exceed the standards set forth by the guidelines as desired. Outpatient behavioral health providers shall determine which incidents, if any, must be investigated as being related to the care provided by the agency. For example, a provider is not obligated to investigate the death of a consumer in an automobile accident when the automobile was not driven by a staff person of the agency. However, if a consumer overdoses on medications provided by the outpatient agency, the agency should conduct a record review in order to determine that appropriate assessment of the suicidality of the patient was conducted and that the staff took appropriate precautions with regard to supplying the patient with unsupervised-medications. Title XIX Home and Community-Based Waiver providers are expected to fully investigate all incidents related to services provided by the agency, regardless of the identity of the Service Coordinator. If more than one agency is involved in a specific incident, the investigation may be cooperative.
INVESTIGATING ALLEGATIONS OF ABUSE AND/OR NEGLECT

Mandatory Reporting:

Adult Protective Services requires reporting of neglect, abuse, and suspected neglect or abuse of an incapacitated adult on the Adult Protective Services Reporting Form. “Incapacitated adult” is defined as “any person who by reason of physical, mental, or other infirmity is unable to independently carry on the daily activities of life necessary to sustaining life and reasonable health.” According to W.Va. Code §9-6-11(a), “A report....shall be made immediately by telephone to the department’s local adult protective services agency and shall be followed by a written report by the complainant or the receiving agency within forty-eight hours.” The WVDHHR’s Abuse Hotline number is 1-800-352-6513.

According to W.Va. Code §9-6-9(a), “If any medical, dental or mental health professional, christian science practitioner, religious healer, social service worker, law-enforcement officer, state or regional ombudsman or any employee of any nursing home or other residential facility has reasonable cause to believe that an incapacitated adult or facility resident is or has been neglected, abused or placed in an emergency situation, or if such person observes an incapacitated adult or facility resident being subjected to conditions that are likely to result in abuse, neglect or an emergency situation, the person shall immediately report the circumstances pursuant to the provisions of section eleven [§9-6-11] of this article: Provided, That nothing in this article is intended to prevent individuals from reporting on their own behalf.” Therefore, all employees of residential programs are mandatory reporters and most employees of outpatient behavioral health providers.

Abuse is “the infliction or threat to inflict physical pain or injury on or the imprisonment of any incapacitated adult or facility resident”, according to W.Va. Code §9-6-1. Any use of restraints that results in injury shall be reported to Adult Protective Services, regardless of the circumstances.

Neglect is “the failure to provide the necessities of life to an incapacitated adult” or “the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult”, according to W.Va. Code §9-6-1. Neglect would include lacking or inadequate medical care by the service provider and inadequate supervision resulting in injury or harm to the “incapacitated” consumer. Neglect also includes, but is not limited to: A pattern of failure to establish or carry out a consumer's individualized program plan or treatment plan that results in negative outcome or places the consumer in serious jeopardy; a pattern of failure to provide adequate nutrition, clothing or health care; failure to provide a safe environment resulting in negative outcome; and/or failure to maintain sufficient, appropriately trained staff resulting in negative outcome or serious jeopardy. This may also include medication errors and dietary errors resulting in a need for treatment for the consumer.
Allegations of abuse and/or neglect must be investigated and reported to the following entities:

- Adult Protective Services;
- OHFLAC (copied from the Adult Protective Services Reporting Form);
- Guardian/Health Care Surrogate;
- Title XIX Home and Community-Based Waiver Staff (if a waiver consumer);
- Any advocate identified in the consumer record;
- Administrator or designee;
- Internal Human Rights Committee; and
- Internal Safety Committee/Quality Assurance Committee.

All investigations shall be maintained in a central investigation file.

Investigation procedures for incidents of alleged abuse/neglect:

Upon notification of an allegation of abuse and/or neglect, all Providers shall take the following actions:

- The Provider shall ensure that mandatory reporting via telephone to the local Adult Protective Services office or abuse hotline (1-800-352-6513) has taken place as appropriate and described above. A written report must follow within forty-eight (48) hours using the form developed by the WVDHHR. If requested by Adult Protective Services, the Provider shall delay the service provider’s investigation until the Adult Protective Services investigation is initiated; however, the Provider remains responsible for ensuring the safety of the alleged victim until such time as the investigation commences, as described below. The Provider must ensure that staff understand that they are mandatory reporters. No agency may have in place a policy which requires staff to consult with management before filing a report.
- The Provider shall ensure that the incident report is completed thoroughly and that when possible, all areas of the incident report are filled out. In most cases, this should occur before the reporter leaves his/her duty for the day.
- The Provider shall ensure that the administrator or his/her designee is notified immediately of any allegations of abuse or neglect. Such notification shall be initialed with indication of date and time of notification in the consumer record and/or on the incident report.
- The Provider shall ensure that steps are taken to protect the immediate safety of the consumer or consumers in question by removing the alleged offender from contact with consumers, removing the alleged offender from contact with the consumer in question, increasing immediate supervision or removing the alleged offender from shift altogether. The action taken shall be commensurate with the severity of the allegation.
- The Provider shall be responsible for identifying any additional supports the alleged victim may require and supplying those supports (e.g., therapy, crisis intervention, transfer to another Provider or building, etc.).
• The alleged offender(s) shall receive a written notification that there has been an allegation of abuse or neglect filed against him/her/them, if the Provider is responsible for having filed the allegation.
• The Provider shall ensure that all individuals who must be notified as listed above are notified. Documentation of the date, time and individual notifying shall be maintained.

Investigation:

• An investigation committee shall be formed. The committee shall consist of at least two (2) individuals, at least one of whom shall not be in immediate authority for the program employing the alleged offender.
• The chairperson of the committee shall be responsible for convening the committee, coordinating committee activities and producing the final report of the committee. The chairperson shall also be responsible for leading the interviewing of victim, alleged perpetrator and witnesses, although the other committee member(s) may participate, as appropriate and necessary.
• The investigation must begin within twenty-four (24) hours of the report of the allegation unless instructed otherwise by Adult Protective Services. If the committee is instructed to hold its investigation by Adult Protective Services, the date, time and individuals involved in the instruction shall be documented. A preliminary report must be received within five (5) days by the administrator or designee (may be verbal, but must be documented) and a full written report must be completed no later than fourteen (14) days after the incident was identified.
• All witnesses are to be interviewed face-to-face unless extenuating circumstances exist (such circumstances must be documented). The committee shall determine who shall be interviewed and interviews shall be conducted in the following order:
  1. Reporter of the incident/allegation;
  2. Person(s) involved including the victim;
  3. Witnesses; and
  4. Alleged perpetrator.
• The person being investigated will be questioned last. All information obtained in the investigation is confidential, as is the identity of the reporter. Should the alleged perpetrator leave the employment of the agency abruptly during the investigation, the investigation should still be pursued to conclusion and documented.
• The alleged perpetrator(s) shall have the right to request that the committee interview any relevant additional witnesses the accused would prefer.
• All committee members must be present for each interview. Location of the interviews shall be private and shall serve to maintain the confidentiality of those involved.
• Interviews shall be summarized in writing and each member of the committee shall initial each of the interviews, verifying that the substance of the summary is as the committee member recalls.
• Past investigations can be part of the interview and committee analysis and will be reviewed to help the committee to be aware of potential patterns of abuse and/or neglect.
• Upon conclusion of the investigation, the committee must make a consensus decision regarding substantiation. If consensus cannot be obtained, the administrator or his/her
designee shall participate in the final decision of the committee, and the administrator shall be responsible for taking action, as he/she deems appropriate. Dissenting opinions must be noted in the final report of the committee.

- The committee shall be responsible for making a determination of substantiation, or lack thereof, and for recommending any action to the administrator such as improved training, staffing patterns, etc.
- In the case of a mortality, the committee shall determine whether any action taken or not taken by the provider could have prevented the death and will make recommendations to the administrator for changes in policy, procedures or clinical practice in order to prevent future mortalities, as appropriate.
- The administrator shall document receipt of the report, action taken, and the file shall be maintained in a central administrative location with limited access.
- The consumer and his/her guardian/health care surrogate (if present) shall be informed in writing of the outcome of the investigation.
- The original incident report shall be filed in the central investigation file with the results of the committee investigation. A reference to the incident report shall be documented in the record(s) of those consumer(s) involved, but it is not required that an incident report be filed in the consumer record.
- At the conclusion of the investigation, the clinical supervisor and/or the interdisciplinary team shall conduct a documented review of the consumer’s treatment plan in order to determine whether any alterations will need to be made to the consumer’s plan of care because of the investigated incident and/or the committee’s recommendations at the conclusion of the investigation.

Quality Assurance:

- The Provider shall ensure that incident reports and summaries of investigations are tracked for patterns of abuse or neglect or areas of Provider function which could use improvement. A report shall be made annually to the governing body of the Provider of the results of tracking.
- The Human Rights Committee shall review results of investigations and patterns of incidents at each Human Rights Committee meeting and shall make recommendations to the administrator as appropriate and necessary.

MORTALITIES

Any mortality which is related to the treatment or supervision provided by a licensed Provider (e.g., a consumer of a group home or supported living setting, an overdose on medications prescribed by a Provider psychiatrist, diversion of methadone causing death) shall be treated as a mandatory reporting issue (Adult Protective Services) and shall be immediately reported to OHFLAC by fax (304-558-2515) or email (ritawhittington@wvdhhr.org or sheilakelly@wvdhhr.org) utilizing the Behavioral Health Center – Initial Mortality Report form. The original form must then be mailed to OHFLAC, Capitol and Washington Streets, 1 Davis Square, Suite 101, Charleston, West Virginia 25301-1799. The Behavioral Health Center – Initial Mortality Report form will be available on OHFLAC’s webpage at www.wvdhhr.org/ohflac, from which it can be downloaded. The form must be completed and
faxed/emailed to OHFLAC within 24 hours of the death of the consumer or within 24 hours of the Provider becoming aware of the death of the consumer. The Provider must conduct a thorough investigation of the death, or the circumstances which led to the death in a hospital or other medical treatment facility. If an individual expires after transfer from the behavioral health facility to a hospital or other medical treatment facility, the Provider shall be responsible for reporting and investigating the incident to the maximum extent possible given the information available at the time of the investigation.

NOTE: The Provider is no longer required to report mortalities to the Bureau for Behavioral Health and Health Facilities, nor must the Provider complete the mortality reviews previously required by the Bureau for Behavioral Health and Health Facilities. Within fourteen (14) days, a copy of the Provider’s internal investigation must be forwarded to OHFLAC in place of the previously required mortality review. For consumers served by multiple agencies under the Title XIX Home and Community-Based Waiver, each agency serving the consumer shall conduct an internal investigation of a mortality, as appropriate, and submit the results of that investigation to the OHFLAC. Please be advised that internal investigations will not be released outside of WVDHHR without a court order and will be destroyed at the conclusion of each agency’s renewal process or two-year period, whichever may be longer.

**CRITICAL INCIDENTS**

Critical incidents are defined as those incidents with a high likelihood of producing real or potential harm to the health and well-being of the person or persons served but not involving abuse or neglect. These incidents might include, but are not limited to the following:

- Attempted suicide with substantial lethality/chance of harm;
- Incidents which may have involved inappropriate behavior on the part of staff not reaching a level characteristic of abuse or neglect;
- Behavior that results in injury requiring medical attention or significant property damage;
- Fire resulting in injury;
- Behavior resulting in interruption of services, including the necessity for movement to a more intensive level of care;
- Use of physical restraints in violation of policy;
- Use of mechanical restraints in violation of policy;
- Use of isolation or seclusion in violation of policy;
- Major involvement with law enforcement authorities;
- Possession of illicit substances including alcohol;
- Possession of weapons;
- Injury resulting in hospitalization or medical treatment;
- Medication errors resulting in less serious negative outcome for the consumer (not reaching level of abuse/neglect or delegated to the facility for investigation by WVDHHR);
- Dietary errors resulting in less serious negative outcome for the consumer (not reaching level of abuse/neglect or delegated to the facility for investigation by WVDHHR);
- Extended and unauthorized absence of a consumer from supervision or shadowing that exceeds his/her treatment plan provision for community access;
• Removal of a consumer from service without his/her consent and/or that of the interdisciplinary team including the guardian;
• Significant injuries of unknown origin resulting in medical treatment; and
• Any other incident judged by staff, foster parent, management or other individual to be significant and potentially having a serious negative impact on the consumer.

For the purposes of sorting allegations of abuse and neglect from critical incidents, the issue of lack of appropriate staff oversight must always be considered. If the incident can be attributed to lack of staff oversight, it is upgraded to an allegation of neglect and must be reported to Adult Protective Services.

**Critical incidents must be investigated and reported to:**

- Guardian and/or Health Care Surrogate;
- Any advocate designated in the consumer record;
- Administrator or designee;
- Internal Human Rights Committee; and
- Internal Safety Committee/Quality Assurance Committee

All investigations shall be maintained in a central investigation file.

**Investigation procedures for all critical incidents:**

- The Provider shall ensure that the incident report is completed to the maximum extent possible and that the administrator or his/her designee is notified immediately of any critical incident.
- The Provider shall ensure the safety of the individual if necessary, possibly including increasing staff supervision, moving the consumer to a higher level of care, installing door alarms (with the approval of the Human Rights Committee), providing therapy, etc.
- The Provider shall ensure that the individuals/parties listed above are notified of the incident. Notification shall be documented on the incident report or in the consumer record and shall be initialed with date and time of notification.
- The Provider shall appoint either an individual with no direct supervisory responsibility for the program involved in the incident, or a committee consisting of at least two (2) individuals, one of whom must not be in a direct line of authority for the provision of service to the consumer in question, to perform the investigation. When a consumer’s inappropriate behavior is causally involved in the incident, the individual investigating or at least one (1) member of the team must have a master’s degree in a mental health profession, or be a registered nurse or qualified mental retardation professional, depending upon the diagnosis and developmental level of the consumer involved.
- The committee or investigating individual shall initiate an investigation within twenty-four (24) hours of notification of the incident. A preliminary report shall be made available to the administrator or his/her designee within five (5) days and a written report within fourteen (14) days.
• Witnesses to the incident shall be interviewed, including the individual involved. All shall be interviewed face-to-face unless circumstances do not permit. Such circumstances shall be documented.
• The committee/investigator shall attempt to identify antecedents and consequences to any episodes involving consumer behavior, including suicide attempts, aggression, incidents of restraint, possession of illicit substances or materials, absences from supervision, etc.
• Medication and dietary errors shall be investigated to ensure that proper protocols were followed in dealing with the incident (e.g., physician notification, emergency treatment, etc.).
• Significant injuries of unknown origin must be fully investigated by the committee/investigator.
• Medication errors resulting in negative outcome for the consumer (depending on the incident may need to be reported to WVDHHR).
• Dietary errors resulting in negative outcome (depending on the incident may need to be reported to WVDHHR).
• The committee’s investigation shall result in a report to the administrator or his or her designee with recommendations for steps to be taken by the Provider for prevention of further incidents of the type in question.
• Once the committee/investigator has completed the investigation and report, the clinical supervisor and/or interdisciplinary team shall conduct a documented review of the consumer’s plan of care in order to ensure that any needed revisions to the plan may be developed and implemented.
• When the person has a guardian or health care surrogate, the Provider shall inform such individuals of the outcome of the investigation.
• The administrator shall initial receipt of the report, indicate what actions were taken if any, initial and date, and shall keep in the administrative file of investigations, with the original incident report attached.
• An indication shall be made in the consumer record that such incident and investigation is contained in the administrative files, although no copies need be maintained in the consumer record.
• At any time during the course of the investigation that an allegation or consideration of abuse or neglect arises, the committee/investigator shall immediately notify the administrator or his/her designee and initiate the appropriate protocol as described herein, including notification of Adult Protective Services as mandated.

Quality Assurance:

• The Provider shall ensure that incident reports and summaries of investigations are tracked for patterns of Provider policy, procedure or function which could use improvement in order to reduce risk of recurrence. A report shall be made annually to the governing body of the Provider of the results of tracking. The Human Rights Committee shall review results of investigations and patterns of incidents at each Human Rights Committee meeting and shall make recommendations to the administrator as appropriate and necessary.
INCIDENTS

Again, lack of staff oversight must always be evaluated as an issue of potential neglect. If the lack led to a negative outcome for the consumer, it must be upgraded to a full investigation of possible neglect. In addition, patterns of injuries of unknown origin must always be evaluated and considered for potential abuse in protected populations.

An incident is defined as any unusual event occurring to a consumer that needs to be recorded and investigated for risk management or quality improvement purposes. Examples would be a minor assault by another consumer with injury resulting; seizures in an individual not prone to seizures; injuries of unknown origin with no detectable pattern; high rates of unusual self-injurious behavior with no significant negative outcome; suicidal threats or gestures without significant injury; minor medication error with minimal or no negative outcome; etc.

Incidents must be reported to:

• Administrator or designee
• The guardian/health care surrogate, unless the guardian/health care surrogate indicates otherwise in writing;
• Internal Human Rights Committee; and
• Internal Safety Committee/Quality Assurance Committee

Incidents must be documented, reviewed, investigated if necessary, and filed in central investigation file.

Investigation procedures for incidents:

The Provider shall review and when necessary, investigate all incidents at a level consistent with the importance of the incident.

• The Provider shall ensure that the incident report is completed as fully as possible and that all individuals listed above are notified as necessary.
• The Provider shall designate an individual to review the incident to determine whether an investigation needs to be conducted. The individual designated may be the program nurse, clinical director, staff member with knowledge and expertise or the staff supervisor unless a possible conflict of interest is identified.
• The reviewer shall assess staff compliance with any service provider policy/procedure that may have been relevant to the incident.
• If the reviewer sees no need for an investigation, he/she shall simply document having reviewed the incident and ensure that proper staff training or corrective action is taken as necessary. The report shall then be entered into the Provider’s tracking system.
• If the reviewer determines a need for an investigation, a designated investigator shall interview all parties involved and prepare a written report to the administrator or his/her designee within fourteen (14) days of the incident.
• The report shall identify any antecedents or consequences potentially triggering or maintaining inappropriate consumer behavior, any systemic problems responsible for
staff errors or inappropriate actions, any staff training which might be helpful in preventing further incidents, any recommendations for treatment or support of the person served (e.g., medication management appointment, individual therapy, etc.), and generally suggest any changes to Provider’s policy/procedure or implementation of procedure that might be helpful.

• The report shall be kept in the central administrative file with the original incident report. A reference to the existence of the report shall be noted in the consumer record, but the report itself need not be filed in the consumer record.

• At any time during the course of the review or investigation that an allegation or consideration of abuse or neglect arises, the reviewer/investigator shall immediately notify the administrator or his/her designee and initiate the appropriate protocol as described above, including notification of Adult Protective Services, as mandated.

Quality Assurance:

• The Provider shall ensure that incident reports and summaries of investigations are tracked for patterns of Provider policy, procedure or function which could use improvement in order to reduce risk of recurrence. A report shall be made annually to the governing body of the Provider of the results of tracking. The Provider safety committee or Human Rights Committee shall review results of investigations and patterns of incidents at each meeting and shall make recommendations to the administrator as appropriate and necessary.

PHYSICAL/MANUAL RESTRAINTS

It shall be the policy of all licensed Providers to review and track the use of physical restraints, regardless of whether performed as part of a therapeutic de-escalation program or behavior support plan.

Written procedures shall govern the use of manual restraint. They shall specify that:

• Manual restraint is used only in emergency or crisis situations to protect individuals from harming themselves or others, or as a part of a written plan of care approved by the Human Rights Committee and Interdisciplinary team;

• Personnel are fully trained to use the least restrictive, safest and most effective methods generally accepted in the field;

• Manual restraint is used in each instance only when less restrictive measures have proven to be ineffective or in an immediately dangerous situation which precludes the use of other interventions;

• The decision to use manual restraint takes into account an analysis which determines that the risk of the individual’s behavior to himself or others outweighs the potential risk of the use of manual restraint, documented as soon as possible after the use of the restraint;

• Manual restraint is discontinued as soon as possible;

• The clinical supervisor or other designated clinician reviews each restraint for appropriateness and the potential need for development of a behavior support plan or other treatment plan revision and/or staff training;
• All direct service personnel shall have access to a copy of written policies and procedures regarding the appropriate and limited use of manual restraint;

• A continuing monitoring system/log is kept documenting:
  1. names of staff restraining;
  2. names or identifiers for individuals restrained;
  3. date and time of restraint;
  4. efforts to de-escalate or divert prior to use of restraint (if possible);
  5. other individuals involved;
  6. circumstances and reasons for manual restraint;
  7. amount of time restrained; and
  8. supervisory review within one working day of the restraint.

• Use of manual restraint is documented in the person’s case record or in program documentation.

Programs governed by federal restrictions of physical restraints will have additional requirements in this area (e.g., Psychiatric Residential Treatment Facilities).

The clinical justification, use, personnel involved, circumstances, efforts to employ less restrictive measures and length of application must be clearly documented for each instance of manual restraint. “Groups” of incidences of restraint (for example, occurring several times subsequently) may be documented once if described adequately.

Each incident shall be administratively reviewed no later than one (1) working day after its use.

If the restraint is part of an approved Behavioral Management Plan, the data sheets may replace other restraint documentation as long as:

• The required information is included; and
• The data is included in the tracking and monitoring system for quality assurance purposes.

Office of Health Facility Licensure and Certification
Bureau for Public Health
West Virginia Department of Health and Human Resources
INCIDENT REPORTING
MINIMUM REQUIREMENTS

• Name of primary consumer/patient involved
• Name of reporter, position
• Type of incident (abuse/neglect, critical, simple)
• Name and status of alleged perpetrator as appropriate (Staff? Consumer? Family member?)
• Date of incident
• Date report completed
• Who discovered the injury/incident/event?
• Where and when was the incident discovered?
• Who was it reported to?
• When was it reported?
• When was the administrator or designee notified? By whom?
• Describe the incident/event/occurrence?
• Where did the incident occur?
• What significant events may have preceded the incident and triggered it?
• What significant events occurred subsequent to the incident, if any?
• Who was involved in the incident? How?
• Who was present to observe the incident?
• What was staff response to the event/behavior? What did staff do, if anything?
• If a consumer to consumer aggression or confrontation, who were the consumers involved? Have there been previous encounters? Is there a pattern of antecedents (triggers) to the confrontations?
• Was a full investigation conducted?
• What administrative action was taken (if any) as a result of the incident report and/or investigation?
• Does the individual have a health care surrogate, guardian or medical power of attorney?
• Was the parent, health care surrogate, Department worker, Power of Attorney or guardian notified? By whom? When? If not, has the guardian, etc. set parameters for notification (e.g., wants to be notified only of significant issues)?
• Was Adult Protective Services notified? By whom? When?
• Did Adult Protective Services advise the organization that it would be conducting an investigation? When was the notification and by whom?
• Was it necessary that medical staff be notified of a medication error, an injury or condition requiring medical treatment? If so, who was notified and when? What was their response?
• Was medical intervention required? If so, describe briefly
• Does the consumer have a designated advocate from the West Virginia Advocates or the EMS/TSN Hartley/Medley Advocates? If so, was the advocate notified, if required by policy? By whom? When?
• Signature(s) of reporter, administrator, QMRP and medical staff as appropriate (since these reports always go to the administrator, they should always be signed and dated by him/her or his/her representative)