Utah Department of Health & Human Services

DHHS Critical Incident Reporting Guide ❖ 2024

The Department of Health and Human Services (DHHS) has updated two department rules to address reporting critical incidents to the Department.
R380-80 is the new Provider Code of Conduct and Client Rights that governs all DHHS employees and providers who serve DHHS clients.
R380-600 is the new Licensing rule that defines critical incident and governs critical incident reporting requirements.
Together, the code of conduct and critical incident reporting requirements in these two rules are applicable to any staff, contracted provider, certificate holder, or licensee serving DHHS clients. All rules and guides may be found on our website.

Additionally non-critical incidents are required to be reported to DHHS for any entity whose contract with the department requires reporting above and beyond just critical incidents.

This guide outlines in the following sections:

- What constitutes a critical incident or non-critical incident
- What needs to be reported
- To whom critical incidents need to be reported
- How critical incidents need to be documented and reported

For purposes of this guide, the following clarifying definitions apply:

❖ Staff

applies to DHHS contracted entities and "Licensees" as defined in 26B-2-101 and means an individual or a human services program licensed by the office. In licensed or DHHS contracted treatment programs this applies to all owners, directors, line employees, support employees, contracted employees, volunteers, and anyone additionally interacting with clients under the program's care.
In foster and proctor settings, this applies to the primary caregiver and spouse, other adults residing in the licensed or certified home, respite caregivers, and anyone additionally interacting with a client under the provider's care.
For certificate holders under the Office of Licensing (OL), this applies to anyone having unsupervised access to the client or the client's file.

*Note in DSPD programs, "under the program's care" or "other adults in the home" are interpreted to mean the individuals employed or engaged by the program to supervise and care for the individuals and ensure their needs are met. It does not necessarily include "anyone additionally interacting with clients", since many DSPD programs provide and permit services offered in the community setting.

❖ Client

applies to the recipient of the services provided by the DHHS contractor, certificate holder or licensee as defined in 26B-2-101, generally a child or vulnerable adult. In foster and proctor settings, the client is the foster or proctor child(ren).

❖ Provider

means the license or certificate holder, or the legally responsible individual or individuals providing services to a client.
From R380-80 (11) "Provider" means:
(a) a license or certificate holder;
(b) the legally responsible individual or individuals providing services regulated by the department;

(c) any individual or business entity that contracts or subcontracts with the department to provide services to clients;
(d) any professionally licensed or certified individuals who provide services to clients under the supervision or direction of an individual or business entity; or
(e) any human services program as defined in Section 26B-2-101.

❖ Critical Incident as defined in Rule R380-600❖

keep in mind these incidents are reportable if they occur under the direct responsibility of the program. A 24 hour-residential program has direct responsibility for the client even if they are off-premises for visits. A DSPD residential provider may not be responsible for a client acting independently offsite in accordance with the Settings Rule.

Except in DSPD settings that are required to provide "dignity of risk" in accordance with the Settings Rule, a non-residential program has direct responsibility for a client any time the client is receiving services under the provider's purview (or if there is information known to the program that could have prevented the incident with appropriate intervention). This doesn't exclude DSPD providers completely and they should not look the other way when a client is showing signs of danger to themselves or others. There should always be documentation of actions taken to mitigate a serious incident regardless of clientele served.

"Critical incident" means an event out of the range of normal experience including any of the following:

In this rule and R501-1 "the range of normal experience" is interpreted by OL to mean the activities and processes permitted within the parameters of treatment or generally accepted in comparable programs. Example: sexual contact between clients or between clients and staff is not part of the treatment and is not generally accepted (or legal) in any program even if it's consensual (except clients governed by the Settings Federal rule).

"normal range of experience" is not defined as what's normal to encounter in a specific program that takes difficult clients, normal range of experience has to be reasonably assumed to be a safe practice or occurrence in order for it to be considered "normal" in a licensed setting.

We know that there are some incidents that occur that are not "normal" ie: a traffic accident or removing an unauthorized person from the premises. We are not looking (or able) to identify every "outside the range of normal experience" situation, but will absolutely require all of the elements listed in the rule (subsections (a)-(k) to be reported any time they occur. For OL to consider "normal experience" beyond the list of rule-required items, we must also evaluate the impact on clients. If an incident that is not listed in subsections (a)-(k) had a negative impact on a client (for example: required follow-up medical care, therapeutic intervention, behavior management) it would be considered outside the "range of normal experience" and require a report.

When in doubt err on the side of caution. You will never be penalized for over-reporting. However, keep in mind that it is a more egregious noncompliance when a provider fails to (knowingly or accidentally) report an incident. When there is a discrepancy as to whether or not a situation falls within the range of normal experience, our administrative team is willing to assist in mediating to come to a fair decision.

(a) an allegation or confirmation of abuse, neglect, or exploitation;

- **"Abuse"** means the same as the term is defined in 26B-6-201, 80-1-102, and R512-80-2.

Abuse includes:

Domestic Violence Related Child Abuse, emotional abuse, fetal exposure to alcohol or other harmful substances, dealing in material harmful to a child, Pediatric Condition Falsification or medical child abuse (formerly Munchhausen Syndrome by Proxy), physical abuse, sexual abuse, and sexual exploitation, emotional abuse, physical abuse, sexual abuse, and sexual exploitation as defined in UCA 76-5-109, inflicting, causing or permitting another to inflict serious injury, injury or abandonment to a child if done intentionally, recklessly or with negligence to result in felony or misdemeanor as outlined in the statute. This also includes exposure to material harmful to a child (pornography or sexually explicit material involving a minor).

A threat of violence including an act with intent to place a person in fear, imminent serious bodily injury, substantial bodily injury, or death, actual property damage over $500.00 or the person makes a threat accompanied by an immediate show of force or violence to do bodily injury to another consistent with Section 76-5-107.

NOTE **Utah law** (Sections 80-2-603 and 26B-6-205) **require reporting of any incident of suspected or witnessed abuse CPS or APS and law enforcement*** Suspected or witness abuse reported to the authorities must also be reported to OL if it occurred in a licensed,

certified, or DHHS contracted setting.

- **"Harm"** means financial, physical, or emotional pain, damage, injury, or fraud. If a program or staff member has caused harm to a client, that harm is included as abuse and must be reported as a critical incident.
- **"Mistreatment"** means abuse if it includes conduct that results in emotional or physical harm.
  Emotional mistreatment includes:
  verbal or non-verbal conduct that results in a client suffering significant mental anguish, emotional distress, fear, humiliation, or degradation; and may include demeaning, threatening, terrorizing, alienating, isolating, intimidating, or harassing a client.
  Physical mistreatment includes:
  misuse of work, exercise restraint, or seclusion as a means of coercion, punishment, or retaliation against a client, or for the convenience of the licensee, or when inconsistent with the client's treatment or service plan, health or abilities; compelling a client to remain in an uncomfortable position or repeating physical movements to coerce, punish, or retaliate against a client, or for the convenience of the licensee; and physical punishment.

  Specific contract language may also exist that requires additional criteria for DHHS contracted providers.

- **"Neglect"** means abandonment or the failure to provide necessary care, including nutrition, education, clothing, shelter, sleep, bedding, supervision, health care, hygiene, treatment, or protection from harm. Neglect also means the same as the term is defined in Sections 26B-6-201; 76-5-110; and 80-1-102.
- **"Exploitation"** requiring reporting to APS or law enforcement includes:

(a) the use of a client's property, labor, or resources without the client's consent or in a manner that is contrary to the client's best interests, or for the gain of some person other than the client, including spending a client's funds for the benefit of another;

“Without a client’s consent” and “client’s best interests” are key to ensuring that if a provider utilizes client property, labor or resources for any reason, there must be a safe practice/policy outlining this and evidence that the client agreed to the situation.
“Community service” cannot be offered by a provider unless approved by the court who ordered the service”

(b) using the labor of a client without paying the client a fair wage or without providing the client with just or equivalent non-monetary compensation, where such use is inconsistent with therapeutic practices;

(c) engaging or involving a client in any sexual conduct; or

(d) sexual abuse of a minor as described in Section 76-5b-201 or vulnerable adult as described in Sections 76-5b-202 and Subsection 76-5-111(2).

Any staff with client sexual misconduct constitutes a critical incident and requires Protective Services or Law Enforcement reporting. Adult clients are afforded consensual sexual activity which is not considered unlawful unless it is not consensual or is otherwise illegal. Additionally, providers should report all illegal activity to law enforcement.

(b) a loss or impairment of the function of a bodily member, organ, or mental faculty or significant disfigurement;

This refers to any incident whereby the client sustains impact to functioning while under the responsibility of the provider.

(c) a death related to an adverse event;

This means any event where the client passes following an event or incident while under the provider's purview. (example: an outpatient treatment provider who isn't responsible for the client while at home is not responsible to report a client's death UNLESS the provider or staff were aware of a situation where they could have prevented the death). The key in this is the provider's culpability for the event that occurred. A death in a hospice setting is not considered a critical incident. A death in a human services setting is considered a critical incident if it was medically unexpected. In health facilities, the death is to be reported when the death is accidental or the probable cause is lack of compliance with rules or regulations.

(d) a death of a minor;

Meaning any death of a minor under a child care or human services program's purview is always a critical incident. In health facilities, the death of a minor is to be reported when the death is accidental or the probable cause is lack of compliance with rules or regulations.

(e) a medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, or hospitalization;

(f) an allegation or confirmation of waste, fraud or abuse of Medicaid funds;

- **"Fraud"** means a false or deceptive statement, act, or omission that causes, or attempts to cause, property or financial damages, or for personal gain. Fraud also means any offenses identified as fraud in Title 76, Chapter 6, Offenses Against Property.

(g) any medical emergency requiring treatment beyond basic first aid;

This is any client injury, including self-directed violence, requiring medical attention beyond basic first aid (Instacare, ED, EMS and medical care offered by an onsite nurse or physician). **"Self directed violence"** means: Behavior that is self-directed and deliberately results in injury to oneself. See page 21 of this reference for details on self directed violence definitions and terms that OL will use as our guidance on this topic.

- **"Beyond basic first aid"** means: anything that exceeds the training offered in a basic first aid class that can be successfully done by non-medical personnel. A provider with access to diagnostic tools (x-ray machines etc.) may conduct diagnostics without reporting, but must report if diagnostics reveal a need for medical care beyond basic first aid even if the care is provided by an onsite physician or nurse.

Any use of force including staff interventions, staff restraints or staff or client force involving injury that requires care beyond basic first aid must be reported individually as they occur, and may also be considered significant criminal activity requiring additional reporting as outlined in (i) below.

Any significant medical emergency must be reported to emergency medical services as required by 26B-2-104(2)(a)-(c). All significant medical emergencies occurring on the premises of where the provider operates involving its clients or on-duty staff members must be reported to medical services (911, ER, EMS) and OL. This includes hospitalization of clients for any reason (expected/unexpected) while under the provider and staff's responsibility or resulting from an occurrence under the provider and staff's responsibility. *"Hospitalization" means admission to the hospital.

A visit to instacare or ER to assess a health condition that is not an evident threat or emergency is not considered a reportable critical incident, but a visit to instacare or ER or ambulance ride due to an emergency need to resuscitate, triage, or immediately treat a condition not otherwise treatable by medical appointment is considered a reportable critical incident.

- **"Significant Medical Emergency"** means an acute injury or illness posing an immediate risk to a person's life or health or requires emergency medical care.

(h) a missing client;

This includes escape from a detention center or secure facility. However, the departure of an adult voluntarily participating in a program is considered an authorized departure. It is up to the provider to identify and follow procedures regarding what is considered an authorized departure and what is considered unauthorized in the policy and procedure manual. For example, an adult leaving a non-court ordered substance use disorder program would not be considered AWOL. In addition to following standard critical incident reporting procedure, unauthorized departure should be reported to law enforcement when the departure poses a danger to the client or community.

In secure and residential treatment settings, departure without individual clinical justification of decreased ratios or independence as part of a step down/transition process to less restrictive care is considered unauthorized immediately upon occurrence. In smaller settings, policies must outline and follow a threshold where departure is unauthorized (subject to OL review and recommendations for updates as needed).

In health care facility settings, an unauthorized departure would be leaving the facility without following proper discharge procedures.

In child care facilities, a missing client is any time a child is missing or leaves the facility without the provider's knowledge.

(i) any significant criminal activity;

Reported to law enforcement as required by 26B-2-104(2) in a human service program or in any program governed by OL if it meets this definition:

- **"Significant Criminal Activity"** means any unlawful activity by or against of the provider's clients or on duty staff members that poses a serious threat to their health, safety, or well-being including:
  (a) any criminal activity that involves law enforcement;
  (b) illegal physical or sexual misconduct or assault;
  (c) riot;
  (d) suspected fraud; and
  (e) suspected exploitation.

The unlawful or unauthorized (by policy) presence or use of alcohol, substances, or harmful contraband items should be reported to OL and to law enforcement (when illegal).
*Authorized alcohol presence only applies to adults in DSPD settings or legal age adults outside of the provider's purview.

Illegal presence of dangerous weapons or use of dangerous weapons must also be reported to law enforcement.

*Dangerous weapons include traditional weapons (knives, guns, brass knuckles, nunchucks etc) or non-traditional weapons (homemade items, broken glass, rocks) only if garnered with intent to use as a weapon or used as a weapon. Example: A client throwing a chair out of anger is not considered a weapon, but it becomes a reportable incident when an injury occurs or when used as a weapon with intent to injure.

(j) any property damage or infestation that jeopardizes services;

It means any change to a client's environment compromising the immediate health or safety of the client including roof collapse, fire, flood, weather events, natural disasters, and infestations. *Reminder emergency plan, relocation rules, and policy updates (and business continuity plans for contracted providers) must be followed during times of disruption/relocation.

Rule 386-702 (section 3) outlines a list of reportable diseases that are required by law to be reported to the health department. Reminder: OL rule additionally requires that policies and procedures are updated according to DHHS and CDC guidelines and are followed during such outbreaks or pandemics. Coordinate with your licensor and local/state health authorities during times of pandemic.

and

(k) any prohibited practice as described in Section 26B-2-123 including misuse or unauthorized use of restrictive interventions, seclusion, or body cavity search.

In general, providers may not use cruel, severe, unusual, or unnecessary practices on a client and should begin with proper de-escalation practices before using any restraint or seclusion for unwanted behaviors.

OL requires by rule that any restraint in a congregate care program is reported to our office and any restraint (in ANY program) resulting in injury beyond basic first aid is reported as a critical incident to our office.

- **"Seclusion"** means, except for medically approved quarantine, the involuntary confinement of an individual in an area:

(a) away from the individual's peers; and

(b) in a manner that physically prevents the individual from leaving the room or area.

A congregate care program:

(a) may use seclusion if:
  (i) the purpose for the seclusion is to ensure the immediate safety of the child or others; and

(ii) no less restrictive intervention is likely to ensure the safety of the child or others; and

(b) may not use seclusion:

(i) for coercion, retaliation, or humiliation; or

(ii) due to inadequate staffing or for the staff's convenience.

"Involuntary confinement away from the individual's peers" includes the withholding of personal interaction, emotional response, or stimulation. This means prohibiting or denying the individual the opportunity to normally socialize with others, rejecting or purposely ignoring emotional needs, or denying the individual from the necessary stimulation for success in the program with the intent to penalize, humiliate, or force compliance.

The following practices are not considered seclusion and, therefore, are not reportable to OL:

1. **Voluntary time-out**. This is a deescalation technique that allows the person to go to their room or other quiet place for self-calming and self-regulation. As long as they are not physically prevented from leaving, we do not consider this seclusion. (this could also be staff-directed as long as the process for the client does not involve physical restrictions on them leaving the calming area and they are properly supervised during their time out episode). Consequences and loss of privileges are acceptable, but if it involves isolating a client from NORMAL interactions with peers and staff (i.e. spend the day in their room) it is inappropriately withholding personal interaction, emotional response, or stimulation as prohibited by 26B-2-123(1)(m). The individual must be properly supervised.

2. **Exclusionary Time-out**. This is a procedure in which an individual served is excluded from the immediate environment by staff to help the individual regain behavioral and emotional control. This procedure involves the staff verbally redirecting the individual to remove themselves from the immediate environment and verbally restricting the individual to a quiet area or unlocked quiet room. In instances where the client poses harm to themselves or others a physical redirection may be necessary. This definition of exclusionary time-out does not include instances in which an individual served is restricted to an unlocked room or area consistent with a program's rules (such as restriction to the individual's sleeping area for quiet time before bedtime or a room or area for homework). Exclusionary Time-out must not exceed 30 minutes.

3. **Social Redirection.** (also referred to as “one on one skill development”). This is the involuntary movement of an individual to a neutral location with appropriate staff members and possibly a trusted peer. The purpose of Social Redirection is for interaction, physical movement, and attunement to assist that individual in regaining emotional and behavioral control. Social Redirection is not a punishment. Social Redirection time may vary according to several factors (reactivity, trauma history, emotional intelligence, cognitive capacity).

Social Redirection involves engaging an individual in a task alongside staff members for the staff members to attune to and assist the individual in calming down through working together (shared attention and shared goals). Social Redirection involves engaging in conversation and activities together. Social Redirection is not having a staff member observe an individual complete chore, but working alongside the individual in a non-hostile, non-confrontational manner until that individual demonstrates that they are able return to program milieu without disrupting the safety of themselves, others, or the therapeutic environment.

- **“Restraint”** means physically restricting a person's freedom of movement, physical activity, or normal access to their body; and includes passive, chemical and mechanical restraint used as a last resort as a means to prevent harm to self or others. Restraint does not mean an escort used to lead, guide, or direct a client.
- **"Chemical Restraint"** means any drug that is used to restrict an individual's freedom of movement for discipline, convenience, or immediate safety and not required to treat the individual's medical symptoms.
- **“Mechanical Restraint”** means the use of a device, material or equipment attached to or adjacent to a person’s body that restricts freedom of movement and normal access to the body.

A restraint is allowed to prevent harm to the client or in protection of others, is only to be completed by an individual with documented training, and it should be used as a last resort emergency safety measure only.

For DHHS Contracted Providers (excluding traditional licensed providers without a specific DHHS contract) documenting physical restraint not resulting in injury or from a restraint: When a Behavior Support Plan outlines specific interventions that were correctly used in the incident, an individual report is not necessary unless there is an injury. OL will instead accept a copy of the monthly report provided to DSPD Support Coordinators as compliant with this reporting requirement.

Congregate care providers must report any of the following unnecessary practices as a critical incident:

(a) a strip search unless the congregate care program determines and documents that a strip search is necessary to protect an individual's health or safety;
(b) a body cavity search unless the congregate care program determines and documents that a body cavity search is necessary to protect an individual's health or safety;
(c) inducing pain to obtain compliance;
(d) hyperextending joints;
(e) peer restraints;
(f) discipline or punishment that is intended to frighten or humiliate;
(g) requiring or forcing the child to take an uncomfortable position, including squatting or bending;
(h) for the purpose of punishing or humiliating, requiring or forcing the child to repeat physical movements or physical exercises such as running laps or performing push-ups;
(i) spanking, hitting, shaking, or otherwise engaging in aggressive physical contact;
(j) denying an essential program service;
(k) depriving the child of a meal, water, rest, or opportunity for toileting;
(l) denying shelter, clothing, or bedding;
(m) withholding personal interaction, emotional response, or stimulation;
(n) prohibiting the child from entering the residence;
(o) any chemical (sedatives, tranquilizers) and Mechanical (handcuffs, shackles, straitjackets) restraint interventions in Human Services or Child Care licensed settings;
(p) any seclusion used:
    (i) for coercion, retaliation, or humiliation; or
    (ii) due to inadequate staffing or for the staff's convenience.

Note Unnecessary practices are further outlined and explained for congregate care providers in the R501-1 Interpretation Manual Sections 501-1-4(4), R501-1-16(1)(p)

Note the office will not accept a blanket practice that utilizes the same rationale for every client to be subjected to an unnecessary practice. There must be individualized documentation indicating the rationale for utilizing the practice in consideration of the individual's immediate health and safety.

❖ Reporting a Critical Incident❖

Any incident that meets the definition of a critical incident in Rule R380-600 or non-critical as described below for contracted providers are required to be reported as follows:

If the client is a minor or has a responsible parent/guardian (guardian includes caseworker if the client is in the custody of a division under DHHS) or any other legal designee, **the provider shall document and issue notification to the responsible party within 24**

hours of the incident occurrence. When there is a lapse longer than 24 hours, noncompliance is likely unless the provider documents (and the office acknowledges) extenuating circumstances. All staff should be trained to report immediately to a responsible party or to OL in order to meet this time requirement.

If a client who is being served under contract with any agency of the department dies, the provider must notify the supervising department agency or office immediately.

If the provider is licensed or certified by OL, submit a critical incident report through the OL Provider Portal **within 1 business day of the incident occurrence.**

If the provider is serving a client of DSPD, OL will accept a report submitted via the **DSPD-UPI/USTEPS system if submitted within 24 hours and a full report is completed in the system within 5 business days**.

Providers may be asked to supply additional information to DHHS if such information is required by DHHS or any other entity making further inquiry of an incident(s)

If for any reason the OL Provider Portal or UPI/USTEPS system is unable to accept an incident report, the backup email address to submit a report is licensingconcerns@utah.gov. The emailed report will only be accepted if there is verification of inability to submit via the required user portal and must include:

- Name of provider and any involved staff, witnesses and clients
- Date time and location of the incident (including when the incident was discovered if different than the actual incident occurrence)
- Descriptive summary of the incident
- Actions taken and actions planned to be taken
- Identification of any involved entities (law enforcement, cps, aps, contracts etc)

For more guidance regarding critical incidents in human services programs, please see R380-600 Interpretation Manual Subsections 380-600-2(11) and 380-600-7(16) and R501-1 Interpretation Manual Subsections 501-1-7(1), 501-1-11(1)(n) and 501-1-1(2)(k) for further guidance regarding critical incident rules under those titles.

❖ Non-Critical Incidents for Contracted Providers❖

Non-critical Incidents are those events or occurrences that do meet the definition of critical incident but need to be reported to the department because of contractual requirements. Please read your contract carefully to see what non-critical incidents are to be reported.

Reporting requirements or procedures for non-critical incidents are the same as outlined for critical incidents above. In addition, the requirements relating to non-critical incidents only apply to those entities serving a DHHS population under a state contract. These do not apply to non-contracted private providers. The following are non-critical incidents may have to be reported if required by contract:

1. Any admission to a psychiatric facility.
2. Suicidal ideation or threats of suicide when the individual does not have services and supports in place to address such behaviors, a description of which are also not being reported on a monthly summary to appropriate case management.
3. Use of emergency behavior interventions as defined in Rule R539-4. This is applicable only to people receiving services under the DSPD system.
4. Aspiration or choking which does not result in hospitalization.
5. Evidence of a seizure or seizure like behavior in an individual with no existing seizure diagnosis, except where seizures have been ruled out and seizure like behavior is a behavior identified as a target behavior in a Behavior Support Plan and reported in a monthly behavior summary sent to the appropriate case management/support coordination.
6. Any involvement of an outside entity such as fire department, law enforcement, etc.
7. Attempted escape from a detention or secure facility.
8. Unlawful or unauthorized possession of pornographic material.
9. Any pending litigation that is specifically related to the provider's services or to an individual receiving services.

Again, although not all restraints and seclusions are considered a critical incident, providers of human services programs and facilities must report to the OL the use of any restraint and seclusion according to 26B-2-104(a)(x)(A).

For questions relating to Critical Incidents, providers may contact their licensor, when applicable, or contact the Office of Licensing at (801) 538-4242.

For questions relating to specific Non-Critical Incidents, contracted providers should contact appropriate case management, case worker or Support Coordinator; and your quality management contract specialist in the Division of Continuous Quality Improvement for general questions related to Non-Critical Incidents.