Frequently Asked Questions

(FAQs)

GENERAL INFORMATION

Q. Can agencies see reports of OHCQ/DDA?

A. By law, OHCQ reports are not discoverable. You can, however, contact your regional DDA office for information on follow-up. Deficiencies are public documents and can be seen by anyone. Agency Board members may also receive deficiencies on a routine basis and the Agency Board president is sent copies of all deficiency statements.

Q. What are considered "working days?"

A. Working days are considered to be Monday through Friday, with the exception of state holidays and service reduction days.

Q. Can a time-out room be used for adults?

A. No, refer to the DDA regulations, 10.22.10.06D3.

Q. Who monitors investigations and surveys completed by OHCQ?

A. As the State Protection and Advocacy Agency, MDLC can request to review investigations and surveys at any time. In addition, the State Medicaid office reviews a sampling of reports annually as part of DDA's federal waiver requirements.

Q. Who is a contact person for jurisdictional issues (e.g., group home in Montgomery County/MD but funding and placement was via DC)?

A. The respective regional office can provide you with this information. The rule of thumb is that if the site is licensed by Maryland DDA and/or the service is funded through Maryland DDA, Maryland DDA and OHCQ will handle any review or investigation warranted. Maryland DDA, D.C. DDA, and OHCQ have a Memorandum of Agreement regarding sites operated in Maryland for individuals receiving supports from D.C. licensed/certified agencies.

Q. Will data collected from agencies be shared back with agencies periodically? (i.e. patterns involving certain staff, homes, individuals, etc., quarterly or annual trends)

A. Agencies should be looking at this information internally and taking action on such trends through their Quality Assurance Plan. Regional offices may also share any patterns they recognize with agencies. Data may be requested from OHCQ through the public information act.

Q. After 6 years, an agency can purge or shred files. Does OHCQ keep files longer? Why the length of time - 6 years?

A. OHCQ keeps its files slightly longer than 6 years. The 6-year length of time comes from the HIPPA regulations, which is federal law.

Q. Are electronic records acceptable?

A: Yes. OHCQ must be able to access the complete record and the agency must have the capability to print out requested documents at the request of an investigator or surveyor. Records must be protected. Please refer to the Maryland Medical Records Act, Health-General Sections 4-301 through 4-309, and the HIPAA regulations, 45 CFR 164.

Q. Does Maryland have a central abuse registry? Can we get stricter laws concerning databases for staff who have been convicted or had allegations of abuse and do convictions or charges show up on police background checks?

A. Maryland does not have a central abuse registry. We are currently looking at other states to see how those states established registries. For private companies doing background checks and using a potential employee's Social Security Number, pending charges can be identified. Background checks through the State Police only reveal convictions through fingerprints.

Q. Must agencies know if an individual has a legal guardian?

A. Yes, the agency should routinely know this information and document it in the individual's plan.

Q. If an individual has a family member, but the family is not involved, should the family be notified of events?

A. Yes, unless otherwise noted in the person's individual plan. It should not be assumed that just because a family member is not involved on a regular basis that they would not want to know about events in an individual's life.

Q. Could the automatic notification of an advocate or guardian possibly infringe on the individual's rights if they don't want that person notified? Where the individual is his or her own guardian and is legally competent, at what point is notifying the family a violation of the individual's human rights?

A. If the individual has a legal guardian, you must notify that person in the case of a reportable incident or other significant event. If the individual has reached the age of majority and does not have a guardian, the SRC or community agency must respect the individual's wishes as documented in his or her individual plan.

FIRE SAFETY/EMERGENCY PLANS

Q. What is the impact of a sprinkler system on the evacuation times for residential sites?

A. The existence of a sprinkler system in a site, does not afford extra evacuation time in the event of a fire emergency. (see below response from Fire Marshal Michael Bond)

"An installed automatic sprinkler system in a residential / health care occupancy does not determine evacuation time. Evacuation time can be a determining factor with reference to a automatic sprinkler system. In other words, in a fire emergency, the activation of the automatic sprinkler system could control and possibly extinguish a fire that was sprinkler controllable, giving residents a little more time to exit the building. A main point to remember is that the smoke from a fire can incapacitate / kill before the automatic sprinkler system activates. That is why working smoke alarms are so important.
Since the State Fire Marshal's Office does not enforce the fire code in residential occupancies with 5 or less residents, a sprinkler system would not be required. However, the local jurisdiction may require it if it was built after a certain date. The Office of the State Fire Marshal would require a full automatic sprinkler system, fire alarm system and smoke detection system in an occupancy that have 6 or more residents in the counties we have jurisdiction in."

Q. Do I need to do anything with our sprinkler system(s)?

A. Periodically observe that nothing is blocking the sprinkler heads, and there should be at least an 18 inch clearance. In addition the sprinkler heads should be free of lint and debris. An annual inspection through an agency licensed to inspect or install sprinkler systems is required to ensure the system is operable.

Q. Is a secondary means of escape always required in sleeping rooms and living areas?

A. A secondary means of escape is not required if one of the following conditions is met: If a bedroom or living room has a door leading directly to the outside at or to grade level, or if it is protected by an automatic sprinkler system.

Q. What size should a window be if it will be used as the secondary means of escape?

A. When a window is designated as the secondary means of escape from a room, the size of the window should be 5.7 square feet. The width of the window should not be less than 20 inches and the height not less than 24 inches. The bottom of the opening should not be more the 44 inches above the floor. If the bottom of a window is a few inches above the required 44" from the floor level, a permanently affixed ladder or step(s) can be placed below the window. However it must be as wide as the window.

Q. Are there any other requirements to be considered for windows when they are to be used as a secondary means of escape?

A. The window must open with minimal effort and without the use of keys or special tools. The window itself should not be covered or blocked such as by a large head board from a bed or other furniture. A bed or other furniture can be placed below a window and would not impede escape.

Q. How long should it take to evacuate a dwelling in the event of a fire?

A. The NFPA Life Safety Code (where they define evacuation capability), states an evacuation time of 3 minutes or less without staff assistance is prompt. An evacuation time of over 3 minutes, but less than 13 minutes and requiring some staff assistance is slow. An evacuation time of more than 13 minutes even with staff assistance is impractical.

Q. Should fire escape plans be posted?

A. If the individuals living in the home are independent and it is documented that they do not want the plan posted on the wall, the plan does not need to be posted. Please keep in mind that in an emergency, most people would probably benefit and need the visual reminder.

Q. How often should fire drills be conducted?

A. There are no specific requirements for how often fire drills must be conducted in homes that are licensed for 1 to 5 individuals The rule of thumb is to conduct frequent enough fire/emergency drills to ensure evacuation from the site within no more than 3 minutes.

Keep in mind that when determining how long a fire drill can last, how often they need to be conducted and at what time of the day, you need to look at the needs of the individuals. If there is one overnight staff and there are 3 non-ambulatory people, you would need to determine whether the people are living in a safe place if direct support staff does not know whether or not individuals can be evacuated in the event of a fire.

Q. Are there different requirements for how many fire drills should be conducted in group homes that have capacities of 6 to 8?

A. Yes. Because Fire Marshal inspections are required in jurisdictions throughout the state for all group homes licensed for 6 or more the following requirements from NFPA apply:

Fire/exit drill shall be conducted six (6) times per year on a bi-monthly basis. Not less than two (2) drills shall be conducted during the night when residents are asleep. Drills shall be held at different times of the day.

Q. How many smoke alarms are required in a home?

A. Smoke alarm(s) should be located in all sleeping rooms, on each level of the dwelling including basements and outside of each sleeping area in the immediate vicinity of the sleeping rooms.

Q. Are homes required to have interconnected electric 110/volt battery back-up smoke alarms?

A. No, battery operated smoke alarms are permitted in existing one and two family dwellings, provided that they are tested on a regular basis by the property owner/occupant, and are operable at the time of the survey.

Q. During a survey or inspection, staff are asked to test the smoke alarms for the OHCQ staff. Why?

A. OHCQ defers to agency staff to test smoke alarms. IN addition to ensuring OHCQ does not damage agency equipment, this is also an indication of the ability of staff to test the alarm and conduct a fire drill.

Q. Can OHCQ require a Fire Marshal inspection when surveying a licensed site?

A. Yes. If OHCQ has concerns regarding fire safety issues that would require the expertise of a Fire Marshal, OHCQ will request an inspection. OHCQ will send the request to the local fire marshal for that jurisdiction.

Q. Are all group homes with a capacity of 6 and above required to have a Fire Marshal inspection?

A. Yes. ALL residential facilities having 6 or more residents not related to the owner are required to have an inspection in the state of Maryland. OHCQ Investigators and Surveyors may ask for a copy of the most recent F.M. inspection for group homes of 6 or above. OHCQ will also check for any fire safety equipment or systems that were required by the F.M. at the time of inspection. If a F.M. inspection has not been completed in more than five years, OHCQ will request a Fire Marshal inspection.

Q. How often are Fire Marshal inspections conducted in all group homes where it is required?

A. Annual inspections are required. However due to staffing shortages this is not always being done by Fire Marshals throughout the state.

Q. Are all day programs supposed to have a Fire Marshal inspection?

A. Yes. F.M. inspections are required for all DD day programs. Inspections are usually requested by OHCQ for day programs unless an agency has already had one completed. A program may be located in a public building that may have already had a F.M. inspection. OHCQ would thenrequest a copy of the approval form.

Q. What kind(s) of space heaters are acceptable?

A. Portable space heaters that are electric; oil filled and look like the old fashioned radiators are acceptable. They should display the “UL listed” designation. Extension cords should never be used on these heaters. Kerosene heaters are considered very dangerous and not acceptable by fire marshals.

Q. Does each licensed site need to have a land-line telephone?

A. No. However, homes without a land line telephone cannot be tracked in the event of an emergency. MD does not have a system yet to track cell phone locations for emergency purposes.

Q. We have a generator for emergencies. Where can we store the gas?

A. Gasoline that is typically used for use in lawn mowers or generators can be stored in garages in a proper storage container. Garages are built with fire walls and fire doors to protect the rest of the home from a fire that may have started in a garage. Gasoline cannot be stored on apartment balconies or within residences.

POLICY ON REPORTABLE INCIDENTS AND INVESTIGATIONS (PORII):

Administrative Issues

NOTE: EFFECTIVE MARCH 29, 2013, A WEB-BASED REPORTING SYSTEM WAS IMPLEMENTED. ALL INCIDENT REPORTS AND AGENCY INVESTIGATIONS MUST BE REPORTED THROUGH THE QA MODULE OF PCIS-2.

Q. Do we report injury to staff or others, such as community people?

A. The section of PORII on injury pertains to individuals, not staff. An incident must be reported if it involves an individual and someone in the community and/or if the police were involved.

Q. If an agency is not sure whether or not to report an incident, what should occur?

A. Reporting procedures as outlined in PORII need to be followed as written. State residential centers (SRC) and community agencies would want to err in favor of reporting. If an agency is unsure, contact with your regional office is recommended.

Q. What happens if an agency deems an incident as internal and later, after further investigation, determines that the incident is reportable?

A. The licensee should report immediately upon making the re-determination. The licensee will not be penalized for not reporting the incident previously because all of the facts were not available. However, a pattern of mis-identifying incidents as non-reportable will be subject to review and possible sanctions.

Q. What are the repercussions if timeframes for reporting are not adhered met?

A. All licensees are to respond in good faith. If repeat issues occur and are not reported on time and a pattern of not reporting is evident, OHCQ will act accordingly. Such a pattern could be grounds for sanction by DDA. Each licensee should also be looking at its process and any noticeable trends should be addressed in its quality assurance plan.

Q. Who is the state protection and advocacy agency?

A. The Maryland Disability Law Center (MDLC).

Q. If you do not have any internally investigated incidents in a quarter, do you still need to complete a report?

A: Yes, on the A5 report the agency shall state that there were no internally investigated incidents during the particular quarter.

Q. What is the timeframe for completing the Agency Investigation Report(AIR) for **reportable** and **internally investigated** incidents?

A: The timeframe for completion and submission of the AIR is within 10 working days of discovery for **reportable incidents**. AIRs for **internally investigated incidents** must be completed and submitted within 21 working days. to OHCQ and DDA.

Q. Relating to individuals outside the program (approved for long-term care outside agency but still funded)... Are we under the same reporting requirements?

A. Consult with your regional office. The outside agency may have other reporting requirements.

Agency Internal Protocol

Q. Can the director designate someone within his/her agency to be contacted if he/she is not available?

A. A designee can be named in the director's absence (see page 5 of PORII). However, this needs to be addressed in the licensee's internal protocol.

Q. Who completes the reportable incident from the agency, the person who sees it or the person who reports it?

A. The licensee's internal protocol should address this issue. Keep in mind that staff should be trained to report and investigate incidents in accordance with PORII.

Q. Should one person in the agency to do all the reporting?

A. This is up to the licensee's internal protocol. Keep in mind that staff should be trained to report and investigate incidents in accordance with PORII.

Q. Where are the records for reportable incidents kept? In an individual's file or separate binder?

A. The licensee's internal protocol needs to address this issue. It is recommended that the agency keep the reports in a place where they are easy to locate. Reports need to be available to the individual and his/her team, but confidentiality of records also must be maintained. Records can be identified by individual name or an unique identifier. Incidents involving more than one individual must be retrievable for all individuals involved.

Q. Are board members to be notified about reportable and internally investigated incidents?

A. Yes, the licensee should include methods of notification in its internal policy. The inclusion of a board member as part of the licensee's standing committee will facilitate this notification.

Q. All incidents are supposed to be reviewed by the standing committee. Must the members be provided the entire investigation or is a synopsis with availability to all information appropriate?

A. The full investigation must be forwarded to the standing committee for its review.

Q. Please clarify, if you are on the agency Standing Committee, you can not investigate.

A. This is correct. Anyone who is directly involved would be considered in a conflict of interest situation under the review of the investigation. One can investigate or review, but not both.

Q. The standing committee will meet within 7 days of what time frame?

A. PORII states that the standing committee must receive the report within 7 calendar days following closure of the matter, not necessarily that the committee meets.

Q. In the situation where an individual is in residential and day services, within the same agency, who is responsible for reporting?

A. The discovering arm of the agency is responsible for reporting, but can defer to the other part of the agency, as per the licensee's internal protocol. Please remember that trained staff from the agency should complete the reporting of all incidents. Please also refer to "Irregular Situations" below.

Q. How does the policy require agencies to handle an incident that is alleged for an individual that:

a) lives in a DDA-licensed residential site;

b) attends a DDA-licensed day program; and/or

c) receives a support service from a DDA-licensed provider,

but the incident did not occur while the individual was under the direct supervision of the agency providing the service, e.g., during a family visit, visit at a relative or friend's home, at another facility, in school, at a camp or while on a vacation trip?

A: The agency shall report to authorities and community resources, as indicated, e.g., law enforcement authorities, Protective Services, etc. and investigate per their direction.

Q. What are the reporting requirements of an agency that discovers an incident that occurred while the individual was receiving services from another agency? (For example, day program staff allege that an incident occurred at a residential site or residential staff allege that an incident occurred at a day program site.)

A: The discovering agency shall:

(1) Document the allegation using the method determined in their internal protocol, and

(2) notify the other agency (agency 2) of the allegation[1] and cc the appropriate DDA regional office

Agency 2 (where the alleged incident occurred) shall:

(1) report the incident, and

(2) shall investigate, correct and monitor the situation and inform the discovering agency of the progress and outcome of those activities.

(3) The Incident Report and AIR are to be submitted to OHCQ, the DDA regional office, and other authorities as dictated by the requirements of PORII.

If the discovering agency is unable to verify that the event/situation has been reported, it shall bring the event/situation to the attention of the appropriate DDA regional office. DDA will follow-up and take steps to assure appropriate action by agency 2.

Q. When there is disagreement between the two agencies as to the location of the incident and which agency is required to report the incident, who is required to report and investigate the incident?

A: When there is disagreement, both agencies are required to report and investigate the incident.

Q. How can one agency ensure follow-up of another?

A. You can always contact your regional office and ask for information regarding follow-up.

Q. If you are involved with a situation concerning a family home, how far can you investigate?

[1] Article - Health – General; Title 7. Developmental Disabilities Law; Subtitle 10. Rights of Individuals §7–1005. (b) (1) In addition to any other reporting requirement of law, a person who believes that an individual with developmental disability has been abused promptly shall report the alleged abuse to the executive officer or administrative head of the licensee.

A. An incident involving an individual's family home must be reported to Child Protective Services (CPS) or Adult Protective Services (APS).

Q. How does PORII relate to APS and CPS referrals?

A. If an incident occurs in a DDA funded or licensed agency, the policy (PORII) must be followed. In addition, CPS or APS must also be notified. If the individual is a child and the Department of Social Services (DSS) is the funding source, then DSS must be notified. General rule of thumb: the funding source and the licensing source must be contacted.

Issues Concerning Certain Incident Types

Abuse:

Q. What actions should the agency initiate with the staff person, if accused of abuse, while the police are completing their investigation?

A. The responsibility of the licensee is to ensure the safety and well-being of all individuals involved in an incident. Licensees should address this issue and their response in their internal protocol.

Q. Where can an agency learn more about the ethical responsibilities of a certified nursing assistant (CNA) or a medication technician (CMT)?

A: COMAR 10.39.07.02 delineates the ethical responsibilities of certificate holders. (Title 10 Department of Health and Mental Hygiene, Subtitle 39 Board of Nursing-Certified nursing Assistants, Chapter 07 Certified Nursing Assistants/Certified Medication Technicians (CNA/CMT) — Code of Ethics)

Q. What is a “Certificate holder?”

A: "Certificate holder" means an individual who is certified under Health Occupations Article, §8-6A-05 or 8-6A-08, Annotated Code of Maryland, as either a certified nursing assistant in any category or a medication technician.

Q. An agency’s investigation indicates a Certificate holder (CNA and CMT) has violated the Code of Ethics. Is the agency required to report to the Maryland Board of Nursing?

A: Yes. For more information please see the Appendix 2A, 2B, and 2I of PORII.

Q. What format are agencies required to follow when making a report to the Maryland Board of Nursing (MBON) regarding a violation of the Code of Ethics?

A: There is no required format, but a complaint form is available on the MBON website. The agency’s internal protocol must indicate the agency’s method of reporting. At the time

these FAQs were revised, ethical breaches are reported via e-mail to econe@dhmh.state.md.us , by fax to 410-358-3530, or by mail to:

Maryland Board of Nursing

Complaints & Investigations Division

4140 Patterson Avenue

Baltimore, MD 21215-2254

For more information, the MBON can be reached by calling 410-585-1925 or 1-888-202-9861.

Choking:

Q. Is choking reportable?

A: Yes, the 2013 revision of PORII added choking as a reportable and internally investigated incident category. Please see Appendices 1G and 2G for information pertaining to when choking is internally investigated and when it is reportable.

Death:

Q. How and where do agencies document that family does not want to be contacted except in case of death?

A: This documentation should be kept in the individual's file and should be updated at least annually, such as during the annual IP meeting.

Q. Do natural or expected deaths have to be reported to the police?

A: All deaths that occur at a licensed site or during the provision of a licensed service must be reported to the police. Agencies must notify the police as noted in HG§7–206. "Upon notification of the death of an individual in a program or facility funded or operated by the Administration, the administrative head of the program or facility shall report the death immediately to the sheriff, police, or chief law enforcement official in the jurisdiction in which the death occurred."

Q. Who notifies the Medical Examiner's Office?

A: In accordance with § 5-309(b) The sheriff, police, or chief law enforcement officer shall inform a medical examiner, and the medical examiner, if necessary, shall conduct an investigation.

Q. Do deaths need to be reported to the health department?

A: All deaths that occur at a licensed site or during the provision of a licensed service must be reported to the health officer in the jurisdiction where the death occurred by the close

of business the next working day. Agencies must notify the health department as required by HG§7–206.

Q. Do deaths need to be reported to the State protection and advocacy system (MDLC)?

A: All deaths that occur at a licensed site or during the provision of a licensed service must be reported to the designated State protection and advocacy system (MDLC) by the close of business the next working day. Agencies must notify the State protection and advocacy system as required by HG§7–206.

Q. Can report of death be left on regional office voice mail?

A: Yes, you can leave a message to report a death, but remember to follow-up with an incident report to both OHCQ and the regional office within one working day.

Q. If the individual is living at home with family, does a report of death have to be filled out?

A: Yes, a report must be completed if the individual is receiving any type of DDA funded service.

Q. If a person receives DDA-funded residential and day services (from more than one agency), who is responsible for reporting death?

A: Both agencies are required to report.

Hospitalization:

Q. Do all hospital admissions meet the criteria of a reportable incident?

A: No. If a person's IP **documents** a need for frequent/repeated hospitalizations because of a chronic condition then the hospital admission is treated as an internally investigated incident.

Q. Can the possible need for hospitalization be documented in 45 day nursing reviews?

A. If the condition is considered to be chronic, it is recommended that the documentation be in the individual's plan.

Q. How do agencies report a planned hospital admission?

A: Agencies do not report (or internally investigate) planned hospital admissions. Examples of planned hospital admissions include scheduled surgery, planned treatments such as chemotherapy, dialysis, testing such as CT scan, ultrasound, colonoscopy, etc.. The team must discuss these planned admissions either at the annual team meeting or an interim meeting prior to the hospitalization and documentation regarding the hospitalization must be part of each individual's IP.

Q. Do you need the name and address of the hospital on the reports for hospitalization?

A. The name of the hospital should be included in the description of the incident.

Q. Must it be reported if independent individuals who manage their own health care admit themselves into the hospital?

A. If the individual is served by an agency, then the policy must be followed as written.

Q. Must it be reported if an individual is hospitalized in another state while visiting his or her family, but lives with a DDA licensed agency?

A. Only if the hospitalization is the result of the care that the individual was receiving prior to visiting his or her family.

Q. Does hospitalization include outpatient surgery such as biopsy, sedation for minor incision or dental care?

A. If the hospitalization is unplanned, according to the policy, it must be reported.

Injury:

Q. How does an agency classify specific injury types not listed on the Appendix 1E?

A: In the text of PORII, injuries have been categorized for the purpose of providing a guideline to agencies in determining the appropriate reporting and investigating requirements. Agencies should exercise cautious judgment in determining the extent of medical attention that is required for any injury in order to establish the appropriate reporting and investigation requirements. For additional information on terms, consult your agency nurse or "The American Red Cross First Aid and Safety Handbook." If still unsure, agencies should consult the DDA regional office for technical assistance.

Q. Do all injuries require either an internally investigated incident or a reportable incident?

A: No. Injuries that may or may not require minor routine treatment do not require the completion of an incident report. These include Minor Abrasions, Blisters (intact, unopened), Skin Irritation, Minor Bruises/contusions of known origin or the result of medical treatment, Sunburn with no peeling or blisters, Insect bites, stings, or other bites (with no evidence of allergic reaction), Minor scratches, Shaving nicks, or Paper cuts.

Incidents Reported To or Requiring Services of a Law Enforcement Agency or Fire Department:

Q. At state residential centers and forensic residential centers, where security is considered a law enforcement agency, do we report to them?

A. Yes.

Medication Error:

Q. Are "self-medication" errors reportable incidents?

A: Yes, if adverse effects are present (see Appendix 1F).

Q. Which non-medical professional is qualified to determine if a medication error may require agency nurse consultation?

A. No non-medical professional is qualified to determine if a medication error requires nursing consultation. All medication errors must be reported to the nurse.

Q. If a family member is at your facility and wants to administer medications and they are not DDA trained, are they allowed to do so at your facility?

A. In a licensed setting, medication distribution is considered a delegated act and staff must be trained. If the family member is trained, yes they can administer medications. It is suggested that this issue be addressed individually in each licensee's internal protocol. Family members should respect the duties of the staff members. The Nurse Practice Act allows family members to administer medications when the individual is in the family member's home.

Q. If an individual goes home and his or her parent does not medicate correctly with repercussions later, what can you do about that?

A. This would be handled as a medication error. Communication between the licensee and the family should occur as well so that such an incident can be avoided in the future.

Q. What about a medication error involving a mental health facility that is discovered by a DD provider?

A. As for all incidents that fall under an irregular situation, licensees may need to report to an outside agency to follow-up such as the health department, APS, CPS, etc.. IN addition, the licensee should be following up with the mh provider and documenting results either through a team meeting or correspondence. If there are adverse effects, the incident must be reported, as per PORII.

Q. If the pharmacy makes a medication error, is that reportable? (maybe hospitalization?)

A. If there are adverse effects, yes. The authorized medication person should be checking the medication prior to administering. A three way check is required each time medication is given (per MTTP): Check the physician's order, Medication Administration Record (MAR), and the prescription label each time a medication is given.

Notification to the Pharmacy Board may also be warranted.

Neglect:

Q. Are all incidents categorized as *neglect* reportable to the police?

A: The 2013 revision of PORII determined that all allegations of neglect will continue to be categorized as reportable incidents. However, not all incidents of neglect continue to require police notification. Please see Appendix 2B of PORII for clarification.

Q. Please provide examples of "substantial risk of life-threatening harm."

A: Examples of substantial risk of life-threatening harm include: Death, Hospitalization, ER visit due to a reportable injury, Human/animal bites, 1st or 2nd degree burns, Lacerations, and diagnosis of malnutrition by LHCP not related to an illness.

Q. Please provide examples of, "circumstances or conditions which might reasonably result in mistreatment and could cause injury."

A: Examples of circumstances or conditions which might reasonably result in mistreatment and could cause injury include: dehydration not related to an illness, failure to follow up with LHCP recommendations regarding a life threatening condition or to rule out a life threatening condition, failure to provide essential medical treatment or follow up that is consistent with that of the general population, failure to provide a safe environment related to IP indication of a history (e.g.PICA) or Behavior Plan guidelines (e.g.: sharps locked due to suicidal ideation) or diagnosis of severe weight loss not related to an illness. Federal guidelines define the following as severe: 1 month-over 5% body weight; 3 months-over 7.5% body weight; 6 months-over 10% body weight

Restraints:

Q. How many times can someone be restrained and are restraints reportable?

A. A restraint is triggered by a challenging behavior and can be implemented as documented in the individual's behavior plan. A restraint must be reported if unapproved or inappropriate, i.e. use of a mechanical restraint which is not allowed under the regulations or usage of a restraint not included in an approved behavior plan. When an unapproved restraint is utilized or a restraint is used in an emergency, the individual's team must be convened within 5 days to review the situation and action taken. Refer to the Behavior Support Services Program Service Plan chapter of the regulations, 10.22.10 for additional information on this subject.

Non-Reportable/Investigated Categories: ***Monitoring of these supports and restraints must be part of each Agency's Quality Assurance Plan.***

Chemical supports: The use of medication as an intervention to support a person for a medical appointment that would not typically require sedation which has been reviewed and approved by the standing committee.

Mechanical supports: The use of a mechanical device to support a person's proper body position, balance or alignment, such as splints, wedges, bolsters or lap trays, or to protect a person with a continuing medical condition from sustaining an injury.

Planned use of restraints: The use of a mechanical device or physical intervention that is approved as part of a person's behavior plan which has been reviewed and approved by the standing committee.

Administration Prioritization and Investigation Procedures(Section VI of PORII)

Q: The OHCQ incident screening and evaluation process refers to "immediate jeopardy." Please provide some examples of immediate jeopardy.

A: Examples of immediate jeopardy may include: fires; second and third degree burns; lack of food, medication or treatment; serious medication errors; status epilepticus; poor diabetic care, or; suicide attempts.

Q: The OHCQ incident screening and evaluation process refers to "high priority incidents." Please provide some examples of high priority incidents.

A: Examples of high priority incidents may include: being hit with an object; denied assistance with activities of daily living; or obtained suspicious injury.

Q: The OHCQ incident screening and evaluation process refers to "medium priority incidents." Please provide some examples of medium priority incidents.

A: Examples of medium priority incidents may include: unplanned hospitalizations, certain rights violations; or lack of appropriate programs.

Q: When OHCQ evaluates incidents and complaints, what factors are taken into account when determining the need for investigation?

A: OHCQ takes into account many factors, including:

i. Did the individual receive needed intervention and health care in a timely manner?
ii. Did the agency's staff competently respond to the incident?
iii. Is there any indication that regulations have been violated?
iv. Is there any evidence of a pattern of abuse or neglect?
v. Is there a pattern of this incident type being reported by the agency?
vi. What is the agency's incident reporting and investigation track record?
vii. Does the individual's incident history add to the impact of the incident under review?
viii. Is the agency currently under sanctions?
ix. Does the situation indicate an on-going threat to the individual?
x. What is the extent or severity of the incident or injury?

Resource Coordination

Q. Are Resource Coordinators required to report incidents?

A: Yes. The 2013 revision of PORII more precisely outlines the responsibilities of Resource Coordinators. Please see Section III of PORII.

Q. Does the policy require agencies send the Incident report to the Resource Coordinator who works with the individual identified in the report?

A: The 2013 revision of PORII and the web-based reporting system provide for notification of the respective resource coordinators when an incident occurs involving an individual the RC works with.

Q. Under what authority are agencies required to disclose Incident Reports to Resource Coordinators?

A: Disclosure of the Incident Report is required under Maryland Code Health General Title 7- Developmental Disabilities Law, Subtitle 10 - Rights of Individuals, Section 7-1010 - Records - Consent to disclosure.

Q. Does the policy require agencies send the AIR to the Resource Coordinator who works with the individual identified in the incident report?

A: No. Agencies are not required to provide the Resource Coordinator with the AIR. Agencies are required to collaborate with Resource Coordinators to make sure that appropriate action is taken to protect the participant from harm. The agency is required to advise the Resource Coordinator of the interventions taken and follow-up plan that will prevent future recurrence.

STANDING COMMITTEE

Q. Does a multi-agency standing committee count another agency's members as "outside agency" representatives?
A. No. All staff are considered inside representatives.

Q. Are board members considered agency or community representatives on standing committees?
A. Board members are counted as agency (inside) representatives.

Q. Is there a minimum size to a standing committee?
A. No, refer to the DDA regulations, 10.22.02.14E for more information on standing committees.

Q. What does "individual" mean on the standing committee?
A. Refer to the DDA regulations 10.22.01.01B(25) for the definition of an "individual".

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