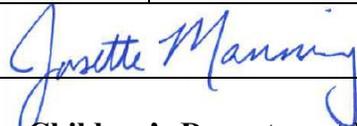


<b>POLICY # 211</b>	<b>SUBJECT: DEPARTMENT SAFETY COUNCIL</b>
<b>EFFECTIVE DATE: April 15, 2007</b> <b>REVISION DATES: June 15, 2016;</b> <b>August 1, 2020</b>	Page 1 of 6
<b>AUTHORIZED SIGNATURE:</b> 	

## Delaware Children's Department Policy

### I. PURPOSE

The Department of Services for Children, Youth and Their Families recognizes the importance of being a self-correcting agency with a focus on safety and continuous quality improvement. The purpose of this policy is to establish processes to identify underlying systemic issues and/or patterns that lead to the occurrence of a critical incident or other identified event with the goal of preventing similar incidents from occurring in the future.

### II. GENERAL

This policy outlines the formation and activity of the Department Safety Council (hereafter referred to as "Safety Council") and additional strategies Safety Council may utilize to aid in critical incident reviews and development of recommendations or improvement plans to prevent incident recurrence.

### III. DEFINITIONS

- A. Causal Factors – Contributing causes of the critical incident under review.
- B. Critical Incident – An unexpected incident that involves the serious injury, hospitalization, death or escape of a child active in the Department. The Department has adopted the following definitions of incidents to be reported:
  - i. Child Death – The loss of life of any child who is active with the Department or has been active within 12 months preceding his or her death. Deaths of children in both department operated and contracted programs are reported.
  - ii. Hospitalizations – An emergency hospital admission of a child active with the Department in any 24 hour department operated or contracted program, including foster care, as follows: (The division active with the child when the report is made should report the critical incident.)
    - 1. Medical or psychiatric hospital admission, including emergency department admission, as a result of an attempted suicide. An attempted suicide is defined as an act to harm oneself serious enough to cause physical consequences/injury resulting in hospitalization for medical treatment or there was potential for serious injury as a result of the

<b>POLICY # 211</b>	<b>SUBJECT: Department Safety Council</b>
<b>EFFECTIVE DATE: April 15, 2007</b> <b>REVISION DATE: June 15, 2016;</b> <b>August 1, 2020</b>	<b>PAGE: Page 2 of 6</b>

attempt. Attempted suicide does **not** include suicide threats, suicide ideation, or planning a suicide.

2. Medical or psychiatric hospital admission where a referral is made to the child abuse and neglect report line for suspected abuse and neglect.
- iii. Repeat Psychiatric Hospital Admissions - When a youth in department care has experienced a third psychiatric inpatient hospitalization and the third admission is 90 days or fewer since discharge from the first inpatient hospital admission.
  - iv. Escape from a Level V Program – The unauthorized departure from any Level V DYRS program. This includes Ferris School, Stevenson House, NCCDC, and any contracted level 5 program (either in state or out of state)
  - v. Stabbing and/or Shooting Incident – An incident in which any child active in a department operated or contracted program is involved as the victim or alleged perpetrator of a stabbing or shooting.
- C. Critical Incident Review – Initial review of the critical incident and department involvement prior to, during, and immediately following the incident on behalf of Safety Council. This review is completed by an administrative case reviewer in the Office of Case Management.
  - D. Improvement Plan - An action plan developed by the division director(s) of each division providing services at the time of the incident. Improvement plans are presented to the Cabinet Secretary following completion of a root cause analysis (defined below) and are tracked by the division(s) and the Department Safety Council. Improvement plans are sometimes referred to as corrective action plans.
  - E. Internal Review – A more comprehensive review of the incident and related events, processes and procedures. An internal review can be completed by the division involved, the Office of Case Management, or a multi-disciplinary team at the request of the Safety Council.
  - F. Root Cause Analysis (RCA) – A systemic process that uses the information gathered during an investigation to determine the fundamental system deficiencies that led to the incident.
  - G. Safety Council – Council is staffed and chaired by the Office of Case Management and is comprised of a representative of the Office of the Cabinet Secretary and two representatives from each of the service divisions. The Council is responsible for conducting a thorough review of all critical incidents (as defined above) and other cases

<b>POLICY # 211</b>	<b>SUBJECT: Department Safety Council</b>
<b>EFFECTIVE DATE: April 15, 2007</b> <b>REVISION DATE: June 15, 2016;</b> <b>August 1, 2020</b>	<b>PAGE: Page 3 of 6</b>

upon request and providing written recommendations to the Cabinet Secretary regarding strategies to address the incident.

- H. Special Incident - An incident that does not fall within the definition of a departmental Critical Incident, but is of concern and referred to the Safety Council for review.

#### **IV. PROCEDURES**

##### **A. Safety Council Activities**

1. Critical incidents are reported within seven (7) calendar days of the incident occurrence by the division(s) to the Safety Council through the department case management record system using critical incident reporting functionality or by generating a DSC incident referral.
2. Special incidents are referred to the Safety Council by the Cabinet Secretary, division director(s), Institutional Abuse, or a division representative. Special incidents are reviewed in the same manner and using the same process as for critical incidents.
3. An OCM administrative case reviewer will conduct a critical incident review and provide review findings to Safety Council members.
4. Safety Council will review and discuss available information and determine if underlying systemic issues contributed to the incident occurrence. As part of the review or as a result of the review, Safety Council may:
  - a. Request additional information from an involved division to determine if causal factors or systemic issues exist,
  - b. Request an internal review to be completed by the involved division(s) or Office of Case Management which includes information requested by Safety Council.
  - c. Recommend a Root Cause Analysis be completed to provide intensive review and analysis by a panel with a goal of determine if there were contributing causal factors and root causes that, if corrected, will prevent recurrence of a similar incident.
  - d. Make recommendations for system changes or improvements to prevent the occurrence of future incidents.
5. In cases where a Root Cause Analysis is recommended, Safety Council will send the completed 'Critical Incident Review & Decision for Root Cause Analysis Referral' form to the Cabinet Secretary for consideration. The referral will include recommendations for the composition of the RCA panel. The panel should include the following:
  - i. A chairperson, who will be approved and appointed by the Cabinet Secretary. Whenever possible, the chairperson should not work in the division(s) or units involved with the critical incident being reviewed.
  - ii. Staff who will bring objectivity and expertise related to the incident (subject matter experts); priority will be given to staff trained on RCA procedures.

<b>POLICY # 211</b>	<b>SUBJECT: Department Safety Council</b>
<b>EFFECTIVE DATE: April 15, 2007</b> <b>REVISION DATE: June 15, 2016;</b> <b>August 1, 2020</b>	<b>PAGE: Page 4 of 6</b>

- iii. Ethnic, cultural and geographic diversity and should include at least one representative from each DSCYF division.
  - iv. Individuals who had direct involvement in the incident should not serve on the team.
6. The Office of Case Management is responsible for recording and tracking conclusions and recommendations made as a result of Safety Council review. Tracking will include preliminary and final outcomes of Safety Council review, including:
    - a. Determination that no underlying systemic issues were factors in the incident with an explanation why (reasons might include: death due to chronic medical conditions/illness; death due to acute medical illness/expected outcome; no known system issues could have prevented; or hospitalization where no abuse or neglect issues are present.),
    - b. Request an internal review be completed by the involved division(s) or the Office of Case Management.
    - c. Recommendations for RCA review,
    - d. Identification of underlying system issues,
    - e. Recommendations for system improvements,
    - f. Division/department response to recommendations,
    - g. Implemented recommendations and completed system improvements.
  7. The OCM Administrator will review Safety Council recommendations and can request clarification and/or further consideration if needed.
  8. Safety Council is not responsible for personnel actions related to critical or special incidents; individual divisions have responsibility for personnel actions.

**B. RCA Team Process**

1. OCM staff will collect all pertinent case information and distribute to team members no later than the first meeting.
2. OCM staff and the RCA team chairperson will coordinate the scheduling of the first RCA team meeting.
3. At the first meeting, the team shall review and sign a confidentiality form and develop a schedule for completing the review and preparing the report.
4. All meetings of the team shall be closed to the public. All information concerning clients are confidential.
5. The RCA team may request any records pertaining to the involved youth/family, service delivery, and division/department processes as deemed appropriate to accomplish its task. This request may also include records of individuals in the case who have received services from a private agency under a purchase of service or care agreement with the Department. All records must remain confidential and compliant with privacy policies. OCM staff will be responsible for providing requested information, arranging meetings and interviews and ensuring that the process follows prescribed RCA procedures.

<b>POLICY # 211</b>	<b>SUBJECT: Department Safety Council</b>
<b>EFFECTIVE DATE: April 15, 2007</b> <b>REVISION DATE: June 15, 2016;</b> <b>August 1, 2020</b>	<b>PAGE: Page 5 of 6</b>

6. The RCA team will review collected department case files, records and chronologies relevant to the incident or system process being reviewed.
7. The RCA team may interview staff members involved in the case, staff members of private agencies who have a purchase of service or care agreement with the Department and any other individuals who have direct involvement in, or knowledge of the case, as appropriate.
8. The RCA team will complete the Root Cause Analysis process and determine if root causes can be identified.
9. The RCA team shall prepare a written report in 30 calendar days (from the date of the initial team meeting). The chairperson may request additional time if needed by submitting a request to the chairperson of the Department Safety Council.
10. The contents of the report may include the following:
  - Incident description
  - Facts and analysis
  - Causal factors
  - Conclusions which may include root causes
  - Risk reduction strategies
  - Recommendations for improvement relating to the critical incident
  - Appendices

The report shall not include recommendations concerning disciplinary actions against any employee.
11. Copies of the report will be submitted to the Cabinet Secretary, directors of divisions involved with the incident, and the Department Safety Council.

### **C. Action Steps following Root Cause Analysis Process**

1. Upon completion of the RCA report, the Safety Council will review the report no later than the next scheduled meeting.
2. The team chairperson presents the RCA report to the Safety Council and participates in the safety council review and discussion.
3. The Safety Council may prepare a written review of the report. The review may include suggested revisions or additional recommendations.
4. A meeting is scheduled with the Cabinet Secretary, directors of divisions involved with the incident, OCM Administrator or designee, chair of the Safety Council, and the RCA team chairperson. The RCA chairperson will present the report and answer questions of participants. The Safety Council chairperson will present any recommendations of the Safety Council.
5. Within 60 calendar days, the involved division(s) will provide a Systems Improvement Plan to the Cabinet Secretary and the Safety Council chairperson. The Safety Council chairperson shall send a reminder after 30 days on behalf of the DSC.
6. Upon approval of the Cabinet Secretary, the involved division(s) will begin implementing the improvement plan. It is the responsibility of the involved division(s) to disseminate the information from the root cause analysis and the Improvement Plan to department staff as appropriate. The RCA chairperson can serve

<b>POLICY # 211</b>	<b>SUBJECT: Department Safety Council</b>
<b>EFFECTIVE DATE: April 15, 2007</b> <b>REVISION DATE: June 15, 2016;</b> <b>August 1, 2020</b>	<b>PAGE: Page 6 of 6</b>

as a consultant to assist in getting the recommendations completed/implemented in their division, program, unit or facility.

7. The Department Safety Council will track number of RCA assignments, critical incident type, system improvement recommendations and timeframes for completion through the department database.
8. The Department Safety Council will maintain documentation of system improvement plan activities, including documentation of system modifications in response to RCA recommendations and recommendations which were not accepted or addressed.
9. Safety Council will provide quarterly reports to the Cabinet Secretary, Deputy Secretary, and division directors summarizing critical incident reviews, findings, recommendations, and other safety council activities.
10. Safety Council will provide critical incident and RCA report aggregate data to department leadership in an annual report. Division directors will disseminate to staff as appropriate.

#### **V. CONFIDENTIALITY**

- A. Members of the Safety Council and any RCA panel must ensure and protect confidentiality of records and persons involved with the incident in accordance with applicable state laws, the Department's policy on confidentiality and the Health Insurance Portability and Accountability Act (HIPAA).
- B. All records, reports and improvement plans maintained in support of Safety Council or RCA activities are stored in locked files in the Office of Case Management and/or in the department database within the critical incident functionality. These records and reports are not part of the client case record and shall not be used for any purpose not stated in this policy.
- C. All documents associated with an RCA are collected by OCM staff upon completion of the RCA process.

#### **VI. IMPLEMENTATION**

- A. Any part of this policy which is in conflict with federal or state laws shall be null and void; all other parts shall remain operative.

#### **VII. RESPONSIBILITY FOR THIS POLICY**

- A. Safety Council is responsible for providing guidance regarding this policy.