



**HEALTH CARE SERVICES
DIRECTIVE-YOUTH SERVICES
Manual of Policies and Procedures**

Title

Clinical Critical Incident Review

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101	National Correctional Healthcare Standards

I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to ensure all mortalities, sentinel events, and serious suicide attempts are reviewed to determine the appropriateness of clinical care, to ascertain whether change to policies, procedures, or practices are warranted, and to identify processes which may need improvement.

II. DEFINITIONS:

- A. **ADMINISTRATIVE REVIEW:** An assessment of correctional and emergency response actions surrounding a youth's death. The purpose is to identify areas where facility operations, policies, and procedures can be improved.
- B. **CLINICAL CRITICAL INCIDENT (CCI) REVIEW:** An assessment of the clinical care provided and the circumstances leading up to the mortality, sentinel event, or serious suicide attempt. The purpose is to identify areas of patient care or system policies and procedures that can be improved.
- C. **PSYCHOLOGICAL AUTOPSY:** A formal systematic review, conducted after a death presumed to be from a suicide, to examine the mental and emotional state of the youth prior to the suicide, as well as a review of the other factors or circumstances including staff training, adherence to procedures, access to care, etc., to determine why the youth ended their life. A psychological autopsy conducted by a psychologist or other qualified mental health professional.
- D. **SENTINEL EVENT (SE):** Any event in a healthcare setting resulting in death, serious physical, or psychological injury to a youth that is not related to the natural course of an illness.
- E. **SERIOUS SUICIDE ATTEMPT (SSA):** Any injurious action that would have been lethal without rapid and effective emergency treatment or with evidence to show intent to die.

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III. GUIDELINES:

A. General Information

All CCI reviews shall be conducted for every youth's mortality, SE, or SSA to determine the appropriateness of the clinical care provided and the effectiveness of the facility's response at the time of death.

Every youth's CCI shall be reviewed by facility Operations, facility Health Services staff, and Central Office Health Services staff. A CCI review consists of:

1. An administrative review;
2. A clinical review to include a comprehensive narrative by the contracted medical vendor;
3. A psychological autopsy if the death is by suicide.

When a CCI need has been identified, both appropriate facility Health Services and administrative staff shall review the circumstances and quality of care within 96 hours and forward to the Health Services vendor's regional office staff. Reviews shall include at least one physician not involved in the care of the patient. Regional office staff shall have a secondary review completed including any corrective action plans identified no later than 14 days from the date of the event in order to:

1. Assess performance and outcomes;
2. Identify strengths and weaknesses; and,
3. Improve services.

Once this review is completed it shall be forwarded to the appropriate Executive Director or designee for final review and assignment of category. This will be completed within 30 days of the event. If the Executive Director assigns a category 3 or 4, a formal collaborative review process will be scheduled.

B. Contents of the Review

When facility Health Services staff review a CCI, the following items shall be used to facilitate the review:

1. Health Record;
2. Incident Reports and associated staff statements;
3. Pertinent ambulance "run sheets";
4. Pertinent hospital records;
5. Autopsy report (preliminary, if only that is available); and,
6. Pertinent laboratory results including those ordered by pathologist / medical

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examiner, if available.

During the CCI review, the following shall be determined and summarized in a comprehensive narrative:

1. Identifying information;
2. Date of event;
3. Date of report;
4. Name and DOC number of the youth;
5. Names, credentials, and positions of the person(s) complete State Form 46986, "Report of Clinical Critical Incident;"
6. Current/Final diagnosis;
7. Cause of death;
8. Pre-existing medical conditions;
9. Past history, heredity, risk factors;
10. Comments regarding labs, x-rays, and other tests;
11. Prognosis, if indicated;
12. Determination of whether appropriate care was provided;
13. Description of the incident at the time of event;
14. Description of interventions provided at, or about, the time of the event;
15. Determination of whether the death was justified;
16. Clinical judgment regarding any interventions necessary to improve future outcomes or reduce risk(s).

Treating staff shall be informed of the CCI review and administrative findings.

Each CCI shall be assigned to one of the following classes:

1. Exemplary Care (Care above expectations);
2. Appropriate Care;
3. Errors of omission/commission which may have contributed to the adverse outcome; and,
4. Errors of omission/commission that likely contributed to an adverse outcome.

A working document with CCI information including assigned class shall be maintained and be available on a shared drive to appropriate Quality Assurance Managers (QAM), Executive Directors, and the Chief Medical Officer (CMO). These metrics shall be available for review at Continuous Quality Improvement (CQI) meetings.

Corrective actions identified through the CCI review process are implemented and monitored through the facility's Quality Assurance Committee.

The object of the review process is to promote improvements in quality of care. While assignment of blame is not a direct part of the process, on occasion, an individual's

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performance may be identified as having been substandard. In such cases, the CCI review cannot be used to initiate either discipline or performance improvement. The review may be used to initiate another review of the case, outside the mortality review process. This outside review may be used to initiate personnel interventions as necessary without compromising the confidentiality of the mortality review process itself.

C. Confidentiality

Investigations, reviews, and other documents developed as part of a medical Continuous Quality Assurance activity shall be considered confidential and are exempt from disclosure, even in legal discovery processes, in accordance with all appropriate statutes, such as Indiana Codes 11-8-5-2 and 34-4-12.6.

Copies of CCI reviews shall not be filed in the youth's health record. Copies of CCI reviews shall be maintained on file only by the facility and contractor Quality Assurance staff.

IV. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to youth.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date