

# NWF Health Network Policy & Procedure

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**Series:** 800: Quality Assurance and Improvement

**Policy Name:** Incident Reporting and Client Risk Prevention

**Policy Number:** 805

**Origination Date:** 2/2/2009 **Board Meeting of:** 08/28/2025

**References:** CFOP 215-6, Incident Reporting and Analysis System  
65C-46.007, F.A.C., Child Abuse & Neglect and Incident Notification Procedures  
Ch. 794, F.S., Sexual Battery  
NWFHN OP 500-500, Prevention, Reporting and Services to Missing Children  
NWFHN OP 800-808, Death Notification  
NWFHN OP 800-811, Special Quality Assurance Reviews  
NWFHN OP 900-912, Use of Information System Resources  
NWFHN OP 900-921, Risk Management Process-HIPAA  
NWFHN OP 1100-1113, Employee Conduct and Disciplinary Action  
NWFHN OP 1500-1501, Confidentiality of Client Information

## Referenced Documents:

800-805 x 1, Incident Reporting/Client Risk Prevention Detail & Follow-Up Form

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## Policy

It is the policy of NWF Health Network (NWFHN), to identify and report critical incident information in order to ensure client and employee safety and to prevent future risk. It is the responsibility of all NWFHN staff and all partner and contract provider staff to report all incidents, accidents, and safety and risk issues in accordance with this Policy.

**Note:** It is the responsibility of all NWFHN staff, contracted partners and contracted providers to promptly report all incidents in accordance with the requirements of the aforementioned procedures through the appropriate operational lines.

## Procedure

### A. Definitions of Reportable Incidents.

1. Adult Death. An individual 18 years or older whose life terminates while receiving services, during an investigation, or when it is known that an adult died within thirty (30) days of discharge from a treatment facility. (This would apply to Independent Living Young Adults, as well as licensed and non-relative caregivers.) The manner of death is the classification of categories used to determine whether a death is from intentional causes or unintentional causes.
  - a. The final classification of an adult's death is determined by the medical examiner. However, in the interim, the manner of death will be reported as one of the following:
    - i. Accident – A death due to the unintended actions of one's self or another.
    - ii. Homicide – A death due to the deliberate actions of another.
    - iii. Suicide – The intentional and voluntary taking of one's own life.
    - iv. Undetermined – The manner of death has not yet been determined.
    - v. Unknown – The manner of death was not identified or made known.

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If an adult's death involves a suspected overdose from alcohol and/or drugs, or seclusion and/or restraint, additional information about the death will need to be reported in IRAS.

2. Allegation of Abuse/Neglect. An allegation of abuse or neglect of a client in a NWFHN licensed facility, foster home or relative/non-relative placement. Also included in this category:
  - a. Child-on-Child Sexual Abuse. Any sexual behavior between children which occurs without consent, without equality, or as a result of coercion. This applies only to children receiving services from the Department, NWFHN, or by a licensed service provider or contracted provider.
  - b. Sexual Abuse/Sexual Battery. Any unsolicited or non-consensual sexual activity by one client to another client, a NWFHN or service and/or contracted provider's employee or other individual to a client, or a client to an employee regardless of the consent of the client. This may include sexual battery as defined in Chapter 794, F.S., as "oral, anal, or vaginal penetration by, or union with, the sexual organ of another or the anal or vaginal penetration of another by any other object; however, sexual battery does not include an act done for a bona fide medical purpose." This includes any unsolicited or non-consensual sexual battery by one (1) client to another client, a NWFHN or service and/or contracted provider's employee or other individual to a client, or a client to an employee regardless of consent of the client.
3. Child Death. An individual less than 18 years of age whose life terminates while receiving services, during an investigation, or when it is known that a child died within thirty (30) days of discharge from a residential program or treatment facility or when a death review is required pursuant to CFOP 175-17, Child Fatality Review Procedures. The manner of death is the classification of categories used to define whether a death is from intentional causes, unintentional causes, natural causes, or undetermined causes.
  - a. The final classification of a child's death is determined by the medical examiner. However, in the interim, the manner of death will be reported as one of the following:
    - i. Accident – A death due to the unintended actions of one's self or another.
    - ii. Homicide – A death due to the deliberate actions of another.
    - iii. Natural Expected – A death that occurs as a result of, or from complications of, a diagnosed illness for which prognosis is terminal.
    - iv. Natural Unexpected – A sudden death that was not anticipated and is attributed to an underlying disease either known or unknown prior to death.
    - v. Suicide – The intentional and voluntary taking of one's own life.
4. Employee Event. Includes the following:
  - a. Employee Arrest. The arrest of a NWFHN employee or a contracted or licensed service provider for a civil or criminal offense.
  - b. Alleged or Known Employee Misconduct. Work-related conduct or activity of a NWFHN employee or its contracted or licensed service providers that results in potential liability for NWFHN or the Department; death or harm to a client; abuse, neglect or exploitation of a client; or results in a violation of statute, rule, regulation or policy. This includes, but is not limited to, misuse of position or state property; falsification of records; failure to report suspected abuse or neglect; contract mismanagement; or improper commitment expenditure of state funds.

(See NWFHN OP 1100-1113, Employee Conduct and Disciplinary Action for further information.)

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5. Falsification of Records. Intentional alteration of documents; misrepresentation of information during an official proceeding; intentional falsification of client case records, including but not limited to: case notes, client contact reports, visitation records, or client home visits, creating false and fictitious files, and timesheets/mileage.
6. Illness/Injury to Client. A severe bodily trauma received by a child who is in the physical custody or under voluntary or court-ordered supervision of NWFHN that requires medical treatment by a licensed health care professional in an emergency setting to address and prevent permanent damage or loss of life (i.e., hospitalization, emergency room visit for broken bone, etc.) Severe bodily trauma requires immediate notification.
7. Behavioral Health Concern or Event. A behavioral occurrence involving a child who is in the physical custody or under voluntary or court-ordered supervision of NWFHN that includes law enforcement involvement. See NWFHN OP 900-912, Use of Information System Resources if the event includes damage to property.
8. Child Arrest. The arrest of a child in the custody of the Department.
9. Media Attention. Should an employee of NWFHN or its contracted or licensed service providers know there is a potential for any type of media attention (i.e., arrest, death, or event involving an alleged perpetrator, parent, caregiver or child involved in an open or recently closed case), that may or may not accompany any of the reportable incidents as defined in this procedure, the information is to be shared verbally with the Case Management Supervisor and/or Manager of the partnering agency responsible for case supervision. The notification to NWFHN is to be provided immediately or within one (1) hour of learning of suspected media attention.
10. Mental Health Hospitalization. A Baker Act
  - a. Suicide Attempt. A potentially lethal act which reflects an attempt by an individual to cause his or her own death as determined by a licensed mental health professional or other licensed healthcare professional.
11. Missing Child. When the whereabouts of a child who is in the physical custody or under voluntary or court-ordered supervision of NWFHN are unknown and attempts to locate have been unsuccessful and, on whom a missing person report has been filed with local law enforcement or attempts are being made for local law enforcement to accept the report. (See NWFHN OP 500-500, Prevention and Services to Missing Children for additional information.)
  - a. If the missing child is 12 years of age or younger or is a disabled child of any age, the Circuit Administrator must be verbally notified immediately (see *Section B., Procedure for Reporting Critical Incidents*, below, regarding immediate notification).
12. Security Incident. Unintentional. An unintentional action or event that results in compromised data confidentiality, a danger to the physical safety of personnel, property, or technology resources; misuse of NWFHN or state property or technology resources; and/or denial of use of property or technology resources. This excludes instances of compromised client information. (See NWFHN OP 1501, Confidentiality of Client Information regarding instances related to client information.)
13. Significant Illness/Injury to Staff. Any severe bodily trauma received by a staff member as a result of work-related activity that requires immediate medical or surgical evaluation or treatment in a hospital emergency room to prevent permanent damage or loss of life.
14. Vehicular Accident. Any motor vehicle accident or traffic collision that occurs to a NWFHN employee or its contracted or licensed service providers through the course of their work and/or involving a child who is in the physical custody or under voluntary ordered supervision of NWFHN.

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15. Other Incident. An unusual occurrence or circumstance initiated by something other than natural causes or out of the ordinary such as a bomb threat, kidnapping, riot or hostage situation which jeopardizes the health, safety and welfare of clients who are in an open case of NWFHN or employee of NWFHN.

## B. Procedure for Reporting Critical Incidents.

1. In responding to an incident, the discovering employee's first obligation is to ensure the health, safety, and welfare of all individuals involved.
2. When the incident involves suspected abuse, neglect, or exploitation, the employee must call the Florida Abuse Hotline to report the incident. The employee must ensure that the client's guardian, representative or relative is notified, as applicable.
3. Critical Incidents require immediate reporting, regardless of time or date. Reporting requirements and deadlines for notification regarding Critical Incidents are to promptly report within one business day all critical incidents in accordance with the requirements of CFOP 215-6.

Critical Incidents that require immediate (within one (1) hour) reporting include:

- a. Adult Death
  - b. Child Arrest
  - c. Child Death
  - d. Child-on-Child Sexual Abuse
  - e. Elopement
  - f. Employee Arrest
  - g. Employee Misconduct
  - h. Escape
  - i. Missing Child
  - j. Security Incident – Unintentional
  - k. Sexual Abuse/Sexual Battery
  - l. Significant Injury to Client
  - m. Significant Injury to Staff
  - n. Suicide Attempt
  - o. Other major event likely to have a significant impact on clients, the Department, NWFHN, or its providers
4. Special/Initial Reporting Procedure for Critical Incidents.
    - a. Critical Incidents will be orally reported up the chain of command immediately upon notification of the incident.
      - i. Contracted Provider will notify the NWFHN Chief Operations Officer or the appropriate Circuit Administrator immediately upon being informed of the incident.
      - ii. The NWFHN Chief Operations Officer and/or Circuit Administrator will report the incident to the Chief Executive Officer immediately upon learning of the incident.
      - iii. Upon notification of any incident of child death, the Chief Executive Officer or Chief Operations Officer will immediately report the incident to the Department of Children and Families' Northwest Region Designee.
    - b. After verbal notification, Critical Incidents will be reported electronically as delineated in *Section E., Electronic Incident Reporting Procedure*, below.

## C. Procedure for Reporting Incidents Involving Missing Children.

1. In responding to an incident, the discovering employee's first obligation is to ensure the health, safety, and welfare of all individuals involved.

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2. When the incident involves suspected abuse, neglect, or exploitation, the employee must call the Florida Abuse Hotline to report the incident. The employee must ensure that the client's guardian, representative or relative is notified, as applicable.
  3. If the missing child is a participant in an open Court case, the assigned Case Manager will notify Children's Legal Services (CLS) of the child's elopement within one business day of the incident.
  4. Upon location of the missing child, the original Incident Report must be updated and submitted in accordance with reporting requirements and deadlines and updated in FSFN (see *NWFHN OP 500-500, Prevention, Reporting and Services to Missing Children*).
- D. Reporting Procedure for Sub-Contracted Residential/Group Care Providers.
1. In responding to an incident, the discovering employee's first obligation is to ensure the health, safety, and welfare of all individuals involved.
  2. When the incident involves suspected abuse, neglect, or exploitation, the employee must call the Florida Abuse Hotline to report the incident.
  3. Sub-contracted residential group care providers must report incidents as defined in this policy via direct notification of the child's assigned case manager.
    - a. Verbal notification is required. Notification via phone message, voicemail, text message or email is *not* acceptable.
    - b. In the event the assigned case manager is unavailable, the provider will notify the case manager's direct supervisor of the incident.
    - c. In the event that the case manager supervisor is also unavailable, the provider will continue up the chain of command until a supervisor or manager is reached and verbally notified.
  4. Missing/runaway child and critical incidents that occur after normal business hours will be reported to the correct CMO on-call number provided at the time of placement.
    - a. Verbal notification is required. Notification by voicemail, text message or email is *not* acceptable.
    - b. If, for any reason, the provider is unable to reach a staff member via the On-Call CMO worker and supervisor, the provider may contact the on-call Placement Line for assistance.
- E. Electronic Incident Reporting Procedure.
1. Upon becoming aware of a reportable incident, the NWFHN provider or partner agency employee will first notify his/her immediate supervisor to provide an oral report of the incident.
    - a. Notification may be made in person or by telephone.
    - b. In the event the employee's direct supervisor is unavailable, the employee will continue up the chain of command until a supervisor or manager is reached and verbally notified.
  2. The employee will then complete the Incident Report Form (*800-805 x 1, Incident Reporting/Client Risk Prevention Detail & Follow-Up Form*) and submit it to his/her immediate supervisor (or immediate supervisor and person notified within the chain of command).
    - a. Incident report forms are to be completed in their entirety and include as much information as is available at the time.
    - b. Unrelated children involved in the same incident should be listed on a separate incident report (i.e., when two or more unrelated clients are involved in an incident, a separate incident report will be completed and submitted for each child involved).

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- c. A copy of the Incident Report will be maintained in the employees' work unit by the unit supervisor and/or in the provider's electronic Incident Reporting system.
  3. The Supervisor and/or Program Manager must review and approve all Incident Reports prior to submission to NWFHN. This review includes:
    - a. Ensuring completeness and accuracy of the information presented on the form to include a clear description of events and participants.
    - b. Ensuring that the Incident Report is properly password protected
    - c. Ensuring the plan for and coordination of all necessary follow-up and/or corrective action is defined and assigned to appropriate staff
    - d. The Supervisor and/or Program Manager's approval, with signature, is required prior to submission to NWFHN
  4. Upon approval by the Supervisor and/or Program Manager, the Incident Report will be submitted to NWFHN.
    - a. The department requires NWFHN to enter all incidents into IRAS within one (1) business day of the incident occurring. Therefore, NWFHN requires all incident reports be submitted to NWFHN by noon local time on the business day following the occurrence of (or case management's notification of) the incident.
    - b. All Incident Reports are to be submitted via email using their agency's appropriate electronic Incident Report Distribution email address.
  5. NWFHN's Circuit Administrator and applicable Management Team members will review each Incident Report to identify any potential case practice concerns and/or the need for additional follow-up. This review of the incident report will assure that:
    - a. Appropriate actions have been or are being taken to address the situation and protect the client/staff
    - b. Appropriate steps have been taken to maintain control of the situation and to limit further risk and liability
    - c. Appropriate arrangements have been made for any necessary medical care and any resulting follow-up on recommendations made by a medical provider, if applicable
    - d. Law enforcement has been properly notification, if necessary
    - e. NWFHN, provider or partner agency employees, have appropriately complied with this policy and procedure
- F. Responding to Requests for Access to Incident Reports. Incident Reports are public documents and may be requested by outside parties. However, client names and other identifying information that may be included in Incident Reports are protected from public disclosure by Florida Statutes. Therefore, protected client information must be redacted as legally required prior to the release of any Incident Report requested by outside parties. Procedure:
  1. Any request from an outside party for access to or a copy of an Incident Report is to be directed to the NWFHN Chief Operations Officer, who will assure that all legal requirements are met.
  2. The Chief Operations Officer (or designee) will collaborate with the Department of Children and Families' Communications Officer to assure that information that is protected from public disclosure by Florida Statutes is redacted from the report prior to its release.

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3. The redacted report will be provided to the requestor in accordance with Florida's public records laws by NWFHN or the Department, as appropriate.
4. Subsequent requests for corrective action plans, status reports or additional information will be addressed on an individual basis as determined by the situation.

## G. Continuous Quality Improvement Process

1. NWFHN collects and tracks data regarding incident reports. Incident trend reports are shared with NWFHN Leadership for risk-related review and discussion.
2. Special Quality Assurance Reviews are conducted on any incidents that meet the criteria identified in NWFHN OP 800-815, Child Protection Quality Assurance Reviews.

## H. Quarterly Review of Risk-Related Incidents In accordance with CFOP 155-10 and CFOP 215-6.

NWFHN will conduct quarterly reviews of risk-related incidents reported by subcontracted network providers. These reviews are part of the broader responsibilities for risk management, quality improvement, and contract oversight.

1. Review Schedule and Oversight The reviews will be Quarterly, and the responsible party will be NWFHN Operational Leadership and Quality Department. This will involve a formal review meeting with documented agenda, data dashboards, trend analysis, and action item tracking.
2. Categories of Review NWFHN will review and analyze the following categories, as reported by providers through the IRAS (Incident Reporting and Analysis System) or other DCF-approved reporting mechanisms.

### a. Facility Safety

- i. Reports involving fire, environmental hazards, unsafe conditions, or facility-related injuries
- ii. Results of provider internal safety audits or DCF licensing inspections (when shared)

### b. Deaths, Serious Illness, or Injury

- i. All deaths of individuals enrolled in or receiving behavioral health services
- ii. Serious injuries or medical emergencies requiring hospitalization
- iii. Compliance with DCF reporting timelines and follow-up protocols (per CFOP 155-10)

### c. Self-Harm or Suicidal Behavior

- i. Suicide attempts, threats with plan, or significant self-injury
- ii. Programmatic responses, safety planning, and provider training adequacy
- iii. Monitoring of frequency and provider response patterns

### d. High-Risk Interventions or Programs

- i. Incidents occurring in intensive settings (e.g., Crisis Stabilization Units, Detox, MAT, Residential Treatment Centers)
- ii. Medication errors or adverse reactions during psychiatric or substance use treatment
- iii. Review of staff-to-client ratios and clinical supervision practices

## 3. Documentation and Follow-Up

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- a. Following each quarterly review, NWFHN will produce a written Risk Summary Report, which will include:
  - i. Aggregated incident data and trend analyses
  - ii. Identified systemic or provider-level issues
  - iii. Risk mitigation strategies and recommended corrective actions
  - iv. Assignments of responsibility and follow-up timelines
  - v. Summary of any technical assistance provided to providers

#### 4. Integration with Broader Quality Oversight

- a. The results of the quarterly risk review will be integrated into:
  - i. NWFHN Annual Quality Management Plan
  - ii. Performance Improvement Projects (PIPs) and Corrective Action Plans (CAPs) for providers as needed
  - iii. Reporting to DCF regional contract managers when required
  - iv. Input into provider training and capacity-building efforts

#### I. Reporting Requirements for Sunshine Health

NWFHN employees working under Sunshine Contract will report Critical Adverse Incidents or potential quality of care incidents as defined in NWFHN's Compliance Training to [Sun\\_Pqgc@Sunshine.health.com](mailto:Sun_Pqgc@Sunshine.health.com) within 1 business day of notification of incident.