Touchstone Family Association
Strengthening Family • Building Community

Touchstone Family Association:
Critical Incident Report Summary
2022

Critical Incident Report Summary (2022)

Overview

Touchstone Family Association believes that an integrated approach to the analysis of critical incidents is essential to effective risk management. Critical incident reports are an important source of information and subsequent planning regarding health and safety – both for individuals receiving services and Touchstone employees.

This critical incident summary report is prepared annually and sent to the Board of Directors, Joint Health and Safety Committee and the Management team for review. This information is useful to assess the potential safety needs of the Association, to analyze trends, and to identify and implement training or interventions in specific areas of concern.

2022 Data Analysis

For the year 2022, Touchstone Family Association documented 169 significant incidents in its programs with the majority of incidents occurring in the Francis House Youth Wellness program, with 143 significant incidents.

Richmond Programs

The 26 incidents that occurred in the Richmond Programs break down into the following categories:

Abuse Disclosure:	12	incidents
Aggressive Behaviour:	5	incidents
Suicide Ideations:	7	incidents
Injury	2	incident
Threatening Client	0	incidents
Alcohol/Drug	0	incident
Service Delivery Issue	0	incidents
Missing/AWOL	0	incidents

The Richmond Programs provide service to over 400 children, youth and families and we consider this total to be a small amount of reportable incidents for a year, yet it is an expected number, given the nature of our programs and services. The number of incidents reported increased slightly (from 20 reports in 2021 to 26 this year). Twelve of the incidents were disclosures of abuse (physical, emotional and/or sexual in nature). There were five incidents of aggressive behaviour which occurred in the family home or Richmond office. All Association staff are trained in Non-Violent Crisis Intervention and are thus adequately prepared to properly debrief with their clients and help them identify triggers. These incidents were reported to the Ministry for Children and Family Development (MCFD) and/or legal

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guardian where necessary. There were seven incidents of suicide ideations this year and two reported minor injuries.

These incidents were followed up by the clients' counsellors, when needed. All incidents were handled in a timely and appropriate manner ensuring that the clients were kept safe.

Causes and Trends (Richmond Programs)

There were no incidents caused by a lack of staff training or failure to follow agency policies and procedures. Additionally, there were no identified environmental factors that may have caused an incident at the Richmond office.

The noticeable trend at the Richmond site continues to be that the majority of reported incidents were pertaining to incidents of disclosures of abuse. This is expected, given the programs and services that Touchstone offers to the community.

Francis House

In reviewing the incidents for 2022, it was noted that the reported number of incidents increased, compared to that of 2021.

The incidents that occurred at Francis House break down into the following categories, with the number of incidents following:

Aggressive or Assaultive Behaviour (including verbal) -	14
Suicide Ideations/Self-harm –	43
Property Damage -	4
Alcohol or Drug Use -	16
AWOL (including late curfew) –	56
Allegations (towards staff or youth) -	3
Unusual Behaviour (erratic behaviour, car accident) –	1
Fire Setting -	0
Injury -	2
Theft -	2
Medication Error -	0
Disclosures -	2

This report noted an increase in the overall number of incidents reported. There were 143 incidents documented at Francis House, an increase from 124 in 2021. The most substantial increase was in the Suicide Ideations/Self-harm category; increasing from 9 in 2021 to 43 in 2022. This dramatic increase is

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because our referral base was mostly comprised with youth that had severe mental health issues. These youth had major anxiety and struggled with emotional regulation and in keeping themselves safe. The reported AWOL related incidents had also increased, due to a number of youth that struggled to engage with the program. Comprehensive safety plans are developed by the youths' treatment teams in an effort to keep these extremely vulnerable youth safe.

There were no Medication Errors in 2022, in regards to staff delivery. That is a decrease from two reported incidents in 2021. Full time staff are now required to take an online Medication Administration course to further enhance his learning in this area. Additionally, the Francis House Wellness program utilizes Pharmasave as its exclusive pharmacy in an effort to manage the youths' medication needs efficiently and effectively. Staff are free to consult with the staff at Pharmasave regarding any medication questions.

Use of Restraint

For the year 2022, there were no restraints used in the residential program (similar to the previous five years). Staff have been able to build relationships, recognize triggers earlier or respond in an appropriate, calm manner to diffuse a potentially volatile situation.

In an effort to minimize or eliminate the number of restraints in the program, Touchstone continues to annually train its staff in Non-Violent Crisis Intervention training. This allows staff to be fully trained or refreshed in proper de-escalation techniques, awareness of personal triggers for youth and staff and to learn or practice the proper technique for restraints. This training has been maintained on a consistent basis (annually) and is reviewed at staff meetings.

Our goal is to minimize and/or eliminate restraints but understand that it may be necessary as a last resort (which is also the mandate taught in Non-violent Crisis Intervention training). This goal will be reviewed annually alongside our review of pertinent training for Touchstone programs.

In terms of factors impeding the elimination of restraints, there are no program or staff factors contributing to this at this time. However, the program receives referrals for youth that are extremely volatile, mentally ill and aggressive; this in itself is a factor that impedes the complete elimination of restraints for the program. The safety of the youth is paramount, thus absolute elimination of restraints may not be plausible, as staff would intervene as a last resort to keep a youth (or others) safe.

It is important to note that the Richmond site and all its related programming has a "no restraint" policy.

In terms of seclusion, the Richmond site and the Francis House residential program do not utilize seclusion as a behaviour management strategy.

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As the clients' needs are complex, additional support is required. Integrated Case Management is an integral part of the client's welfare and helps provide the necessary comprehensive care of these clients. Francis House continues to work in collaboration with other professionals when dealing with some of these incidents. MCFD After Hours, Police, Ambulance, Licensing (VCH) and Child and Youth Mental Health have all provided invaluable assistance to the staff of Francis House. These additional resources continue to be an asset to the youths' overall well being.

Causes and Trends (Francis House)

In summary, the staff of Francis House have resolved these significant incidents in an appropriate and professional manner. The management and staff teams, as well as the Joint Health and Safety Committee, consistently review these incidents in search of improvements, alternative interventions, trends or patterns. Francis House continues to strive to be a safe and therapeutic environment for the youth at all times.

In terms of environmental factors, some incidents occurred due to the mix of youth within the program. All youth are thoroughly screened by the Program Director and the Ministry of Children and Family Development Resource liaison worker in an effort to determine the best "fit" of each youth into the program. At times, the mix of youth can upset the dynamics within the home, creating duress amongst some youth, leading to incidents. Efforts are put in place to mitigate these stressors (extra staffing, extra counselling, etc.) until the youth have re-stabilized. This year, 2022, had a particularly challenging mix of youth. The therapeutic milieu was often upset, leading to acting out behaviours.

The only noted trend over this last year is that the AWOL category remains high, while the Suicide Ideation/Self-harm category continues to increase due to the number of youth admitted to the program with mental illnesses. The Covid-19 global pandemic contributed to the overall stress and anxiety levels of the youth, subsequently increasing the number of incident reports.

One factor that may have led to an increase in incidents is the fact that the Francis House program had a challenging year in terms of staff retention. Youth form significant attachment to the workers and are often dysregulated for a period of time when staff move on.

Training Needs

Touchstone Family Association is an accredited Association and Francis House is a licensed facility (Vancouver Coastal Health Authority). These governing bodies ensure that Touchstone delivers a high level of service at all times. All Association staff are trained in Non-Violent Crisis Intervention and First Aid.

Accreditation standards ensure that there is competency-based training provided to the Francis House staff on an annual basis. This includes, but is not limited to: trauma, attachment, learning disabilities,

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growth and development and the effects of placement on children. The Francis House staff are trained annually on proper Medication Management and have a Clinical Counsellor that provides family and individual counseling to the youth and their families.

The most significant training for the Francis House team in 2022 was the Non-Violent Crisis Intervention training provided by the association. With this training, staff reviewed incident reports from the program (as we do in staff meetings) and discuss the outcomes and possible alternate interventions. Staff are also trained to recognize triggers for the youth and subsequent strategies to engage these youth.

At this time, we have also modified and improved our training on Medication Management, as it is paramount that medication errors are eliminated. New staff are now required to take a college level Medication Administration course in addition to the onsite training. The Francis House Program Director will register new staff into this training.

This report, in combination with the annual Performance Outcome Evaluation Reports, identifies the training needs of the staff. By regularly reviewing incidents on a multi-level capacity and by providing relevant training to staff, we aim to decrease the number of recurring incidents. Regular staff meetings and supervision also contribute to the prevention of significant incidents and the recurrences thereof.

Reporting Requirements

Internal: All incident reports are completed by the staff involved in the incident on the same day of the incident. The report is then sent to the Program Director for review. Once the Program Director reviews the report from the program, the incident report is then sent to the management team for further review.
After thorough review by the management team, the Director of Services will sign-off (approve) the incident report. All incident reports are subsequently reviewed by the Joint Health and Safety Committee and the staff team (at staff meetings). Reports are reviewed and discussed to examine causes, trends or other possible strategies for the particular incident.

External: All incident reports are sent to the MCFD social worker of the client/youth and to the MCFD Resource worker when applicable. Additionally, the residential program is a licensed facility and is required to report to the Vancouver Coastal Health Authority. Reports may go to collateral professionals as appropriate (probation officers, mental health workers, etc.).

Conclusion

In conclusion, upon review of the incidents at Touchstone Family Association for the year 2022, it is noted that each incident was handled professionally and in a timely manner. The appropriate authorities were contacted as needed and any necessary follow-up was performed. The reports were reviewed at

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multiple levels, allowing for direct and consistent communication pertaining to incidents, throughout the Association.

The staff at Touchstone work with an extremely vulnerable and/or high risk clientele and encounter crisis almost daily. Their commitment to their client's safety and well being is commendable. We greatly appreciate the skilled, consistent and intensive care that the staff provide to all persons served.

Respectfully submitted,

Chris Samulak
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