P U L S E F O R G O O D

Behavioral Health

Client Safety Feedback Toolkit

Capture Early Warning Signals Related to Safety, Dignity, and Care Quality

A specialized toolkit for behavioral health organizations using anonymous feedback to detect safety risks, protect client dignity, and improve care quality. Contains 10 ready-to-use documents covering trauma-informed survey design, clinical escalation protocols, documentation aligned with clinical records, anonymous vs. identified guidance, trend monitoring, and continuous quality improvement integration — built for the unique ethical and clinical context of behavioral health services.

10 Behavioral Health Safety Documents

Survey Templates • Escalation Protocols • Clinical Integration • CQI Alignment

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Toolkit Contents

This toolkit addresses the unique requirements of behavioral health settings where clients may be in crisis, in treatment for trauma, managing psychiatric symptoms, or navigating substance use recovery. Every document is designed with trauma-informed principles, clinical integration, and regulatory alignment in mind.

DOCUMENT 1

Client-Facing Safety Question Templates

Non-alarming, trauma-informed survey questions designed for behavioral health settings

📋 **INSTRUCTIONS:** *These questions are designed to surface safety concerns without re-traumatizing clients, triggering defensive responses, or creating alarm. Behavioral health clients are often in vulnerable states — the language of safety questions must be inviting, not clinical or interrogative. Choose from these templates based on your setting and population. Every question has been reviewed for trauma-informed language, reading level (≤5th grade), and kiosk usability.*

Design Principles for BH Safety Questions

Trauma-Informed Survey Design

1. NORMALIZE: Frame questions so that all answers feel acceptable. “Do you feel safe?” can feel like a test. “How comfortable do you feel here?” invites honesty.
2. EMPOWER: Give clients control. Always include “Prefer not to answer.” Never force a response.
3. AVOID CLINICAL JARGON: Clients should not need to know clinical terminology to describe their experience.
4. SEPARATE DOMAINS: Don’t combine physical safety and emotional safety in one question. They are different experiences.
5. END WITH OPENNESS: The last question should always be open-ended, giving the client space to share anything that didn’t fit elsewhere.

Template A: Core Safety Questions (Recommended for All BH Settings)

#	QUESTION	RESPONSE TYPE	SAFETY DOMAIN
S1	How comfortable do you feel at this program?	😣 😟 😐 🙂 😄 (5-point emoji)	Overall sense of safety
S2	Do the staff here treat you with respect?	👎 👍 (Thumbs)	Dignity & respect
S3	Have you felt afraid or unsafe at any time while receiving services here?	👎 No 👍 Yes ⭕ Prefer not to answer	Physical/emotional safety
S4	Do you feel you can speak up if something bothers you without getting in trouble?	👎 👍 (Thumbs)	Psychological safety / voice

S5	Have your belongings and personal space been respected?	👎 👍 (Thumbs)	Privacy & property
S6	Is there anything you want us to know about your safety or comfort here?	Open text (optional)	Catch-all / unstructured

Template B: Expanded Questions for Residential / Inpatient Settings

Add these to Template A for residential behavioral health, inpatient psychiatric, or crisis stabilization programs:

#	QUESTION	RESPONSE TYPE	SAFETY DOMAIN
R1	Do you feel safe in your sleeping area?	👎 👍 ⭕ Prefer not to answer	Physical safety — residential
R2	Have you experienced any unwanted physical contact from anyone here (staff or other clients)?	👎 No 👍 Yes ⭕ Prefer not to answer	Physical boundary violation
R3	Do you feel your medications are being managed safely and explained to you?	👎 👍 ⭕ Not applicable	Medication safety
R4	Are you able to reach a staff member when you need help?	👎 👍 (Thumbs)	Access to care
R5	Do you feel like your treatment plan reflects what YOU want to work on?	👎 👍 ⭕ Not sure	Person-centered care

Template C: Supplemental Questions for Substance Use Treatment

#	QUESTION	RESPONSE TYPE	SAFETY DOMAIN
SU1	Do you feel supported in your recovery here?	☹️ 😟 😐 🙂 😄 (5-point)	Recovery environment
SU2	Have you been exposed to substances or substance use while receiving services here?	👎 No 👍 Yes ⭕ Prefer not to answer	Environmental safety
SU3	Do you feel pressured by anyone here to do things you're not comfortable with?	👎 No 👍 Yes ⭕ Prefer not to answer	Coercion / exploitation

Question Design Guardrails

☐	Every safety question includes a “Prefer not to answer” option
☐	Question S3 (afraid/unsafe) is positioned AFTER rapport-building questions (S1, S2), not first
☐	No question uses clinical terminology (e.g., “ideation,” “acuity,” “contraindication”)
☐	Questions about physical contact (R2) use behavioral language, not legal terms
☐	Open-ended question (S6) appears last, giving the client final agency
☐	All questions have been tested at ≤5th-grade reading level
☐	Questions about medication (R3) include “not applicable” for outpatient clients
☐	Survey includes a closing screen: “Thank you. If you are in immediate danger, please tell any staff member right away.”

DOCUMENT 2

Red-Flag Response Threshold Definitions

Clinical criteria for triaging safety-related feedback in behavioral health settings

📋 **INSTRUCTIONS:** *This document extends the general Crisis Toolkit classification system with behavioral-health-specific criteria. In BH settings, red flags include clinical safety indicators (self-harm, medication errors, coercion) alongside the general safety indicators (abuse, physical danger). Every person who reviews feedback data must be trained on these thresholds.*

Level 1: Immediate Clinical Response (Minutes)

⚠ Activate Immediately — Do Not Wait for Supervisor Consultation

INDICATORS IN FEEDBACK:

- Explicit statement of suicidal intent or plan (“I want to die,” “I’m going to end it tonight”)
- Disclosure of active self-harm (“I’ve been cutting every night”)
- Report of sexual assault or sexual contact by staff or another client
- Report of ongoing physical abuse at the facility
- Disclosure of medication that was not administered, was administered incorrectly, or caused a serious reaction
- Description of restraint or seclusion that the client experienced as unsafe or punitive
- Explicit threat of violence toward self or others

RESPONSE: Activate on-call clinician or clinical supervisor immediately. If imminent danger: call 911. Follow escalation pathway (Document 3). Initiate safety planning if self-harm/suicidal content.

Level 2: Urgent Clinical Review (Same Day)

🚨 Notify Clinical Supervisor Within 2 Hours

INDICATORS IN FEEDBACK:

- Passive suicidal ideation without explicit plan (“Sometimes I wonder if anyone would care”)
- Reports of feeling coerced into treatment activities or medication decisions
- Allegations of verbal abuse, intimidation, or threats by staff

- Reports of substance use or substance access on-site
- Client describes feeling “trapped,” “punished,” or “controlled” in the program
- Reports of unwanted physical contact (non-sexual) from staff or other clients
- Feedback indicating a client does not understand their treatment plan or rights
- Descriptions of discrimination or harassment based on identity

RESPONSE: Notify clinical supervisor within 2 hours. Assess for mandatory reporting. Determine whether clinical follow-up, environment modification, or investigation is needed.

Level 3: Elevated Monitoring (24–48 Hours)

Flag for Next Clinical Review

INDICATORS IN FEEDBACK:

- General discomfort without specific safety threat (“I don’t feel totally comfortable here”)
- Reports of sleep disruption, noise, or environmental stressors affecting wellbeing
- Feeling unheard by treatment team (“No one listens to what I want”)
- Complaints about peer conflict that don’t rise to the level of harassment or threat
- Dissatisfaction with medication management that does not indicate an error
- Feeling that rules are unfair or inconsistently applied

RESPONSE: Add to next scheduled clinical team review or data review meeting. Consider whether pattern is emerging. Document in standard feedback log.

BH-Specific Classification Aid

FEEDBACK CONTENT	CLASSIFY AS	CLINICAL RATIONALE
“I want to die” or “I’m thinking about ending my life”	Level 1	Any expression of suicidal intent in a BH population requires immediate risk assessment
“Staff touched me and I didn’t want them to”	Level 1	Potential boundary violation requiring immediate investigation
“They make me take medication I don’t want”	Level 2	Potential coercion; requires same-day clinical review of consent documentation
“I don’t feel like anyone here cares”	Level 2–3	Could indicate therapeutic rupture, isolation, or passive suicidality. Context matters.
“Another client	Level 2	Interpersonal violence risk; requires immediate

threatened me”		milieu assessment
“The food is bad and the beds are uncomfortable”	Not a red flag	Route through standard feedback prioritization
“I feel worse since starting this program”	Level 2–3	Clinical deterioration signal. Review treatment plan and engagement.

DOCUMENT 3

Immediate Escalation Decision Tree

Step-by-step clinical escalation for safety-related feedback in behavioral health

📋 **INSTRUCTIONS:** *This decision tree is specific to behavioral health settings and integrates clinical escalation steps that general organizations do not have. Print this and post it at every data review workstation. The tree accounts for the fact that BH clients may be identifiable from context even in anonymous systems, and that BH organizations often have on-site clinical staff available for immediate response.*

The BH Safety Escalation Tree

STEP 1: A safety-related response has been identified. Is anyone in IMMEDIATE physical danger right now?

→ **YES:** Call 911 or on-site security. Activate on-call clinician. Then continue to Step 2.

→ **NO or UNKNOWN:** Continue to Step 2.

STEP 2: Classify using the BH Red-Flag Thresholds (Document 2). What level?

→ **LEVEL 1 (Immediate Clinical Response):** Notify on-call clinician or clinical supervisor NOW. Go to Step 3.

→ **LEVEL 2 (Urgent Clinical Review):** Notify clinical supervisor within 2 hours. Go to Step 3.

→ **LEVEL 3 (Elevated Monitoring):** Flag for next clinical team review. Go to Step 5.

STEP 3: Can the client be identified from the feedback content or context?

→ **YES (client named themselves, described a specific identifiable event, or can be inferred):** Clinical team conducts a welfare check and individualized risk assessment. Do NOT contact the client through the feedback system — use standard clinical channels.

→ **NO (client is truly anonymous):** Activate environmental response: increase milieu monitoring, post crisis resources, brief clinical staff on the identified theme. Go to Step 4.

STEP 4: Does this response trigger a mandatory reporting obligation or regulatory notification?

→ **YES (abuse, neglect, assault, medication error, restraint/seclusion concern):** File mandatory report per state requirements. Notify compliance officer. Complete incident report in addition to feedback documentation. Go to Step 5.

→ **NO:** Document per Document 5. Go to Step 5.

→ **UNSURE:** Consult clinical supervisor and compliance officer same day. When in doubt, report.

STEP 5: Activate follow-up protocols.

→ Complete Documentation Checklist (Document 5) within 24 hours.

→ Notify leadership per Leadership Notification Template (Document 8).

→ Initiate Post-Escalation Follow-Up Workflow (Document 7) within 48 hours.

→ Add to Trend Monitoring Worksheet (Document 9) for ongoing tracking.

BH Quick Reference: Who To Call

ROLE	NAME	PHONE	HOURS	BACKUP
On-call clinician				
Clinical supervisor				
Medical director (medication concerns)				
Compliance / risk management				
Client rights officer (if applicable)				
State reporting hotline				N/A
Executive director				

DOCUMENT 4

Staff Scripts for Safety-Related Feedback

What clinical and non-clinical staff should say when a client raises a safety concern in person

📋 **INSTRUCTIONS:** *In behavioral health settings, clients may disclose safety concerns directly to non-clinical staff (front desk, peer support, residential aides) who are not trained therapists. These scripts equip all staff to respond with compassion, appropriate boundaries, and proper routing — without attempting to provide clinical intervention.*

For Non-Clinical Staff (Front Desk, Aides, Peer Support, Maintenance)

SITUATION: A client says they don't feel safe

RESPONSE: "Thank you for telling me. Your safety matters to everyone here. I want to make sure the right person hears this."

"Can I connect you with [clinical staff name / on-duty counselor / supervisor] right now? They're the best person to help with this."

IF CLIENT DECLINES: "I understand. Just so you know, you can bring this up anytime — with me, with any counselor, or anonymously on the feedback kiosk. You're not in trouble for saying this."

AFTER: Notify your supervisor or the on-duty clinician immediately, even if the client declined further help. Document that the conversation occurred.

SITUATION: A client discloses self-harm or suicidal thoughts

RESPONSE: "Thank you for telling me. I'm really glad you said something. I'm not a counselor, but I'm going to get someone who can help right now."

DO: Stay calm. Stay with the client if safe to do so. Immediately contact on-duty clinician or call the clinical supervisor.

DO NOT: Attempt to assess the client's risk level. Promise confidentiality. Leave the client alone without arranging coverage. Minimize ("I'm sure you'll be fine").

AFTER: The clinician takes over from here. Your role was critical — you created a bridge to care.

For Clinical Staff (Counselors, Therapists, Case Managers)

SITUATION: You discover a safety concern in feedback data rather than in session

RESPONSE TO THE DATA: Document the feedback response. Classify per Document 2. Follow escalation (Document 3).

IF THE CLIENT IS IDENTIFIABLE: Conduct a clinical risk assessment during the next scheduled contact — or sooner if the concern is Level 1. Frame it therapeutically:

"I wanted to check in with you about how you've been feeling. Sometimes people have experiences or feelings they find hard to bring up in session. I want to make sure I'm asking the right questions."

DO NOT: Say "I read your feedback." This compromises the anonymity of the system and may deter future honest feedback. Instead, use clinical judgment to open the conversation organically.

SITUATION: A client alleges staff misconduct affecting their safety

CLINICAL RESPONSE: "Thank you for telling me. What you're describing is something I take very seriously. I'm going to make sure this is reviewed by the appropriate person."

"I want you to know that reporting this does not affect your treatment or standing in the program. You have a right to feel safe here."

AFTER: Notify clinical supervisor and compliance officer immediately. Do NOT investigate or interview the accused staff member. Ensure the reporting client has continued access to treatment from a different staff member if the accused is their assigned provider.

Universal Rule for All Staff

⚠ Never Say These in a BH Safety Context

✘ "Are you sure that's what happened?" (questioning credibility)
✘ "That's just part of treatment." (normalizing potential harm)
✘ "You need to bring this up in your session." (deflecting responsibility)
✘ "I can't do anything about that." (abandoning the concern)
✘ "You'll feel better once your medication kicks in." (dismissing via pathology)

✘ “Don’t worry about it.” (minimizing)

DOCUMENT 5

Documentation Checklist Aligned with Clinical Records

Bridging anonymous feedback documentation with clinical record-keeping standards

📋 **INSTRUCTIONS:** *Behavioral health organizations maintain clinical records subject to regulatory requirements (HIPAA, state BH regulations, accreditation standards). This checklist ensures that safety-related feedback incidents are documented in a way that integrates with — but does not compromise — both the feedback system's anonymity and the clinical record's integrity.*

Dual Documentation Principle

Two Records, Two Purposes

1. FEEDBACK INCIDENT LOG: Documents what was found in the anonymous feedback system, what actions were taken, and the outcome. This is an operational record. It does NOT identify the respondent (unless the respondent self-identified).

2. CLINICAL RECORD (if client is identified): Documents the clinical assessment, intervention, and follow-up. This follows standard clinical documentation practices (progress notes, safety plans, incident reports). It references that the concern was surfaced through the feedback system but does NOT include the full text of the anonymous response.

These two records are maintained separately. They intersect only when a specific client is identified AND clinical intervention occurs.

Feedback Incident Log Checklist

☐	Incident ID assigned (format: BH-YYYY-MM-DD-###)
☐	Date and time the red-flag response was identified
☐	Identified by (name and role of the person who found it)
☐	Classification level (Level 1 / 2 / 3 per Document 2)
☐	Verbatim content of the flagged response (for internal record only — never shared externally without redaction)
☐	Safety domain affected (physical safety, emotional safety, medication, coercion, boundary violation, etc.)
☐	Was the respondent identifiable? (Yes / No / Partially — with basis for determination)

☐	Immediate actions taken (with timestamps)
☐	Escalation pathway followed? (Yes / No — if no, document why)
☐	Persons notified (names, roles, times, methods)
☐	Mandatory reporting triggered? (Yes / No / Under review)
☐	If yes: report filed with [agency], date, reference number
☐	Clinical intervention initiated? (Yes / No / Not applicable)
☐	Resolution status (Open / In Progress / Resolved)
☐	Follow-up actions scheduled (per Document 7)
☐	Completed by (name, role, date) and reviewed by (supervisor, date)

Clinical Record Documentation (If Client Is Identified)

☐	Progress note documents that a safety concern was identified through participant feedback monitoring
☐	Progress note does NOT include the verbatim text of the anonymous response
☐	Clinical risk assessment was completed and documented per standard protocol
☐	Safety plan was updated if suicidal ideation or self-harm was identified
☐	Treatment plan was reviewed and modified if the concern affects care goals
☐	Incident report was filed if required by regulatory or accreditation standards
☐	Client was informed of any mandatory reporting per informed consent procedures
☐	If staff misconduct is alleged: separate HR investigation file was opened (not in the clinical record)
☐	All documentation complies with HIPAA minimum necessary standard

Regulatory Cross-Reference

REGULATORY BODY	RELEVANT REQUIREMENT	YOUR COMPLIANCE STATUS
HIPAA	Minimum necessary standard for clinical documentation. Feedback text is operational, not clinical.	
42 CFR Part 2 (SUD records)	Substance use treatment records have heightened privacy protections. Feedback referencing SUD must comply.	
Joint Commission / CARF	Critical incident reporting requirements may apply to Level 1 findings.	
State BH licensing	State-specific requirements for incident reporting, restraint/seclusion documentation,	

	client rights.	
Mandatory reporting (state)	Timelines and agencies for reporting abuse, neglect, and harm.	

DOCUMENT 6

Anonymous vs. Identified Safety Feedback Guidance

When anonymity serves safety and when identification is clinically necessary

📋 **INSTRUCTIONS:** *Anonymous feedback systems are designed to elicit honest responses that identified systems cannot. In behavioral health, this tension is amplified: clients in treatment may fear that honest feedback will affect their care, discharge status, or legal standing. This guidance helps organizations navigate the boundary between protecting anonymity and protecting clients.*

The Core Tension

Anonymity Enables Honesty. Identification Enables Intervention.

Your feedback system's power comes from anonymity — clients share safety concerns they would never raise in a therapy session. But anonymity means you may know that someone is in danger without knowing WHO is in danger.

This is not a design flaw. It is a feature. The system is designed to surface patterns and environmental issues, not to replace clinical assessment. Individual safety assessment is the job of clinical staff through clinical channels.

Decision Framework

SCENARIO	ANONYMITY STATUS	RECOMMENDED ACTION
Feedback indicates a general environmental concern (e.g., "I don't feel safe in the hallway at night")	Maintain anonymity	Address environmentally: improve lighting, staffing, monitoring. No need to identify respondent.
Feedback indicates active suicidal intent AND the respondent is identifiable from context	Anonymity partially breached by respondent's own disclosure	Conduct clinical risk assessment through standard clinical channels. Do NOT say "we read your feedback."
Feedback indicates active suicidal	Anonymity maintained	Environmental response: increase milieu monitoring, post crisis resources (988 number), brief all clinical

intent but respondent is truly anonymous		staff to conduct check-ins with all clients.
Feedback alleges staff-on-client abuse	Maintain respondent anonymity. Investigate the allegation.	Investigate the ACCUSED, not the reporter. Protect the reporter's anonymity throughout.
Feedback indicates a medication error	If identifiable: clinical follow-up. If not: investigate systemically.	If the error is identifiable to a specific client, treat as a clinical safety event. If not, review medication administration processes.
Feedback describes substance use on-site	Maintain anonymity	Environmental response: review security protocols, searches (if permitted), staff observation. Do NOT try to identify the respondent.
Client approaches staff after using the kiosk and says "I just wrote something I want to talk about"	Client has voluntarily self-identified	This is now a clinical conversation. Respond per standard clinical practice. Document in clinical record.

What Never to Do

⚠ Anonymity Violations That Will Destroy Trust

✘ Never cross-reference feedback timestamps with entry/exit logs to identify respondents

✘ Never review security camera footage to identify who used the kiosk

✘ Never ask clients in session "Did you write [X] on the kiosk?"

✘ Never tell a client "We saw your feedback" even if you are confident you know who wrote it

✘ Never discuss specific feedback content in group settings or community meetings

✘ Never share raw feedback text with non-clinical staff who don't have Tier 1 data access

If clients believe their anonymous feedback can be traced back to them, the system is dead. In BH settings, the stakes are even higher: clients may believe honest feedback will lead to involuntary hold extensions, medication changes, or loss of privileges.

DOCUMENT 7

Post-Escalation Follow-Up Workflow

Structured follow-up after a safety concern has been escalated and initially addressed

📋 **INSTRUCTIONS:** *Escalation is not resolution. After the initial crisis response, this workflow ensures that the underlying concern is fully addressed, the client is safe, the environment has been assessed, and the incident informs ongoing improvement. Every Level 1 and Level 2 escalation triggers this workflow.*

Follow-Up Timeline

TIMEFRAME	ACTION	RESPONSIBLE	STATUS
Within 24 hours	Confirm initial escalation actions are complete. Client safety verified (if identifiable).	Clinical Supervisor	
Within 24 hours	Feedback Incident Log (Document 5) completed and reviewed by supervisor.	Data reviewer + supervisor	
Within 48 hours	Environmental assessment: has anything changed in the milieu since the concern was raised?	Program Manager / Milieu Lead	
Within 48 hours	If client was identified: clinical follow-up documented in clinical record.	Treating Clinician	
Within 72 hours	If mandatory report was filed: confirm receipt by receiving agency. Document reference number.	Compliance Officer	
Within 1 week	Post-incident review conducted with involved staff. Focus: what worked, what to change.	Clinical Supervisor	
Within 1 week	Leadership notification sent (Document 8) if not already.	Feedback System Owner	
Within 2 weeks	Check: is the concern resolved? Has the environment changed? Any recurrence in feedback?	Data Analyst + Clinical Supervisor	
Next quarterly review	Add to Trend Monitoring Worksheet (Document 9). Review for patterns.	Data Analyst	

Follow-Up Documentation

FIELD	YOUR CONTENT
Incident ID	[From Document 5]
Original classification level	Level 1 / 2
Initial response summary	[Brief: what was done immediately]
Client safety status (if identifiable)	Safe / Monitoring / Ongoing concern
Environmental changes made	[What changed in the physical or programmatic environment]
Clinical follow-up completed?	Y / N / N/A (anonymous respondent)
Mandatory report status	Filed / Received / Under investigation / N/A
Staff debriefed?	Y / N
Recurrence detected in subsequent feedback?	Y / N / Monitoring
Resolution status	Resolved / In progress / Requires ongoing attention
Follow-up completed by	[Name, role, date]

DOCUMENT 8

Leadership Notification Template

Informing clinical and executive leadership of safety-related feedback findings

📋 **INSTRUCTIONS:** *Leadership must be informed of safety findings — but informed appropriately. Clinical directors need clinical context. Executive directors need operational and risk context. Board members need high-level assurance that systems are working. This template provides structured notification formats for each audience.*

Notification: Clinical Director / Medical Director

FIELD	CONTENT
Subject	Client Safety Feedback Alert — [Level 1/2] — [Date]
Classification	Level 1 (Immediate) / Level 2 (Urgent)
Safety domain	[Physical / Emotional / Medication / Coercion / Boundary / Self-harm]
Summary	[2–3 sentence factual summary of the concern. No respondent identification unless respondent self-identified.]
Client identifiable?	Yes / No / Partially
Clinical actions taken	[Risk assessment completed, safety plan updated, welfare check conducted, etc.]
Mandatory reporting	Filed / Not triggered / Under review
Environmental changes	[Milieu modifications, staffing changes, monitoring increases]
Follow-up needed from you	[Specific ask: treatment plan review, staff consultation, policy review, etc.]
Reported by	[Name, role, date/time]

Notification: Executive Director / CEO

FIELD	CONTENT
Subject	Safety Feedback Incident Report — [Level] — [Date]
Classification	Level 1 / Level 2
Summary	[1–2 sentences. Focus on what happened and what was done. No clinical detail beyond what leadership needs.]
Regulatory exposure	[Has a mandatory report been filed? Any licensing / accreditation implications?]

Organizational risk	[Reputational, legal, or regulatory risk assessment. Low / Medium / High.]
Actions completed	[List key actions already taken]
Pending decisions	[Any decisions requiring executive authority: staffing, funder notification, media preparation]
Communication status	[Freeze in place? Released? Staff informed?]

Quarterly Safety Summary for Leadership

In addition to incident-specific notifications, provide a quarterly summary:

METRIC	THIS QUARTER	LAST QUARTER	TREND
Total safety-related responses (S3, R2, SU2, SU3 “Yes” + open-ended flags)			
Level 1 escalations			
Level 2 escalations			
Level 3 flags monitored			
Mandatory reports filed			
Average time from identification to escalation			
Safety-related feedback as % of total responses			
Repeat safety themes (from Document 9)			
Environmental changes made from safety feedback			
Client safety scores trend (S1, S3 averages)			

DOCUMENT 9

Trend Monitoring Worksheet for Repeat Safety Concerns

Detecting patterns that individual incident reviews miss

📋 **INSTRUCTIONS:** *Single incidents are handled through escalation. Patterns require systemic intervention. This worksheet tracks safety-related feedback themes over time to identify repeat concerns that may not meet the threshold for individual escalation but collectively signal a serious problem. Review this worksheet at every quarterly prioritization meeting.*

Active Safety Theme Tracker

THEME ID	SAFETY THEME	FIRST DETECTED	TOTAL MENTIONS	Q1	Q2	Q3	Q4	TREND
ST-001								↑ / → / ↓
ST-002								↑ / → / ↓
ST-003								↑ / → / ↓
ST-004								↑ / → / ↓
ST-005								↑ / → / ↓
ST-006								↑ / → / ↓

Escalation Thresholds for Patterns

PATTERN	THRESHOLD	REQUIRED ACTION
Same safety theme appears 3+ times in a single quarter	Automatic escalation to clinical supervisor	Root cause investigation. Environment assessment. Staff training review.
Same safety theme appears 2+ consecutive quarters	Automatic escalation to clinical director	Systemic intervention required. Add to CQI agenda (Document 10).
Safety-related	Leadership alert	Full programmatic review of safety culture.

feedback as % of total exceeds 15%		Consider external consultation.
2+ different safety themes trending upward simultaneously	Leadership alert	Indicates possible systemic safety culture deterioration. Comprehensive audit.
Any safety theme involving the same specific allegation type recurring	Immediate compliance review	Pattern may indicate a specific staff member, location, or process failure.

Quarterly Trend Analysis

QUESTION	YOUR ASSESSMENT
Are any safety themes increasing in frequency?	
Are any safety themes decreasing (positive trend)?	
Have any new safety themes appeared this quarter that were not present before?	
Are safety concerns concentrated in a specific site, shift, or program?	
Do any safety themes correlate with specific staff scheduling patterns?	
Has any previous intervention successfully reduced a safety theme?	
Are equity dimensions present? (Do safety concerns come disproportionately from any subgroup?)	

Resolved Themes Archive

THEME ID	SAFETY THEME	PEAK FREQUENCY	INTERVENTION	RESOLUTION DATE	HOW CONFIRMED
					Feedback data showed sustained decline for 2+ quarters

DOCUMENT 10

CQI Integration Checklist

Connecting anonymous feedback data to your continuous quality improvement program

📋 **INSTRUCTIONS:** *Behavioral health organizations that are accredited (CARF, Joint Commission, COA) or state-licensed are required to operate a Continuous Quality Improvement (CQI) program. This checklist ensures that anonymous participant feedback is integrated into — not separate from — your existing CQI infrastructure. Feedback data should be one input among many in your quality ecosystem, not a standalone initiative.*

CQI Alignment Principle

Feedback Is a CQI Data Source, Not a Separate Program

The most sustainable feedback systems are those that are woven into existing quality structures. If feedback operates as a standalone initiative, it will eventually be deprioritized when resources are tight. If it is part of CQI, it becomes part of how the organization operates.

Integration Checklist: Data Inputs

☐	Anonymous feedback data is formally listed as a data source in the organization's CQI plan
☐	Feedback summary reports are distributed to the CQI committee on the same schedule as other quality data
☐	Safety-related feedback findings (Document 9 trend data) are standing items on the CQI agenda
☐	Feedback data is cross-referenced with other quality data: incident reports, grievances, clinical outcomes, satisfaction surveys
☐	Disaggregated feedback data is included in equity-related CQI indicators
☐	Feedback response rates are tracked as a CQI process metric (engagement indicator)

Integration Checklist: CQI Governance

☐	The Feedback System Owner (Governance Toolkit, Document 1) has a seat on the CQI committee or reports directly to it
☐	CQI committee reviews feedback-driven action items quarterly and incorporates them into the organization's quality improvement plan
☐	Performance Improvement Projects (PIPs) may be initiated based on feedback data

	when thresholds are met
☐	CQI meeting minutes reference feedback data alongside other quality metrics
☐	The CQI plan's annual update includes a review of feedback system effectiveness

Integration Checklist: Accreditation & Regulatory Alignment

STANDARD	HOW FEEDBACK DATA SUPPORTS IT	INTEGRATED?
Client rights and responsibilities	Feedback monitors whether clients feel their rights are respected (dignity, privacy, autonomy)	Y / N
Safety and risk management	Safety-related feedback provides early warning data for risk management programs	Y / N
Person-centered care planning	Feedback about treatment plan relevance (R5) directly informs person-centered care assessments	Y / N
Grievance and complaint tracking	Anonymous feedback supplements (but does not replace) formal grievance systems	Y / N
Cultural competency	Disaggregated feedback by race, language, and gender supports cultural competency CQI goals	Y / N
Medication management	Feedback about medication safety (R3) supports medication management QI indicators	Y / N
Restraint/seclusion reduction	Feedback about feeling "controlled" or unsafe during interventions supports R/S reduction goals	Y / N
Client satisfaction	Overall satisfaction feedback is a direct input to client satisfaction CQI metrics	Y / N
Staff training and competency	Safety-related feedback patterns inform training needs assessments	Y / N
Performance measurement	Feedback scores and action completion rates serve as measurable quality indicators	Y / N

Integration Checklist: Reporting & Documentation

☐	Quarterly feedback summaries are included in the organization's CQI documentation / quality binder
☐	Feedback-driven PIPs are tracked using the same format as other CQI improvement projects
☐	Annual feedback summaries are included in the organization's annual quality report
☐	Accreditation surveyors / state reviewers can access feedback integration evidence during site visits

☐	Board quality reports include feedback data alongside clinical outcome data

Annual CQI Integration Assessment

DIMENSION	CURRENT STATE (1–5)	GAP	ACTION NEEDED
Feedback data included as a named CQI data source			
CQI committee regularly reviews feedback findings			
Feedback-driven PIPs have been initiated			
Feedback data cross-referenced with incident reports			
Safety trend data is a standing CQI agenda item			
Accreditation evidence includes feedback integration			
Staff training needs informed by feedback patterns			

Scale: 1 = Not integrated, 2 = Mentioned but not active, 3 = Partially integrated, 4 = Integrated with gaps, 5 = Fully embedded in CQI operations

Sign-Off

CQI integration review completed by: _____ Date: _____

CQI committee chair acknowledgment: _____ Date: _____

End of Toolkit

For implementation support, contact your Pulse For Good account manager or visit pulseforgood.com