

Critical Incident Investigations for 1915(c) Home and Community Based Services (HCBS) Waivers Direct Service Providers and Case Managers

**Commonwealth of Kentucky
Cabinet for Health and Family Services
Division of Developmental and Intellectual Disabilities**

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AGENDA

1. Background
2. Critical Incident Investigation Requirements
3. Purpose for Critical Incident Investigations
4. How to complete Critical Incident Investigations
5. Critical Incident Investigation Report

BACKGROUND

On May 7, 2019, the Department for Medicaid Services (DMS) announced a new approach to incident management, with an interim solution to begin on June 7, 2019.

The new approach applies to all Kentucky 1915(c) HCBS waivers for both traditional supports and participant-directed services (PDS)

Acquired Brain Injury (ABI)	Acquired Brain Injury Long Term Care (ABI LTC)
Home and Community Based (HCB)	Michelle P. Waiver (MPW)
Model II Waiver (MIIW)	Supports for Community Living (SCL)

Additional information about the new approach to incident reporting is available on DMS's Division of Community Alternatives website: <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>

- ❖ A recording of the May 7, 2019 webinar during which DMS announced these changes
- ❖ The new Incident Reporting Form
- ❖ The new Critical Incident Investigation Report
- ❖ Incident Reporting Instructional Guide

CRITICAL INCIDENT INVESTIGATION REQUIREMENTS

Who is responsible for completing Critical Incident Investigations:

- ❖ The agency that submitted the ***Incident Reporting Form*** (direct service provider, case manager) is responsible for the completion of the ***Critical Incident Investigation Report***.
- ❖ Exception: During this interim solution, ***Critical Incident Investigation Reports*** will not be completed when the reporting entity serves as a support broker/service advisor.

When must the ***Critical Incident Investigation Report*** be completed?

- ❖ Investigations are required for all ***Critical Incidents*** (note exception on slide 8)
- ❖ The ***Critical Incident Investigation*** should begin immediately after the provider witnesses or discovers the ***Critical Incident***.
- ❖ ***Critical Incident Investigation Reports*** must be submitted to the appropriate regulating agency within ten (10) business days* of the date of the critical incident/discovery of the critical incident

*Business day = day that Kentucky government is operating; excludes state holidays

PURPOSE FOR CRITICAL INCIDENT INVESTIGATIONS

Critical Incident Investigations:

- ❖ Begin with taking **immediate steps** to ensure the health, safety, and welfare of impacted participants
- ❖ Identify **causal factors** that contributed to the critical incident's occurrence
- ❖ Identify **preventative strategies** to reduce the likelihood that the critical incident will recur

HOW TO COMPLETE CRITICAL INCIDENT INVESTIGATIONS

Step 1: Ensure Health, Safety, and Welfare

- ❖ This step begins as soon as the critical incident is witnessed or discovered.

- ❖ Each critical incident is unique. Depending on the situation, steps may include one or more of the following:
 - Obtain needed medical care
 - ❑ Call 911/Emergency Services if needed
 - ❑ Contact primary care physician, specialist, or pharmacist
 - ❑ Follow existing medical orders/protocols

Immediate Steps to Ensure Health, Safety, and Welfare (continued)

- Obtain needed psychiatric care
 - ❑ Community based psychiatric services
 - Consultation with the participant's psychiatrist or psychologist
 - Community Mental Health Center:
 - ✓ Crisis Line
 - ✓ Crisis Unit
 - Evaluation in or admission to a private psychiatric unit
 - ❑ If warranted, consider filing a 202A/Mental Inquest Warrant
 - Process for involuntary commitment to a state psychiatric facility
 - Criteria:
 - ✓ Danger to self or others
 - ✓ Due to a mental illness
 - ✓ Hospitalization is least restrictive environment
 - ✓ Person can be reasonably expected to benefit from treatment

Immediate Steps to Ensure Health, Safety, and Welfare (continued)

- Consider Staffing/Level of Supervision
 - ❑ Remove (replace) direct support staff person
 - ❑ If the setting does not permit the removal of a staff person pending the outcome of the investigation (such as a family home provider), consider relocating the participant
 - ❑ Increase level of supervision

- If the critical incident involved a conflict between two participants, consider:
 - ❑ Separating the participants
 - ❑ Keep in mind that the participants may be together in alternate environments (such as Medicaid non-emergency transportation) and take appropriate steps

Immediate Steps to Ensure Health, Safety, and Welfare (continued)

- ❖ Each critical incident is unique, and the list of considerations reviewed here is not exhaustive.
- ❖ In order to ensure health, safety, and welfare, multiple actions (including steps not discussed here) may be required.
- ❖ A review of the immediate steps should be conducted to determine if these steps were timely and complete.

Step 2: Identify Causal Factors

- ❖ Often more than one issue/event contributed to the occurrence of the critical incident.
- ❖ Don't stop with a simple "why" ~ continue to ask "why" to get to the root cause(s).

Identify Causal Factors that contributed to the critical incident's occurrence (continued)

Example: A serious medication error occurred in a residential setting. Joe lives in a staffed residence funded through the Supports for Community Living waiver. The Direct Support Professional (DSP) administered 7:00 am medications to Joe that were prescribed for his housemate. Joe had an adverse reaction, requiring treatment in the emergency room.

Identify Causal Factors that contributed to the critical incident's occurrence (continued) ~ Example

- ❖ Why did the medication error occur?
 - The DSP did not follow proper procedures as taught in the medication administration training, “pre-poured” (set the medications up in advance in med cups for all three participants in advance) and handed the wrong medication cup to the participant.
- ❖ Why did the DSP not follow proper procedures when administering medication?
 - The DSP felt rushed/was in a hurry.
 - The DSP was tired.

Identify Causal Factors that contributed to the critical incident's occurrence (continued) ~ Example

- ❖ Why did the DSP feel rushed/in a hurry/tired?
 - All three participants required assistance with bathing, breakfast, and medication administration and the three (3) participants were to be picked up for day training at 7:30 am.
 - The DSP's primary job was working at the day training site. The day before the medication error occurred, the DSP picked up an additional shift/working the evening (4pm – midnight) shift at the staffed residence. The third shift (midnight-8:00 am) DSP called in sick, and so the DSP worked the overnight shift as well.
 - The DSP needed to leave the staffed residence to get to the day training site as soon as the participants were picked up.

Identify Causal Factors that contributed to the critical incident's occurrence (continued) ~ Example

- ❖ What is the agency's policy on how many hours a DSP can work?
 - The agency does not have a policy on how many consecutive hours or total hours a DSP can work.

- ❖ What is the agency's process to find coverage for a shift when a DSP calls in sick?
 - The residential manager locates a staff person to provide coverage or covers the shift. The first person who agrees to work the shift does so without consideration of prior hours worked/future hours scheduled.

Step 3: Identify Preventative Strategies

- ❖ Preventative Strategies are intended to be an action plan to reduce the likelihood that the critical incident (or a similar one) will happen again in the future.
- ❖ The **Preventative Strategies** should address the identified **Causal Factors**.

Identify Preventative Strategies to reduce the likelihood that the critical incident will recur (continued)

Example: The example critical incident, regarding a serious medication error, included multiple **Causal Factors**. Multiple **Preventative Strategies** would therefore be required.

Identify Preventative Strategies to reduce the likelihood that the critical incident will recur (continued) ~ Example

Causal Factor 1: The DSP did not follow proper procedures for medication administration.

Preventative Strategy 1: The DSP will be re-trained on medication administration procedures during the next medication administration class, scheduled for 5/23/19. The DSP will not administer medications until after successfully completing class and competency measure.

Identify Preventative Strategies to reduce the likelihood that the critical incident will recur (continued) ~ Example

Causal Factor 2: The DSP was rushed/tired.

Preventative Strategy 2: The Executive Director will draft a policy limiting the number of hours Direct Support Professionals can work consecutively and in a work week by 5/31/19. The new policy will be reviewed with residential supervisors during a manger's meeting on 6/4/19 and with all agency personnel during the staff meeting on 6/7/19.

CRITICAL INCIDENT INVESTIGATION REPORT

Completion of the Critical Incident Investigation Report

- ❖ All waiver providers will use the same Critical Incident Investigation Report.
- ❖ The form is a fillable PDF document and may be accessed on the DMS Division for Community Alternatives' website. <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>
- ❖ The boxes on the form will expand as text is added.

Completion of the Critical Incident Investigation Report (continued)

Kentucky 1915(c) Home and Community Based Services (HCBS) Waiver Programs Critical Incident Investigation Report

Timeframe for Reporting: The direct service provider or case manager must begin its investigation into the critical incident immediately upon witnessing or discovering the incident and submit this document to the appropriate regulating agency within ten (10) business days.

Waiver Participant's Name: _____ Waiver Participant's Medicaid #: _____

Incident Date (MM/DD/YY): _____
Time (AM/PM): _____

Discovery Date (MM/DD/YY): _____
Time (AM/PM): _____

Waiver: <input type="checkbox"/> ABI <input type="checkbox"/> ABI-LTC <input type="checkbox"/> HCB <input type="checkbox"/> MIIW <input type="checkbox"/> MPW <input type="checkbox"/> SCL	Yes No -Does the waiver participant have Rights Restrictions? <input type="checkbox"/> <input type="checkbox"/>
If reported to DCBS (APS/CPS), was the incident accepted for investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	-Was the incident related to the Rights Restrictions?(if yes, attach Rights Restrictions) <input type="checkbox"/> <input type="checkbox"/>
Recent Medical Concerns: _____ _____ _____	-Does the waiver participant have a Behavior Support Plan (BSP)? <input type="checkbox"/> <input type="checkbox"/> -Was the incident related to the BSP? (if yes, attach BSP) <input type="checkbox"/> <input type="checkbox"/> -Did incident include Restraint? <input type="checkbox"/> <input type="checkbox"/> • Type: _____ • Duration: _____

Completion of the Critical Incident Investigation Report (continued)

Investigation Summary / Analysis of Cause



Completion of the Critical Incident Investigation Report (continued)

Waiver Participant Review
How many times has this kind of incident happened with this waiver participant in the past three months?
What did you do to keep the waiver participant safe and well following the incident?
What are investigating staff's recommendations for preventing future occurrences?
What were the waiver participant's, guardian's, case manager's, and family members' recommendations to prevent the incident from reoccurring or concerns regarding the incident?

Completion of the Critical Incident Investigation Report (continued)

Staff/System Review
How many times has this kind of incident happened in your agency in the past three months?
What policies, procedures, or protocols were reviewed in order to prevent reoccurrence?
After review, what were the agency's findings?
Describe any adjustments to policies, procedures, or protocols. (Include effective date of adjustment.)
Who will be responsible for monitoring adjustments to policies, procedures, or protocols?

Completion of the Critical Incident Investigation Report (continued)

Investigating Staff Name/Title: _____		Supervisor Name: _____	
Signature: 	Date (MM/DD/YYYY): _____	Signature: 	Date (MM/DD/YYYY): _____

Revised 5/7/19



Completing Critical Incident Report Investigations

Questions?