


Office for Citizens With Developmental Disabilities	Operational Instruction # F-5
SUBJECT: Critical Incident Reporting, Tracking and Follow-up Activities for Waiver Services	DEVELOPED BY: Critical Incident Reporting and Tracking Workgroup
APPLICABLE UNITS: All OCDD entities and its designees providing waiver services	
ADOPTED: JULY 22, 2008 Implemented by draft July 1, 2008	REVISED: September 18, 2009 For implementation on October 1, 2009. May 12, 2010
APPROVED: 	REVIEWED:

## CRITICAL INCIDENT REPORTING, TRACKING AND FOLLOW-UP ACTIVITIES FOR WAIVER SERVICES

### I. Applicability

The Office for Citizens with Developmental Disabilities (*OCDD*) *Operational Instruction F-5: Critical Incident Reporting, Tracking and Follow-up Activities for Waiver Services* applies to the reporting, tracking and follow-up activities for all critical incidents, as defined within this Operational Instruction, related to persons (referred to as “participants”) who are receiving services through Home and Community-Based Services (HCBS) waivers from the Department of Health and Hospitals (DHH) – OCDD and its designees, the community services regional offices and the human services authorities and human service districts (authorities/districts).

### II. Purpose

This operational instruction has been developed to establish uniformity and consistency in the reporting of, responding to, tracking of and follow-up activities related to critical incidents for the population defined in Section I and to ensure the health and well-being of these participants.

### III. Types of Reportable Incidents (Incident Categories)

**Abuse (child)** means any of the following acts, which seriously endanger the physical, mental, or emotional health, and safety of the child including:

- The infliction or attempted infliction, or, as a result of inadequate supervision, the allowance or toleration of the infliction or attempted infliction of physical or mental injury upon the child by a parent or by any other person.
- The exploitation or overwork of a child by a parent or by any other person.
- The involvement of a child in any sexual act with a parent or with any other person, or the aiding or toleration by a parent or the caretaker of the child's sexual involvement with any other person, or the child's involvement in pornographic displays or any other involvement of a child in sexual activity constituting a crime under the laws of this state (*Louisiana Children's Code, Article 1003 (1)*).
- **Child abuse, primary** means that the accused or perpetrator is identified as the biological mother, father, stepmother, stepfather or legal guardian/curator.
- **Child abuse, non-primary** means the accused, or perpetrator is identified as a staff person of a Direct Service Provider Agency, a neighbor or others.

**Abuse (adult/elderly)** means the infliction of physical or mental injury on an adult by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value, to such an extent that his/her health, self-determination, or emotional well-being is endangered (*R.S. 15:503*)

**Death** is determined by the physician or coroner who issues the death certificate for an individual. All deaths are reportable regardless of the cause or the location where the death occurred.

**Exploitation** means the illegal or improper use or management of an aged person's or disabled adult's funds, assets, or property, or use of the person's or disabled adult's power of attorney or guardianship for one's own profit or advantage (*R.S. 15:503*).

**Extortion** means the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority (*R.S. 15:503*).

**Fall** means a fall occurring when the person is:

- Found down on the floor or ground (un-witnessed event); or
- Comes to rest on the floor or ground unintentionally, assisted or unassisted (witnessed).

**Involvement with Law Enforcement** occurs when a participant, his/her staff, or others responsible for the participant's care, are involved directly or indirectly in an alleged criminal manner, resulting in law enforcement becoming involved such as:

- A participant is arrested for an offense/crime.
- An on-duty staff person is arrested/charged with an offense/crime.
- An on-duty staff person is issued a citation for a moving violation while operating an agency vehicle, or while transporting a participant(s) in a private vehicle (e.g. staff-owned vehicle).
- Victim of a crime: A participant is the victim of a reportable offense under local, state, or federal statutes. Note: Do not enter a Critical Incident Report (CIR) with this category if the offense may meet the definition of abuse, neglect, exploitation or extortion; report such incidents to Adult Protective Services (APS), Elderly Protective Services (EPS) and Child Protective Services (CPS) for a determination, electronic entry and investigation, as outlined under *V. Responsibilities of OCDD Regional Offices, Human Services Authorities and Districts, Support Coordination Agencies, Direct Service Provider Agencies and the Participant and/or Family*.

**Loss or Destruction of Home** means damage to or loss of the participant's home that causes harm or the risk of harm to the participant. This may be the result of any man-made or natural action, including, but not limited to, wind damage, fire, flood, eviction, and an unsafe or unhealthy living environment.

**Major Behavioral Incident** means an incident engaged in by a participant that is alleged, suspected, or witnessed by the reporter that can reasonably be expected to result in harm, or that may affect the safety and well being of the participant. The following are major behavioral incidents:

- **Attempted Suicide:** the intentional and voluntary attempt by the participant to take his/her own life. A suicide attempt is limited to the actual physical attempt and does not include suicidal threats.
- **Suicidal threats:** any clearly stated verbal expression by a participant of intent to voluntarily take his/her life. The participant does not physically carry out an act of suicide.
- **Self-endangerment:** any act or lack of action by the participant that is likely to lead to serious injury or death to oneself.
- **Elopement/Missing:** the participant is missing or unaccounted for a period of time in excess of any unsupervised period provided in his/her Support Plan or other plan; or the participant has no supervision requirements in the support plan(s), but is missing or the whereabouts are unknown when he is supposed to be present for receipt of service(s),
- **Self-injury:** any suspected or confirmed participant self-inflicted wound or injury requiring medical treatment by a physician, nurse, dentist, or any other health care provider.
- **Property destruction:** any confirmed serious destruction of property caused by the participant and estimated to be greater than fifty dollars (\$50.00) in damages to the participant's property or that of another.
- **Offensive sexual behavior:** The participant imposes non-physical sexually oriented activities upon another person.
- **Sexual aggression:** any act of the participant physically forcing sexually oriented activities upon another person.
- **Physical aggression:** the participant physically attacks another person that results in injury or harm to the other person.

**Major Illness** means any substantial change in health status, illness, or sickness (suspected or confirmed) which requires unscheduled treatment, or other medical intervention by a physician, nurse, dentist, or other licensed health care providers.

*Note: All illnesses that meet the definition of major illness are reportable critical incidents as "other major illness". The following specific major illnesses are additionally reportable by category:*

- **Major Illness/Bowel Obstruction** – as diagnosed by a treating physician
- **Major Illness/Decubitis** – Any lesion caused by unrelieved pressure and results in damage to the underlying tissues, as diagnosed by a licensed nurse or treating physician.
- **Major Illness/Pneumonia**- as diagnosed by a treating physician
- **Major Illness/Seizures** - as diagnosed by a treating physician

**Major Injury** means any suspected or confirmed wound or injury to a participant of known or unknown origin requiring medical attention by a physician, nurse, dentist, or any

licensed health care provider. Note: Use this category only if there is no reason to suspect abuse or neglect. If abuse or neglect is suspected, then the proper category is either abuse or neglect and the incident should reflect the applicable category.

**Major Medication Incident** means the administration or self-administration of medication in an incorrect form, not as prescribed or ordered, or to the wrong person, or the failure to administer or self-administer a prescribed medication, which requires or results in medical attention by a physician, nurse, dentist, or any licensed health care provider. The following are major medication incidents:

- **Staff error:** the staff fails to administer a prescribed medication or administers the wrong medication or dosage to a participant, or fails to fill a new prescription order within twenty-four (24) hours or a medication refill prior to the next ordered dosage.
- **Pharmacy error:** the pharmacy dispenses the wrong medications or mislabels medications.
- **Person error:** the person (participant) unintentionally fails to take medication as prescribed.
- **Medication Non-Adherence** - Participant refuses prescribed medications for 3 consecutive days. (Medications for acute illness or seizures; psychotropic medications for psychiatric illness or behavioral control).
- **Family error:** a family member intentionally or unintentionally fails to administer a prescribed medication refill to the participant prior to the next ordered dosage.

**Neglect (adult/elderly)** means the failure by a caregiver responsible for an adult's care or by other parties to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her well being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall, for that reason alone, be considered to be neglected or abused (*R.S 15:503*).

**Neglect (child)** means the refusal or failure of a parent or caretaker to provide the child with necessary food, clothing, shelter, care, treatment, or counseling for an injury, illness, or condition of the child, as a result of which the child's physical, mental, or emotional health and safety is substantially threatened or impaired. Whenever, in lieu of medical care, a child is being provided treatment in accordance with the tenets of a well-recognized religious method of healing having reasonable, proven record of success, the child shall not, for that reason alone, be considered neglected or abused. (*Children's Code, Article 1003*).

- **Child Neglect Primary** means that the accused or perpetrator is identified as the biological mother, father, stepmother, stepfather or legal guardian/curator.
- **Child Neglect Non-primary** means the accused or perpetrator is identified as a staff person of a direct service provider agency, a neighbor or others.

**Restraint Use** – means any personal, physical, chemical, or mechanical intervention used to control acute, episodic behavior that restricts movement or function of a person or a portion of a person's body. *OCDD Policy # 701 Restraints and Seclusion* contains comprehensive information on all categories of restraint. Behavioral and Medical

Restraints are the categories of restraint that are applicable to home and community-based waiver services and are further defined below. Refer to Policy # 701 for any further clarification needed on these categories and subcategories.

- **Behavioral Restraint** means those restraints used to suppress a person's behavior and do not include restraints utilized when conducting a medical treatment. Behavioral restraints may be planned or unplanned and may involve personal, mechanical, or chemical restraints.
- **Medical Restraint** means those restraints that are applied as a health related protection that are prescribed by a licensed physician, licensed dentist, or licensed podiatrist. Such restraints are only used when absolutely necessary during the conduct of a specified medical or surgical procedure or when absolutely necessary for the protection of the person during the time that a medical condition exists. Medical restraints may be planned or unplanned and may involve personal, mechanical, or chemical restraints. The appropriate use of "light sedation" is not considered a medical restraint.
  - **Chemical Restraint** - those that involve the use of any medication to suppress non-selectively an individual's behavior.
  - **Mechanical Restraint** – involve the application of any physical device to the body of an individual for the purpose of restricting or suppressing the individual's movement and/or preventing normal access to the body.
  - **Personal Restraint** – involves the application of body pressure to an individual for the purpose of restricting or suppressing the person's movement.

**Self-neglect means the failure by the adult's action or inaction** to provide the proper or necessary supports or other medical, surgical, or any other care necessary for his/her own well being. No adult who is being provided treatment in accordance with a recognized religious method of healing, in lieu of medical treatment, shall for that reason alone be considered to be self-neglected (*R.S. 15:503*).

#### IV. **Health care admissions that may result in a critical incident**

**Health care admission** means the admission of a person to a hospital or other health care facility for the purpose of receiving medical care or other treatments, et cetera. Note: Scheduled treatment of a medical condition on an inpatient or outpatient basis for a routine or planned visit is not considered a reportable critical incident and is not reportable. The following are reportable health care admissions:

- **Acute care facility** means a hospital where the admission is for treatment for a serious illness or injury for an accident, or after surgery. The treatment is in a hospital by trained persons/staff, and is usually for only a short period of time less than 30 days.
- **Emergency Room (E.R.)** means the use of a hospital emergency room, whether admitted or discharged.

- **Nursing Home** means an inpatient admission to a licensed skilled nursing facility for short or long-term care as prescribed by a treating physician nursing home. The purpose of such an admission is for temporary skilled nursing treatment and care. Examples include, but are not limited to, stabilization of a person receiving nourishment through an enteral tube, medication management, recovery from a serious illness or injury, and support for the person while staff develop skills to meet the person's needs.
- **Psychiatric hospital** means an inpatient admission to a psychiatric facility including crisis facilities and the psychiatric departments of acute care hospitals for the purpose of evaluation or treatment or both, whether voluntary or involuntary. The admission may also include review or adjustment of medications or both for the treatment of psychiatric symptoms or to address challenging behaviors.
- **Rehabilitation facility** means an inpatient admission to a rehabilitation facility, or the rehabilitation department of a medical facility with the goal of restoring a person to the previous level of health, i.e. good physical or emotional health, et cetera. Examples include, but are not limited to, post surgical rehabilitation, substance abuse treatment, or other medical concerns.
- **Respite Center/Supports and Services Center (SSC)** means admission of a person to a licensed respite center or a Supports and Services Center, or on a temporary, unplanned basis, for psychiatric, behavioral, or medical stabilization, or due to loss of supports.

**V. Responsibilities of OCDD Regional Offices, Human Services Authorities and Districts, Support Coordination Agencies, Direct Service Provider Agencies and the Participant and/or Family**

**A. Participants and/or their family members**

The participant and/or his/her family members shall be responsible for completing all of the following actions:

1. Report critical incidents as soon as possible to the direct service provider and/or the support coordination agency;
2. Provide information about the circumstances and details of the critical incident; and
3. Participate in any planning meetings convened to resolve the critical incident or to develop strategies to prevent or mitigate the likelihood of similar critical incidents occurring in the future.

**B. Direct Service Provider Agencies (DSP)**

Direct Service Provider Agencies shall be responsible for completing all of the following actions:

1. Immediately take the necessary action(s) required to assure the participant is protected from further harm and respond to any emergency needs of the participant.

2. Immediately contact the appropriate protective service agency if abuse, neglect, exploitation, or extortion is suspected.
3. When there is an allegation of abuse or neglect, the DSP shall ensure that any accused staff involved are removed from and shall not have any contact with the alleged victim (participant) or other participants receiving supports and services, pending the outcome of the internal investigation.
  - a. If the abuse, neglect, or exploitation involves a child, birth to seventeen (0-17) years of age and the perpetrator is a direct service worker (DSW), immediately verbally report the incident and forward a copy of the completed *DHH HCBS Critical Incident Report Form* (Appendix A) to the local law enforcement agency and to the DHH Health Standards Section (HSS).
  - b. If the abuse, neglect, or exploitation involves a child's family member, immediately verbally report the incident and forward a completed copy of the *DHH HCBS Critical Incident Report Form* to the local parish Child Protection Services (CPS).
  - c. If the abuse, neglect, exploitation or extortion involves participants ages eighteen to fifty-nine (18–59), immediately report the incident to Adult Protective Services (APS). The DSP shall only verbally report to APS and not forward a copy of the completed *DHH HCBS Critical Incident Report Form*.
  - d. If the abuse, neglect, exploitation, or extortion involves participants ages sixty (60) and above, immediately verbally report and forward a copy of the completed *DHH HCBS Critical Incident Report Form* to Elderly Protective Services (EPS).
4. Cooperate with appropriate protective service agency identified in 5.B.3 above, once that agency has been notified and an investigation commences. In addition, the DSP is required to provide relevant information, records and access to members of the agency conducting the investigation.
5. Contact the support coordination agency/support coordinator by phone or fax immediately after taking all necessary actions to protect the participant from further harm and responding to the emergency needs of the participant but no later than 2 hours after the discovery of the critical incident.
6. Complete the *DHH HCBS Critical Incident Report Form* and submit it to the support coordination agency/support coordinator as soon as possible upon discovery but no later than 24 hours after the discovery of the critical incident. Utilize the “Critical Incident Description Section” of the *Report Form* (page 4) to provide all applicable descriptive information regarding the incident. Refer to the definitions sections of this *Operational Instruction* to obtain and include accurate information about the types of child/adult and elderly abuse reported.

7. Submit a follow-up report regarding the critical incident to the support coordinator by the close of the third (3<sup>rd</sup>) business day following the initial report.
8. Follow-up and take all necessary actions to address the critical incident in conjunction with the participant and his/her support coordinator.
9. Participate in all planning meetings convened to resolve the critical incident or to develop strategies to prevent or mitigate the likelihood of similar critical incidents occurring in the future.
10. Submit updates to the support coordination agency and support coordinator regarding the critical incident, as necessary, and until the incident is resolved.
11. Track critical incidents in order to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed for incident resolution.

**C. Support Coordination Agencies and Support Coordinators**

Support coordination agencies and support coordinators shall be responsible for completing all of the following actions:

1. When the support coordinator discovers an incident, contact the DSP within two (2) hours of discovery and inform the provider of the incident, collaborate to assure that the participant is protected from further harm, and assure that emergency actions are taken.
2. Enter critical incident report information into the On Line Tracking Information System (OTIS) by close of business the next business day following notification of a critical incident by the direct service provider or the discovery by the support coordinator; and
3. Enter follow-up case notes within six (6) business days after the initial critical incident report is received from the direct service provider or the discovery by the support coordinator.
4. Convene necessary planning meetings that may be required to resolve the critical incident or to develop strategies to prevent or mitigate the likelihood of similar critical incidents from occurring in the future and revise the participant's support plan accordingly.
5. Continue to follow-up with the direct service provider, the participant and others as necessary, in order to update the case notes in OTIS until the incident is resolved and the case is closed.
6. Send the participant and the direct service provider a copy of the incident participant summary within fifteen (15) days after final supervisory review and closure by the OCDD regional office or the human services authority or district. The participant summary should not include the identity of the reporters or any sensitive or unsubstantiated allegations. In the event of the participant's death, the participant summary should be forwarded to the Medicaid-authorized representative or legal guardian.



7. Track critical incidents to identify required remediation actions and quality improvement goals and to determine the effectiveness of strategies employed.
8. In the event that a support coordinator is a witness to or discovers abuse, neglect, exploitation, or extortion, immediately take action to assure that the participant is protected from further harm and respond to the emergency needs of the participant; and
9. Immediately verbally report and forward a copy of the completed *DHH HCBS Critical Incident Report Form* to CPS or EPS.

- a. If the incident involves a participant age eighteen to fifty-nine (18–59), the support coordinator should only verbally report the incident to APS and do not enter information into OTIS.

Note: Conversion of a Waiver Incident to an APS Case - When the support coordination agency suspects that a waiver incident meets the definition of an APS case, they must report the case immediately to APS. If APS accepts the case, they will take the lead on the investigation and change the case type in OTIS. The incident will no longer exist as a waiver case.

- b. Enter the abuse, neglect, exploitation, or extortion information involving participants ages zero to seventeen (0–17) and sixty (60) years of age and older into OTIS within twenty-four (24) hours of witness or upon discovery of the incident.
10. Support coordination agencies and support coordinators are also responsible for meeting the required actions involved in the following instances:
    - a. Death of a Participant - Upon receipt of the Mortality Review Committee (MRC) checklist and the signed *Release of Information Letter* from the regional offices/authorities/districts, provide the information as required by the *Operational Instruction F-1 Mortality Review Process*.
    - b. Transfer of Open Cases - The transferring support coordination agency must supply the accepting support coordination agency with the OTIS incident ID number(s) at the time of Transfer of Records. Additionally, they must notify the regional waiver office. The accepting agency must review, assign, take actions to resolve the incident, and enter follow-up notes into OTIS until closure of the incident.

**D. Responsibilities of the OCDD Community Services Regional Administrator (CSRA) or designee and the Developmental Disabilities Director (DDD) or designee of the Human Services Authority or District**

The OCDD CSRA/designee and the DDD/designee shall be responsible for completing all of the following actions:

1. On a daily basis, review all new incoming critical incident reports, determine the report priority level (i.e., urgent or non-urgent), and assign the report to appropriate staff.
2. Immediately, or within twenty-four (24) hours, notify verbally and in writing (via e-mail) the OCDD Central Office Quality Management Section designee when critical incidents involve the death or the arrest of a participant or when critical incidents of the abuse/neglect of a participant results in the involvement of law enforcement. Note: The notification information shall include, but is not limited to the following:
  - a. Participant's full name,
  - b. Cause of death, if known, including pre- and post-death diagnoses,
  - c. Previous reports concerning the participant's care, safety, and well-being; if arrested, the reason for the participant's arrest; and the specifics of the incident (i.e., report specifics of who, what, when, where, how).
3. Alert regional staff members of urgent cases within one (1) business day of receipt of the critical incident, and assure that regional staff takes appropriate action in response to the critical incident.
4. Review and approve extension requests made by staff of the OCDD regional offices and the authorities/districts. (Note: Extensions shall not be granted for more than thirty (30) days at a time.)
5. Assure that all mandatory information is entered into OTIS prior to case closure.
6. Track critical incidents by report to identify remediation needs and quality improvement goals and to determine the effectiveness of the strategies employed to assure resolution to the critical incident report.
7. Close cases after all needed follow-up has occurred and all necessary data has been entered into OTIS (Supervisor Review and Closure).
8. Periodically, the CSRA/designee and the DDD/designee shall select a sample of critical incidents to review for adherence to policy including a review to determine if all necessary actions were taken to address and resolve critical incidents.
9. The CSRA/designee and the DDD/designee is responsible for complying with the *Operational Instruction F-1 Mortality Review Process* if the death of a person covered by the above *Operational Instruction* occurs within the domain of his/her region or authority/district.
10. Assure that all critical incidents involving deaths remain open until after the OCDD Mortality Review Committee (MRC) has met and until recommended closure is received from Central Office Critical Incident Program Manager/designee. (Note: this may require granting Extension(s) to staff until all information is received from support coordinator and until after MRC has met or if MRC requests additional information based upon their review).

11. The CSRA/designee and the DDD/designee is responsible for following the *Process for Closing APS Cases* (Appendix D) of this *Operational Instruction*.

**E. Staff Responsibilities of OCDD Regional Offices and Human Services Authorities and Districts**

The staff of the OCDD regional offices and human services authorities/districts shall be responsible for completing all the following actions:

1. Continue to follow-up with the support coordination agency providing technical assistance as necessary and requesting additional information in writing until closure of the critical incident;
2. Make timely referrals to other agencies as necessary;
3. Assure that the support coordination agency enters all necessary information into the OTIS;
4. Assure that activities occur within required timelines, including closure of the incident within thirty (30) days, unless an extension has been granted;
5. Submit requests for extension to the Community Services Regional Administrator (CSRA) for review and approval;
6. Assure that the participant summary is completed for all cases including APS, EPS, and CPS. The participant summary should not include the name of the reporter of the incident or any other sensitive information.
7. Comply with the requirements of the Operational Instruction # F-1, *Mortality Review Process* when the death of a participant occurs.
8. Comply with the following process for the conversion of a waiver incident to an APS Case:
  - a. When waiver staff suspect or become aware that a waiver incident meets the definition of an APS case, they must report the case immediately to APS. If APS accepts the case, they will take the lead on the investigation and change the case type in OTIS. The incident will no longer exist as a waiver case.
  - b. Once confirmed that APS has accepted the case for investigation, contact via e-mail OCDD Critical Incident Program Manager to alert and request that incident be deleted from OTIS to avoid duplication in OTIS.

**F. OCDD Central Office Responsibilities**

OCDD Central Office Quality Management Section shall be responsible for completing all of the following actions:

1. Upon receipt of e-mail or verbal notification involving the unexpected death (death not considered prognosis for a pre-existing medical condition or advanced age) of a participant, the arrest of a participant, or of the abuse or neglect of a participant involving law enforcement, immediately,

but not more than twenty-four (24) hours, notify in writing via e-mail all the following:

- OCDD Assistant Secretary or designee
  - OCDD Deputy Assistant Secretary
  - Executive Director of Waiver Supports and Services
  - Executive Director of Community Services
  - DHH Bureau of Media & Communications
  - OCDD Quality Management Staff
  - DHH Deputy Chief of Staff
  - Other staff of the OCDD Central and regional offices and the authorities/districts as deemed appropriate.
2. Provide technical assistance to the regional offices and the authorities/districts as needed.
  3. Identify statewide needs for training regarding the following:
    - Responding to critical incidents,
    - Adhering to the Critical Incident Reporting and Tracking Operational Instruction,
    - Entering critical incident data into OTIS,
    - Tracking critical incidents and using data for remediation and/or quality enhancement,
    - Adhering to the Operational Instruction F-1, *Mortality Review Process* and/or other related topics;
  4. Select a sample of critical incidents to review for adherence to policy, including a review to determine if all necessary actions were taken to address and resolve critical incidents;
  5. Identify necessary remediation to be taken by the direct service provider, the support coordination agency and support coordinator, and the staff of the OCDD regional offices and the human services authorities and districts;
  6. Aggregate critical incident data and analyze the data to identify trends and patterns;
  7. Review reports of the trends and patterns to identify potential quality enhancement goals; and
  8. Utilize critical incident data to determine the effectiveness of OCDD quality enhancement strategies.
  9. The OCDD Central Office Quality Management Section is responsible for complying with the required actions of the *Operational Instruction F-1*

*Mortality Review Process* when a critical incident involves the death of a participant.

## **VI. Quality Management**

OCDD Central Office will utilize the information and data collected on critical incidents for quality management purposes, including but not limited to the following:

- A. Development and review of reports to assure timely reporting, follow-up and case closure of critical incidents occur according to this operational instruction;
- B. Analysis of data to identify trends and patterns for effective program management to ensure the safety and wellbeing of participants receiving OCDD supports and services and to ensure that participants receive quality supports and services from OCDD;
- C. Analysis of data to determine the effectiveness of quality enhancement goals and activities; and
- D. Identification of participants who experience frequent critical incidents and whose support plans will need to include strategies to mitigate risks from future incidents.

## **VII. Appendices**

Appendix A - HCBS Critical Incident Report Form Special Instructions

Appendix B - HCBS Critical Incident Report Form

Appendix C - HCBS Critical Incident Description Supplemental Pages

Appendix D - Process for Closing APS Waiver Cases

Appendix E - Glossary

Appendix F - OCDD - OTIS Definitions