

Support Coordinator (SC) Critical Incident Report (CIR) Guide

When a CIR occurs, take immediate action to ensure the participant is protected from further harm. Report incidents involving abuse, neglect, exploitation, or extortion to Adult Protective Services (APS) or Elderly Protective Services (EPS). If the allegation involves provider staff, any accused staff cannot serve or have access to the participant until the investigation is completed.

Use this guide to ensure all required information is accurate and included in the CIR.

When entering a CIR, note the following:

- Ensure that the appropriate CIR category is selected. (e.g. Major Medical Event (MME) vs. Major Injury; MME vs. Major Medication Incident).
- When applicable, multiple CIR categories may be selected.
- Enter the participant's first and last name in the event description and the exact date the incident occurred.
- Develop strategies to minimize risks and share with the participant's support team.
- Evaluate the situation and determine further steps:
 - Does the team need to meet to come up with a plan to reduce the risk of further injury or incidents?
 - Does the Direct Service Worker (DSW) or Direct Service Provider (DSP) require additional training?

Reminders:

- The SC is always the reporter for all Community Choices Waiver (CCW) Self-Direction (SD) option participants and Adult Day Health Care (ADHC) participants.
- The SC is the reporter for all CCW participants not enrolled in the SD option when they have first knowledge of a critical incident outside of DSW service delivery.
- The SC is the first level reviewer after an incident is reported. It is the SC's responsibility to ensure an incident meets CIR criteria and includes all necessary information.
- All critical incidents for OAAS HCBS certified waiver participants must be reported, investigated, and tracked. This includes all certified waiver participants residing in a Nursing Facility.

Helpful links:

- Statewide Incident Management System (SIMS) Frequently Asked Questions:
<https://ldh.la.gov/assets/docs/OAAS/CIR/OAAS-P-20-004-SIMS-FAQs-I-3-16-20.pdf>
- CIR Manual OAAS-MAN-19-002:
https://ldh.la.gov/assets/docs/OAAS/SIMS/OAAS_MAN_19_002_Critical_Incident_Reporting_Manual_for_SIMS_I_5_3_19.pdf
- CIR Timeline Guide:
<https://ldh.la.gov/assets/docs/OAAS/publications/otis/CIRProcessFlowChart.pdf>

Critical Incident Report Categories

MAJOR INJURY: Any **injury** that results in unexpected medical care. Must be a suspected or confirmed injury to the participant's physical self or a wound (head or eye injury, deep cuts requiring stitches, fractures, etc.). Do not use this category to record medical conditions or illness.

CIR should include:

- Description of the injury.
- Individuals present and their relationship to the worker. (e.g., Family, natural support, Direct Service Worker (DSW))
- If the participant was alone at time of injury. Was the DSW was present? If not, was he/she scheduled to provide services that day?
- If the participant sought medical treatment, note the facility name, medical professional who provided treatment and the treatment that was provided.
- The exact date of the medical appointment or hospital discharge.

Follow-up documentation should include:

- Discharge/follow-up instructions (e.g., new medications, orders for Home Health, orders for therapies).
- Any doctor recommended supplies or durable medical equipment (DME) received. When supplies or DME is not received, document the reasons why. Also, include any training the participant needs to use the DME properly.
- The participant's status after the major injury. (e.g., broken leg remains in cast. Participant is non-ambulatory.)
- Whether the participant is back to their "regular" activity.

NOTE: Continue to provide follow-up information until the participant is back to his/her baseline. Also, indicate if the participant has a new baseline following the injury.

MAJOR MEDICAL EVENT (MME): The participant receives a medical procedure from a physician, nurse practitioner, dentist, or other licensed health care provider. The procedure can be received at a non-scheduled inpatient visit or outpatient visit. A new diagnosis and/or new orders for medications, services (Home Health/Hospice), therapy, DME, health-related tasks, or treatments must be prescribed.

CIR should include:

- What happened? (e.g., Why? What? Where?)
- Was 911 was called?
- State if it was an ER visit or hospital admission. Include the facility's name.
- How was the participant transported to the hospital? (e.g., did a natural support/direct service worker bring them? were they transported by ambulance?)
- Who was present? (e.g., natural support? Was the DSW was present? If not, was he/she scheduled to provide services that day?)

Follow-up documentation should include:

- If a medical procedure/treatment was provided by a licensed health care professional.
- If a new diagnosis was given.
- If the participant transferred to another facility from the ER/hospital. List the transfer date and facility name.
- Any discharge/follow-up instructions. (e.g., Follow-up with a medical professional, new medication; home health/hospice/new therapies) List the discharge date.
- Specific equipment/DME or medication recommended by the doctor.
- The participant's status after the MME. (e.g., Once the participants has returned home).

Team Meeting Considerations:

- Could the participant visit their Primary Care Physician (PCP) or an urgent care instead of the hospital?
- Are routine medical visits or follow-ups occurring to prevent ER/hospital admissions?
- Is a meeting with the participant, their natural supports and/or providers needed to discuss strategies to reduce the risk of an ER visit/facility admission?

NOTE: Refer to the Major Medical Event Flow Chart (OAAS-PC-14-003) for CIR criteria. It can be found at the following link: <https://ldh.la.gov/assets/docs/OAAS/CIR/MME-Flow-Chart.pdf>.

DEATH: All deaths of participants are reportable, regardless of the cause or the location where the death occurred. The CIR **MUST** include the circumstances surrounding the death, prior to and at the time of death.

CIR should include:

- Who was present at the time of death? (e.g., natural support and/or staff on duty).
- When and where the death occurred.
- Whether the participant was receiving hospice or home health services at the time of death.
- What was happening immediately prior to the participant's death (e.g., medical attention sought, died in route to hospital, symptoms/actions prior to death)

Follow-up documentation should include:

- The cause of death or the diagnosis that contributed to the cause of death. It is not necessary to wait for a death certificate.

NOTE: Make a reasonable, but gentle attempt to gather necessary information from the family.

FALL: Any unintentional change in position where the person ends up on the floor, ground, or other lower level. This includes falls that occur while being assisted by others.

CIR should include (for all types of falls):

- Was anyone else present when the participant fell? (e.g., the participant was alone, natural supports, DSW was on duty)
- What was the participant doing when he/she fell? (e.g., was he/she getting out of the bathtub or transferring out of a chair? Was he/she getting out of a car?)
- How the participant got up. (e.g., did someone help them or did they get up on their own? Were they assisted to their feet or were they able to get up independently?)

Fall situations:

- **Resulted in No Injury**
 - Document that the fall resulted in no injury or medical follow-up.
- **Resulted in Injury- Participant Refused Medical Attention**
 - Document the recommendation of medical attention and why the participant did not follow-up. (e.g., Participant fell, had scratches and bruises, 911 was called to help but the participant refused medical attention).
- **Resulted in an Injury- Participant Required and Received Medical Attention**
 - Date of the follow-up appointment.
 - Recommendations from the follow-up appointment.
 - If it is a reoccurring fall, include strategies that will be put in place to prevent future falls. (e.g., walker will be placed next to bed; client will request assistance with transferring)
- **Resulted in an Injury Requiring ER/hospital admission**
 - Refer to the incident category MME above. Mark the CIR as both a fall and MME category.

Follow-up documentation should include (for all types of falls):

- The participant's status (i.e., How is he/she doing now? Does he/she have any bruises or lingering pain? Is he/she taking any medications for pain from the fall?).
- Did the participant go to an ER/hospital or other facility following the fall? Has he/she been discharged? If so, document the discharge date and instructions/recommendations.

NOTE: If a participant has 2 falls within 30 days OR 3 or more falls within 6 months, a team meeting is required.

Team Meeting Considerations:

- Discuss strategies with the participant and team members to reduce falls.
- Does the participant need additional DME/assistive devices?

During DSP service delivery:

- Ensure that the DSP completes the **OAAS Fall Assessment Form** and **Fall Analysis & Action Form**.
- Validate the information in the **OAAS Fall Assessment Form** with the participant and/or natural supports.
- Work with the DSP and natural supports to implement preventative strategies. Include preventative strategies in the POC (as necessary).
- Timely enter the CIR into the critical incident reporting system. The entry **MUST** be made when the SC first discovers a CIR.

Outside of DSP service delivery:

- When the fall is initially reported to or discovered by the SC, the **SC is responsible** for completing the **OAAS Fall Assessment Form and the OAAS Fall Analysis and Action Form**.

The **Fall Assessment (OAAS-PF-10-012)** form and **Fall Analysis & Action (OAAS-PF-10-013)** form can be found at the following link: <https://ldh.la.gov/index.cfm/newsroom/detail/1418?uid=1295548571800> listed under **Related Files**.

MAJOR MEDICATION INCIDENT: Medication is not administered as prescribed/ordered or is administered to the wrong person, requiring treatment by a physician, nurse, dentist, or any licensed health care provider. Hospitalization is **NOT** a requirement.

CIR should include:

- Describe what occurred and the events leading up to the medication incident.
- List the persons involved in the medication incident and their relationship to the participant. (e.g., Natural support? Was the DSW present or scheduled to be present?)
- Indicate if the participant sought medical attention and the treatment he/she received. If not, was their PCP/home health/hospice nurse notified of the incident?

Follow-up documentation should include:

- Does the participant need a pill pack/medi-planner pill organizer?
- Does the participant need medication administration?

MAJOR BEHAVIORAL INCIDENT: Any behavioral health episode resulting in either an ER visit, behavioral health hospital visit, or hospital admission.

CIR should include:

- The date the incident occurred.
- Describe what occurred. (e.g., Hallucinations, delusions, changes in behavior, changes in mental status, unable to put thoughts into words, speaking but not making sense)
- Individuals involved. (e.g., Staff on duty/natural supports/police).
- Name of the behavioral health hospital or ER where the participant was treated.
- Medical attention sought and provided. (e.g., was there an ER/Hospital/Psychiatric Hospital Placement?)
- If the participant was self-committed or received a Coroner Emergency Certification (CEC) or a Physician Emergency Certification (PEC) to the treatment center.

Follow-up documentation should include:

- If the participant will begin or continue any outpatient services.
- The participant's overall status. (e.g., returned to current home, are not allowed back in their current home or apartment building, homeless)
- Any new diagnosis(es), new medication, or change in medication.
- Any new discharge instructions.
- Any follow-up with a mental health professional/Primary Care Physician (PCP).

Team Meeting Considerations:

- Could the participant visit their PCP or mental health professional instead of going to the hospital?
- Could he/she develop positive coping strategies to avoid a major behavioral health incident?
- Would the participant benefit from a behavioral health referral?
- Is a meeting with the participant, natural supports, and/or providers needed to discuss strategies to reduce the risk of an ER visit/facility admission?

INVOLVEMENT WITH LAW ENFORCEMENT: Any incident in which law enforcement was called **DUE TO AN ISSUE WITH THE PARTICIPANT**. The incident **DOES NOT** require an arrest.

CIR should include:

- The details of why law enforcement was called.
- Individuals present when law enforcement was called. (e.g., was DSP scheduled/on duty or supposed to be on duty?)
- Individual who called law enforcement. (e.g., did the DSP/natural support/participant/landlord/neighbor call?)
- If law enforcement used de-escalation/crisis techniques and were they successful. (e.g., neighbors/landlord were fighting and police intervened).

Follow-up documentation should include:

- If the incident resulted in an APS or EPS referral.
- Is it always necessary to contact law enforcement? Could natural support, other support systems, or a crisis team be contacted instead?

NOTE: If law enforcement determined further evaluation was needed (i.e., behavioral health status check), see Major Behavioral Incident category above. Document the CIR category as both Involvement with Law Enforcement AND a Major Behavioral Incident.

PARTICIPANT IS A VICTIM OF A CRIME: A participant is the victim of a reportable offense under local, state, or federal statutes.

The CIR should include:

- What are the details of the event?
 - Who is involved? What occurred? Where did it occur?
 - Was DSW present? If not, was he/she scheduled to provide services?

Follow-up documentation should include:

- Did the participant seek medical attention because of the event?
- Who was notified about the event?
 - Was law enforcement notified and/or a police report filed?
 - Was Protective Services (APS/EPS/HSS) involved or is referral required?

LOSS OR DESTRUCTION OF HOME: Damage to or loss of the participant's home causing harm or risk of harm to the participant, due to either a man-made or natural event. The participant can no longer live in the home, even temporarily.

The CIR should include:

- Details of what occurred. (e.g., a fire, hurricane, flood)
- Describe how extensive the damage was. (e.g., Floors and 4 feet of walls had to be removed, roof was torn off)
- If the participant was injured. If the participant sought medical attention? (If yes, also mark as an MME category).

Follow-Up documentation should include:

- All repairs completed, even if temporary. (e.g., a tarp on a roof)
- If repairs to the house are needed. If so, whether the dwelling becomes livable during repairs.
- The Participant's living arrangements since the incident. (e.g., living at a family member's house)
- Any plans to rebuild/repair the home. (Include any estimated timeframe).

Team Meeting Considerations:

- Has the house been damaged or destroyed in a previous disaster or event?
- Is permanent alternative housing needed?

NOTE: The CIR cannot be closed until a plan is in place for living arrangements. You MUST provide the plan as soon as it is written.