


Office for Citizens With Developmental Disabilities (OCDD)	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. (K. Kleibert) December 9, 2021
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 critical incidents, as defined within this Operational Instruction, related to persons (referred to as "participants") who are receiving linked and certified Home and Community-Based Services (HCBS) waivers from the Louisiana Department of Health (LDH)—OCDD. This operational instruction is applicable to Local Governing Entity Waiver Service offices, approved Support Coordination Agencies, Direct Service Provider Agencies licensed for by LDH Health Standards section.

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 is defined as any of the following acts, which seriously endanger the physical, mental, or emotional health, and safety of the individual.

Abuse (child) includes the following:

- 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 (I)*).
- **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) is defined as 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 is defined as the illegal or improper use or management of an aged person's or adult with disability's funds, assets, or property, or use of the person's power of attorney or guardianship for one's own profit or advantage (R.S. 15:503).

Extortion is defined as 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 occurs when the participant is found down on the floor or ground [unwitnessed event] (not intended to include finding someone on the floor engaged in intentional activity such as a child playing on the floor even if the act of sitting to play was unwitnessed); or comes to rest on the floor or ground unintentionally, witnessed (not intended to include participants who fall in the course of playing sports or other activities when these activities are not contraindicated by their plan of care and falling or sliding is a normal occurrence of the activity.)

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 or law enforcement is called to the scene due to actions of the participant.
- 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).

Loss or Destruction of Home is defined as 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 manmade or natural action, including, but not limited to, wind damage, fire, flood, eviction, and an unsafe or unhealthy living environment.

Major Behavioral Incident is defined as 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:

- **Suicidal threats:** is defined as any clearly stated verbal or clearly observed physical expression by the participant of intent to take his/her life or the intentional and voluntary attempt by the participant to take his/her own life or any clearly stated verbal expression by the participant of intent to voluntarily take his/her life.
- **Missing person:** 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 and the participant cannot be contacted or located by natural supports.
- **Self-injury:** any suspected or confirmed participant self-inflicted wound or injury requiring medical treatment by a licensed health care provider. The category of major injury is to be used in conjunction with this category.
- **Nonconsensual sexual behavior (offensive sexual behavior or sexual aggression):** any act of the participant physically forcing sexually oriented activities upon another person or engaging in sexually suggestive activities (i.e., touching oneself suggestively, propositioning another sexually, etc.) outside of the privacy of their residence and in an intentional manner without the consent of other individuals.
- **Physical aggressive behavior:** the participant physically attacks another person that results in injury or harm to the other person or danger to others; or the participant willfully destroys property of another person (greater than \$50).

While an ER visit or hospital admission is not required to meet the Major Behavioral Incident definition, any incident that results in an ER visit or hospital admission of the participant as a result of the behavior in question qualifies as reportable as a critical incident.

Major Illness is defined as any substantial change in health status, (suspected or confirmed) which requires medical treatment at one of the following locations:

- Urgent Care Clinic
- Emergency Room
- Acute Care Facility (outpatient procedure or admission)

Note: Any illnesses/conditions that result in treatment at one of the above facilities are reportable critical incidents as "other major illness". The following specific major illnesses are additionally reportable by category as part of OCDD's risk management obligation:

- Bowel Obstruction
- Decubitus
- Pneumonia
- Seizures

Major Injury is defined as any suspected or confirmed wound or injury to a participant of known or unknown origin requiring medical attention by a licensed health care provider at one of the following locations:

- Urgent Care Clinic
- Emergency Room
- Acute Care Facility

Note: If abuse or neglect is suspected, the proper category is either abuse or neglect and the incident should reflect the applicable category.

Major Medication Incident is defined as 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 at one of the following locations:

- Urgent Care Clinic
- Emergency Room
- Acute Care Facility

The following are major medication incidents if they meet the definition as noted above:

- **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, when the participant has self-medication as an approved activity in the Comprehensive Plan of Care
- **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 is defined as the failure by a caregiver responsible for a person'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.

Neglect (child) is defined as 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.

Neglect (adult/elderly) is defined as 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 wellbeing. 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).

Self-neglect (adult/elderly) is defined as the failure by an adult participant'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).

Restraint Use is defined as the application of a physical hold (personal restraints), mechanical device (mechanical restraint), and/or medication (chemical restraint) for the purpose of restricting or suppressing an individual's movement or preventing an individual access to their body. Use of any procedure expressly prohibited by OCDD policy or CMS regulations should be reported to the appropriate APS authority under the abuse category.

The following are actions that may be confused for restraint but are not restraint:

- The use of orthopedic appliances or medical procedures in accordance with standard medical practice in the community
- Approved techniques such as physical guidance, redirection or escorts involving brief hold/physical contact of less than 30 second in which no aggressive resistance is observed
- Transports (physically moving an individual from one place to another) whereby no aggressive resistance is observed and/or the individual does not verbally or nonverbally (e.g. gestures, pulling away, vocalizing dislike when touched) refuse the transport
- Typical activities that are momentary in nature that one would do in a moment of imminent risk for any individual such as blocking someone from entering a street when a vehicle the individual does not see is near and the individual would otherwise come to significant harm.

IV. Health care admissions that result in a critical incident

Health care admission is defined as the admission of a person to an acute care facility, hospital or other health care facility for the purpose of receiving medical care or behavioral stabilization. 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 is defined as a hospital where it is expected that the patient will require treatment by licensed health care providers either as an out-patient (less than 24 hours) or as a patient who stays more than 24 hours. This includes psychiatric hospital stays/admissions.
- Emergency Room (ER) is defined as a hospital emergency room or an urgent care center.

These are not separate categories of incidents but are covered in the categories in the previous section. Every incident/action that results in a visit to an ER or a hospital admission is reportable.

Questions about incident category should be directed to the support coordinator or the LGE if there is confusion about reporting.

V. Roles and Responsibilities in OCDD's Critical Incident Reporting Process

A. Participants of all OCDD waiver services and/or their family members

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

- Keep a copy of the OCDD Critical Incident Reporting operational instruction and paper copies of the critical incident report form available at the participant's home location;
- Understand the definition of a Critical Incident and the HCBS waiver program requirements for reporting them timely to one's residential service provider (if applicable) and support coordinator;
- Understand that all ER visits and hospital admissions are reportable within the critical incident categories and alert your residential provider (if applicable) or support coordinator to any ER visit or hospital admission even if you are unsure of which other category would apply.
- Report critical incidents as soon as possible but no later than 24 hours after the incident to the direct service provider and/or the support coordination agency;
- Provide information about the circumstances and details of the critical incident including but not limited to:
 - hospital, emergency room or urgent care discharge summary/orders
 - medication changes
 - arrest information, court dates, incarceration;
- Participate in all planning meetings convened to resolve critical incidents or to develop strategies to prevent or mitigate the likelihood of similar critical incidents occurring in the future.

B. Direct Service Provider Agencies (DSPA)

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. When there is an allegation of abuse or neglect, the DSPA 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.
 - i. 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.
 - ii. If the abuse, neglect, or exploitation involves a child's family member, immediately verbally report the incident.
 - iii. If the abuse, neglect, exploitation or extortion involves participants ages eighteen to fifty-nine (18-59), immediately report the incident to LDH Adult Protective Services (APS). Do not enter incident into the OCDD Incident Management System.
 - iv. If the abuse, neglect, exploitation, or extortion involves participants ages sixty (60) and above, immediately verbally report.
3. Cooperate with appropriate protective service agency identified above once that agency has been notified and an investigation commences. In addition, the provider is required to provide relevant information, records and access to members of the agency conducting the investigation.
4. Contact the support coordination agency (SCA)/support coordinator (SC) by email 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 24 hours after the discovery of the critical incident.
5. Enter critical incident into the OCDD statewide incident management system (SIMS) [access can be found at [Statewide Incident Management System \(SIMS\) | Department of Health | State of Louisiana \(la.gov\)](#)] as soon as possible upon discovery but no later than 48 hours after the discovery of the critical incident. Provide all applicable descriptive information regarding the incident. Refer to *Section III. Types of Reportable Incidents (Incident Categories)* of this Operational Instruction to obtain and include accurate information about the types of child/adult and elderly abuse reported.
6. 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 and as needed until case closure
7. Continue to follow-up with the direct service provider, the participant and others as necessary, in order to update the case notes in the OCDD statewide incident management system (SIMS) until the incident is resolved and the case is closed.

8. Participate in support team meeting(s) to develop an action plan(s) in response to critical incident(s). Provide documentation of support team meetings(s). Develop and implement strategies recommended by the participant's support team, LGE waiver office, and Critical Incident Review Committee (CIRC) to reduce or eliminate the occurrence of critical incidents for the affected participant in the future.
9. Provide assistance in obtaining information and documentation for review by the LGE, including proactive strategies that have been attempted and the results.
10. Document and review all critical incidents for each individual and consider related previous incidents or trends in any future actions taken. When appropriate, if concerning trends across participants emerge, include actions to reduce critical incidents within the agency Quality Improvement Plan.

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 provider 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. 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 immediately verbally report and forward a copy of the completed DI-IH 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 the OCDD statewide incident management system (SIMS).
 - 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 the OCDD statewide incident management system (SIMS) within twenty-four (24) hours of witness or upon discovery of the incident.
3. Enter critical incident report information into the OCDD statewide incident management system (SIMS) [at the following [Statewide Incident Management System \(SIMS\) | Department of Health | State of Louisiana \(la.gov\)](#)] within 48 hours following the discovery by the support coordinator or in the following circumstances:
 - a. Waiver participant is linked to supports waiver or uses self-direction;
 - b. The incident occurs at a day habilitation or work site;
 - c. Participant is approved for waiver services but is not at this time utilizing services through a licensed direct support provider;
 - d. The direct services provider is unable to enter into the OCDD Statewide Incident Management System (SIMS).

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4. Support Coordination Agencies should review Critical Incidents daily for new Critical Incident Reports or requested follow-up from the LGE Waiver office.
5. 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. At a minimum this must occur in response to each critical incident as described in OI F-8.
6. Revise the participant’s support plan as needed to include actions or services to implement recommended strategies. Assist in linking the participant to needed supports and services.
7. 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 and as needed until case closure.
8. Continue to follow-up with the direct service provider, the participant and others as necessary, in order to update the case notes in the OCDD statewide incident management system (SIMS) until the incident is resolved and the case is closed.
9. Compile documentation as required for critical incidents that require LGE or CIRC review per OI F-8 and response to any recommendations. This information/documentation should be provided to the LGE for submission to the CIRC.
10. Send the participant a copy of the incident participant summary within fifteen (15) days after final supervisory review and closure by the local governing entity. 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.
11. At each quarterly meeting for each participant, review critical incidents for any trends and facilitate discussion with the support team to identify any additional actions or services that need to be implemented.
12. Support coordination agencies and support coordinators are also responsible for meeting the required actions involved in the death of a participant. Upon receipt of the Mortality Review Committee (MRC) checklist and the signed Release of Information Letter from the LGE, SCAs and SCs are to provide the information as required by the Operation Instruction F-1 Mortality Review Process.

D. Responsibilities the Developmental Disabilities Director (DDD) or designee of the Local Governing Entity

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 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. Previous reports concerning the participant's care, safety, and well—being
 - c. If reporting a death, the cause of death, if known, including pre- and post-death diagnoses,
 - d. If reporting an arrest, the reason for the participant's arrest; and the specifics of the incident (i.e., report specifics of who, what, when, where, how).
3. Review and approve extension requests made by staff of the LGE. (Note: Extensions shall not be granted for more than thirty (30) days at a time.)
4. Assure that all mandatory information is entered into the OCDD statewide incident management system (SIMS) prior to case closure.
5. Track critical incidents (or assure designated staff do) to assure that any incidents identified in OI F-8 that require LGE review or CIRC review are identified and requirements of OI F-8 are followed.
6. Close cases after all needed follow-up has occurred and all necessary data has been entered into the OCDD statewide incident management system (SIMS) (Supervisor Review and Closure).
8. Periodically, 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 IDDD/designee is responsible for complying with the Operational Instruction Mortality Review Process if the death of a person covered by the above Operational Instruction occurs within the domain of his/her region or LGE.
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 DDD/designee is responsible for following the Process for Closing APS Cases.

E. Staff Responsibilities of Local Governing Entity (LGE)

The staff of the LGE shall be responsible for completing all the following actions:

1. Continue to follow-up with the support coordination agency and DSPA 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 and DSPA enters all necessary information into the OCDD statewide incident management system (SIMS);
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 DDD/Designee 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 Instructions # F-1, Mortality Review Process and F-8 Critical Incident Review Committee.
8. Comply with the following process for the conversion of a waiver incident to an APS Case. When waiver staff suspect or becomes aware that a waiver incident meets the definition of an APS case, they must report the case immediately to APS.

F. OCDD Central Office Responsibilities

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

1. Notify CIRC chair and OCDD's Executive Management Team upon receipt of e-mail or verbal notification of any incident that involves or may involve a degree of risk/danger such that immediate action from OCDD is required and may (or has) resulted in involvement of the media and/or legal system (not including a single arrest incident which should follow typical reporting and actions). Provide technical assistance to the authorities/districts as needed.
2. 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 the OCDD statewide incident management system (SIMS);
 - Adhering to the Operational Instruction F-1, Mortality Review Process, Operational Instruction F-8, Critical Incident Review Committee and/or other related topics;

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- 3. 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;
- 4. 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 local governing entities;
- 5. Pull aggregate reports of critical incident data and participate on the CIRC;
- 6. 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 and F-8 when specific identified critical incident thresholds are met.

VI. Critical Incident Review Committee and Quality Enhancement

OCDD Central Office has established a CIRC that reviews individual incidents that cross set thresholds as established by OI F-8 and conducts the following quality enhancement activities for all aggregate critical incident data:

- A. 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;
- B. Analysis of data to determine the effectiveness of quality enhancement goals and activities; and
- C. Identification of participants who experience frequent critical incidents and whose support plans will need to include strategies to mitigate risks from future incidents including review within 1 business day of all incidents reported in F-1 above with a follow up report and recommendations to the OCDD Assistant Secretary and EMT as well as the LGE.
- D. Immediate review and recommendations for actions related to any incidents identified in V.F.1. above with a report to the OCDD Executive Management Team and any follow up actions and reporting as needed until the incident is closed satisfactorily.

