Par. 1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 535-05, Personal Care Services . New language is in red and underlined and old language is in red and has been struck through.

Par. 2. **Effective Date** – July 1, 2021

Critical Incident Reporting 535-05-57

Critical Incident

A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of any ~~client~~ individual receiving HCBS.

In order to assure the necessary safeguards are in place to protect the health, safety, welfare of all ~~clients~~ individuals receiving HCBS, all critical incidents (as defined in this chapter) must be reported and reviewed (as described in this chapter). The goal of the incident management system is to proactively respond to incidents and implement actions that reduce the risk of likelihood of future incidents.

This chapter includes all ~~consumers~~ individuals receiving personal care service, including those that receive MSP-PC in a Basic Care setting.

~~A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of any client receiving HCBS.~~

Reportable Incidents

1. Abuse (physical, emotional, sexual), neglect, or exploitation
2. Rights violations through omission or commission, the failure to comply with the rights to which an individual is entitled as established by law, rule, regulation, or policy
3. Serious injury or medical emergency, which requires care that would not be routinely provided by a primary care provider
4. Wandering or elopement
5. Restraint violations

6. Death of any HCBS ~~client~~ individual who has an open case, regardless of where the death occurred or if it was witnessed by the provider. A report of an ~~client~~ individual's death must include and the cause (including death by suicide)

7. Medication errors or omissions

    - Medication errors that occur in a setting other than a basic care facility include all medication errors and omissions

    - Medication errors in a basic care facility are defined to align with the reporting requirements of the Department of Health. A reportable medication error for the purposes of this chapter is defined as "a medication error by facility staff member which results in a negative outcome to a resident or a pattern of medication errors"

8. Any event that has the potential to jeopardize the ~~client's~~ individual's health, safety or security if left uncorrected.
9. Changes in health or behavior that may jeopardize continued services.
10. Illnesses or injuries that resulted from unsafe or unsanitary conditions.

HCBS Case Manager will follow up with all reported critical incidents.

If HCBS Case Manager has first-hand knowledge of a critical incident, follow incident reporting requirements.

Apart from a critical incident that occurs within a basic care facility, if the case involves abuse, neglect or exploitation, a formal VAPS (Vulnerable Adult Protective Services) referral will be initiated according to ND Century Code 50-25.2-03(4). VAPS will be responsible for independent review and follow up.

If the incident involves a provider, the complaint protocol will be followed to determine the next steps, which may include involving law enforcement.

Incident reporting requirements

Any paid provider or paid family member who is with an ~~client~~ individual, involved, witnessed, or responded to an event that is defined as a reportable incident, is required to report the critical incident. If the incident is a death an incident report must be completed even if the death is not witnessed by the paid provider or paid family member.

Note: A General Event Report (GER) in the Therap case management system is the same as a Critical Incident Report (CIR) referenced in this policy.

As soon as a paid provider or paid family member learns of a critical incident involving an ~~client~~ individual, the incident must be:

1. Reported to the HCBS Case Manager and

2. ~~Complete an incident report (SFN 53601 – Risk Management Medical Services Incident Report). Complete and submit a~~ A Critical Incident Report (CIR) must be completed and submitted to the HCBS Case Manager within 24 hours of the incident. The CIR must be submitted using a General Event Report (GER) offline form.

    a. ~~SFN 53601 is found here: https://www.nd.gov/eforms/Doc/sfn53601.pdf~~. The GER offline form can be accessed here: https://help.therapservices.net/app/answers/detail/a_id/2039/related/1#OfflineForms-GER
    b. The GER Event Report along with the GER Event Type form (e.g. medication error, injury, etc.) must be completed and submitted together.

    b. ~~The completed SFN 53601 then to be forwarded to the HCBS Case Manager within 24 hours of the incident.~~

    ~~c.~~ The HCBS Case Manager will forward to Aging Services. The program administrator will then enter the GER Event Report and Event Type into Therap.

Examples

Example 1: If an ~~client~~ individual falls while the QSP is in the room but the ~~client~~ individual didn't sustain injury or require medical attention, a critical incident report is not required.

Example 2: If a family member informs the case manager or the facility that an ~~client~~ individual is in the hospital due to a stroke, a critical incident report is not required because the case manager nor ~~QSP~~ the facility staff witnessed or responded to the event. If the ~~client~~ individual dies while in the hospital an incident report must be submitted if the ~~client's~~ individual's HCBS case is still open.

Example 3: If an employee in the facility ~~QSP~~ comes to an ~~client's~~ individual's ~~home~~ room and the ~~client~~ individual is found on the floor and the ~~QSP~~ staff member calls 911 so the ~~client~~ individual may receive medical attention, a critical incident report is required because the ~~client~~ individual required medical attention AND the ~~QSP~~ staff member responded to the event (fall).

Example 4: If an ~~client~~ individual was not given a dose of digoxin and developed heartbeat irregularity a critical incident report is required because the medication error resulted in a negative outcome.

Department Responsibilities

Within 24 hours or 1 business day of receiving the report from the HCBS case manager, the department will submit a medical case incident report for high level incident reports into the ND Risk Management Incident Reporting system.

The program administrator will also enter GER offline reports into Therap within 24 hours of receiving report or 1 business day.

The department will hold quarterly critical incident team meetings to review all critical incident reports for trends, need for increased training and education, additional services, and to ensure proper protocol has been followed. The team consists of the ND DHS Aging Services Division Director, HCBS program administrator(s), HCBS nurse administrators, Vulnerable Adult Protective Services (VAPS) staff, LTC Ombudsmen, and the DHS risk manager.

The Department of Justice (DOJ) agreement coordinator (Aging Services Division Director) is responsible to ensure that critical incidents are reported as described in the settlement agreement to the DOJ and the subject matter expert (SME) within 7 calendar days of the receipt of the critical incident.

Remediation Plan

A remediation plan is required to be developed and implemented for each incident except for death by natural causes as required by the DOJ and the Aging Services Division. The department will be responsible to monitor and follow up as necessary to assure the remediation plan was implemented.

The remediation plan will include corrective actions taken, a plan of future corrective actions, and a timeline to complete the plan if applicable. The HCBS case manager and program administrator are responsible to follow up with the QSP to ensure the remediation plan is acceptable.