Critical Incident and Mortality Review Process

Money Follows the Person/Pathways to Community Living
Transition Coordinator Training
Federal CMS Requirements

- CMS mandates that all MFP initiatives develop forms & processes to capture the following:
  - Risk identification/inventory, mitigation planning & management
  - 24 hour back-up plans
  - Critical incident reporting, tracking & analysis

- Quality of Life surveys
What is a Critical Incident?

- A serious or traumatic event which causes, or is likely to cause, physical and/or emotional distress, risk or change in health and well-being to the MFP participant.
Why Report Critical Incidents?

✓ To **understand** the causes of critical incidents. What put the participant at risk and resulted in a critical incident

✓ To **prevent** new critical incidents from happening.

✓ To **improve** the care, treatment and services for participants.
What Critical Incidents Must We Report for MFP?

- Nursing Facility Placement
- Suicide Attempt
- Hospital admission, Emergency Department Visit or Psychiatric Hospital admission
- Fire – Accidental, purposeful, started by participant, or started by other
- Unexpected or Suspicious Death - Accidental Death, Suicide, Unusual circumstances, Other Unexpected or Sudden Death
What Critical Incidents Must We Report to MFP?

Sexual or physical assault – alleged victim or alleged perpetrator

Suspected abuse, neglect or exploitation

Alleged fraud or misuse of funds – by participant, provider or both

Behavioral Incident

Missing Person

Other serious injury – burn, cut or puncture wound, serious bruise, fall, medication related

Suspected abuse, neglect or exploitation

Property damage

Criminal Activity

Physical Altercation

Vehicle Accident
Critical Incident Reporting

- TC begins investigation by interviewing all parties involved and reviewing available material.
  - Collect as much information as possible about the incident: who, what, why, when, and how it occurred.
- TC completes Form M in the online WebApp within 2 working days of the incident (or of learning of the incident)
- TC notifies their supervisor that an incident has occurred
  - TC supervisor should complete the internal review portion of the critical incident report.
- TC notifies UIC pod leader that a critical incident has occurred and a critical incident report has been completed and provides their availability for incident teleconference.
Critical Incident Reporting continued

- A conference call is held to discuss the critical incident, findings, and adjustment of the mitigation plan.  
  - To occur within 5 business days of the TC learning of the incident
- TC updates the mitigation plan and other supporting documents (e.g., risk assessment, mitigation strategies, medication chart, 24 hour back-up, personal resource list, post-transition update).
- TC implements and monitors new mitigation plan.
- TC shares new mitigation plan with participant and/or caregiver(s).
- UIC completes external review portion of the critical incident report and provides TC with a written action plan generated from the critical incident conference call.
- UIC will follow-up 30-days post-critical incident review.
Case Study

- Review and discuss the detailed case study handout.

- Summary: 58 year-old Caucasian female, morbidly obese. Institutionalized over 3 years after an accident that resulted in paraplegia. Her primary language is English and she can read and write. History of domestic violence. Little family support. Type 2 Diabetes controlled with oral medication. History of alcohol use, plus current diagnoses of depression, and anxiety. Has bowel and bladder incontinence. Does not adhere to cardiac/diabetic diet. Has multiple cardiac issues including previous myocardial infarction. Has difficulty sleeping. Needs assistance to transfer.
Case Study: Mitigation Plan

Mitigation plan covered the following domains:

- Medical issues: Physical and Mental Health
- Medication Management (pre and post-transition)
- Supplies and Equipment needed
- Community Providers needed
- Caregivers needed
- Safety/Environment issues
- Behavioral issues
- Lifestyle issues
- Self-management needs
Case Study: Critical Incident

The first few days after transition were very busy for the participant. She completed activities that she wasn’t used to such as developing a new daily routine, performing new self-management skills, attending medical appointments, managing personal assistants and generally adjusting to the independence of the community after 3 years in the nursing facility.
Case Study: Critical Incident

- One evening during that first week, she was alone in her apartment, in bed. She began to feel quite dizzy and nauseated. Using her trapeze, she attempted to transfer into her wheelchair to get a snack, thinking her blood sugar was low. She tumbled off the bed and landed sideways in her wheelchair which toppled to the floor. She hurt her wrist trying to break her fall.

- She did not know where her lifeline lanyard was so she scooted crawled to the living room where she called 911. She was unable to reach a snack in the kitchen so by the time the paramedics arrived, she was unconscious from low blood sugar. They had to break down the locked door as no-one was available to unlock the door.

- She was transported to the hospital where she was admitted. She contacted her personal assistant the next morning who in turn contacted you, the TC.
Case Study: Critical Incident

What should the TC do?

- Visit the participant in the hospital to determine the details of the incident and the discharge plan
- Determine what needs to be done to improve the mitigation plan and prevent a similar incident from occurring after discharge
  - Implement these changes immediately.
- Complete an incident report (Form M) and contact UIC to initiate the review process.
Case Study: Critical Incident Questions for Discussion

- What problems did you identify when you learned of the details of the critical incident?
- What would you implement immediately to prevent a similar incident from occurring?
- What will you do to assist the participant to follow hospital discharge instructions?
- What do you anticipate in terms of “Action Plan Recommendations” from UIC?
Case Study: Critical Incident Review

After following the recommended reporting and review process, and discussing the critical incident in a teleconference with the agency’s contact at UIC – an action plan was developed by the group that participated in the teleconference.
Case Study: Critical Incident

Action Plan

- Develop and monitor a task list for PAs including night-time ritual that includes:
  - Checking glucose with PA assistance at bedtime.
  - Having glucose pills or small candies near her bed to avoid having to get out of bed for a snack.
  - Ensuring lanyard is on bedside table.

- Monitor that participant is recording glucose readings on chart at least daily or as recommended by provider.

- Monitor that participant is taking her medications as prescribed.
Case Study: Critical Incident
Action Plan

- Determine hospital discharge plan and assist participant to follow plan.
- Ensure participant follows up with her primary care provider or endocrinologist and reports this incident.
- Determine recommended follow up schedule and new orders/medications. Assist with implementation and monitoring of any new orders.
- Update Mitigation Plan and Medication Chart.
Case Study: Action Plan Documentation

- During the next weeks, the TC implements and monitors the action plan items.

- Within 30 days following the incident, the TC should write a detailed note to document the status of EACH action plan item.

- A 30-day call will be held to discuss the implementation of the action plan and the participant’s current status.
Case Study: Action Plan Follow Up Note

9/4/2012: Action Plan 30-day follow up note

Hospital discharge instructions included follow up with PCP and to take a pain medication for 5 days for sprained wrist. Created task list for morning and evening PA that are posted on the fridge, including recommended night-time ritual. PCP appointment attended with PA. Participant to check/record blood sugar morning and night. PA will assist and TC will monitor at each visit. PCP appointments required monthly and added to calendar. Home health nurse implemented once a week for four weeks for diabetes education and monitoring. Medication chart updated and provided to participant.
Purpose of the Mortality Review

- To identify patterns, themes, or behaviors surrounding this death that could be beneficial to transition coordinators (TC), and others in the management of future MFP/Pathways participants who transition to the community.
Mortality Review Process

- In the event of a participant death, a mortality interview will take place instead of the usual critical incident call.

- When a death occurs:
  - The TC fills out a Critical Incident Report (Form M) and documents the event in the case notes section of the WebApp.
  - The TC notifies the UIC pod lead as soon as possible.
  - The UIC pod lead will send the TC a copy of the mortality interview and a list of requested documents needed to complete the mortality review process. The UIC pod lead will also schedule a time for completion of the interview.
Mortality Review Process

- The TC reviews the mortality interview questions and obtains the documents needed to complete the mortality review process.
  - Hospital records if the death occurred in the hospital (if available or possible);
  - Death certificate and/or cause of death from the hospital;
  - History of service plans, agency assessments, additional notes, DONs, CCCs, etc
- The TC, pod lead, agency supervisor or other representative, and division/department lead participate in the mortality interview.
- The TC completes the disenrollment form only after the process is complete.
In Summary

- Transition coordinators have a vital and complex role in success of transitions.
- Routine follow-up and monitoring is essential.
- Questions? Contact your UIC pod leader and/or refer to the MFP manual and website.
Conclusion

- Questions?