Policy Number: SE4.080	Policy Section: Supports and Services	Effective: April 2007 Amended: June 24, 2009
Title: Critical Incidents	Executive Sponsor: Directors, Regional Operations	

1. PURPOSE

This policy provides information about the prevention, reporting, review and follow-up of critical incidents involving individuals with developmental disabilities receiving CLBC funded services. It outlines the roles and responsibilities of CLBC staff and contracted service providers.

2. DEFINITIONS

Individual: A person 19 years of age or older who is eligible for CLBC services, as described in the CLBC eligibility policy.

Critical Incidents: serious or unusual events that involve an individual receiving services funded by CLBC.

Licensed facility: any facility licensed under the Community Care and Assisted Living Act; subject to investigation by the Medical Health Officer through each regional Health Authority.

PARIS: the CLBC information management system

Unlicensed facility or resources: includes home share resources, community inclusion activities or any other service that operates under contract with CLBC and not licensed under the Community Care and Assisted Living Act.

3. POLICY

The prevention, reporting, review, and follow-up of critical incidents function as an important, formal safeguard designed to help protect the safety, health, well-being and rights of individuals receiving CLBC funded services.

Individuals, families, and support networks are encouraged to develop appropriate personal and community safeguards to prevent critical incidents. CLBC facilitators can assist with the development of safeguards as part of the individual planning process.

Service providers under contract with CLBC to deliver services to individuals are required, as one of the conditions of their contract, to document and report to CLBC Quality Service Analysts details of any critical incidents involving the individuals served.

CLBC Quality Service Analysts have the responsibility for the review, documentation and follow-up of critical incident reports. Ongoing review and analysis of critical incident patterns is an important part of the analyst's contract liaison and monitoring role with service providers.

CLBC works collaboratively with individuals, families, service providers, and other mandated community investigative agencies to ensure conformance with this policy, to continuously improve the quality of services, and to reduce the number and severity of reportable critical incidents.

4. PROCEDURES

4.1 Analysts work with service providers to ensure they understand their contract responsibilities in the prevention of and accurate, prompt reporting of critical incidents. They supply service providers with the CLBC *Critical Incidents: Service Provider Requirements* guidelines.

Prevention and Monitoring of Critical Incidents

4.2 Facilitators work with individuals, families and their support networks to develop safeguards as part of individual support planning to prevent critical incidents.

4.3 Quality Service Analysts, with support from Quality Service Managers, analyse critical incident patterns or re-occurring issues as part of their ongoing monitoring and contract management responsibilities. Periodic reviews are conducted with service providers of all critical incidents to identify trends, causes and recommendations to prevent critical incidents and improve service delivery practices. Analysts can review factors such as time, location, personnel, individuals served, types of incidents, and potential risks. Prevention and monitoring also includes:

- Ensure service providers utilize safe, proactive and positive principles of practice which minimize risks for the individuals they serve. In addition, analysts inform service providers about other related policies such as Behaviour Support and Safety Planning.
- Ensure service providers maintain a system for the review of critical incidents to identify causes and areas for improvement.
- Ensure service providers document unexpected or unusual incidents which are not identified by this policy as reportable, as part of the service provider's internal monitoring

procedures. Analysts will periodically review these records with the service provider. An example of a non-reportable incident which requires documentation by the service provider is a medication error that does not adversely affect an individual and does not require emergency care of the individual by a physician or transfer of the individual to hospital.
- Identify systemic issues or trends that extend beyond single service contractors.

Reporting of Critical Incidents

4.4 All reportable critical incidents must be reported to CLBC by the service provider responsible for the service where the incident occurred. The service provider forwards the critical incident report to the Quality Service Analyst at the office responsible for the service provider's contract. *Appendix One: Critical Incidents Definitions & Categories* outlines incidents reportable to CLBC. Analysts provide service providers with *Appendix One: Critical Incidents Definitions & Categories* and CLBC *Critical Incident Report* forms.

4.5 There are different reporting requirements for licensed and unlicensed facilities. In addition to a report to CLBC, licensed facilities are required by the Community Care and Assisted Living Act to inform the regional health authority's Medical Health Officer of critical incidents that involve individuals receiving service. The *Incident Report for Community Care Facilities* form outline which incidents are reportable to a Medical Health Officer.
- Licensed facilities inform the regional health authority's Medical Health Officer of reportable incidents, utilizing the *Incident Report for Community Care Facilities* form. These forms are provided by the Community Care Licensing office. Every incident that is reportable to the Medical Health Officer must also be reported to CLBC. Service providers forward the completed *Incident Report for Community Care Facilities* form to the Medical Health Officer and submit the "Funded Agency" copy of the form to the CLBC Analyst.
- Licensed facilities must also report critical incidents to CLBC which are not identified by the *Incident Report for Community Care Facilities* form as reportable. A completed CLBC *Critical Incident Report* form is forwarded to the analyst for these incidents.
- Unlicensed homes, home share resources, and community inclusion contracted activities must report critical incidents by forwarding a completed CLBC *Critical Incident Report* form to the analyst.

Review and Follow-up of Critical Incident Reports

4.6 Analysts are responsible for reviewing critical incident reports including assessment of the incident, documentation and follow-up decisions, with support from Quality Service Managers. Assessment of and follow-up planning for each incident should consider the critical incident type, severity, frequency, impact on the individual's health and safety, and the implications for current service provision to the individual.

4.7 Upon receipt of a critical incident report, the analyst must determine urgency of response required. Responses to critical incidents that require immediate action consider incident

severity, safety and risk to the individual and other adults in the resource or program. Prompt contact and consultation with other community investigative agencies (medical health officer, police officer), the Quality Service Manager, and facilitator may be necessary.

4.8 Notification about reportable critical incidents should be made to family and other community investigative agencies as soon as possible. The required timeframe for notification and who should be notified of a critical incident report are categorized by the type of critical incident, as identified in *Appendix 2 - Critical Incidents Notification Chart*.

- Analysts are responsible for notifying all community investigative agencies, the Quality Service Manager, and the facilitator.
- Analysts should confirm that service providers have notified families of individuals involved in critical incidents.

4.9 Reportable critical incident types are divided into events that analysts must **ALWAYS** follow-up and those that **MAY** be followed up, as identified in *Appendix One: Critical Incidents Definitions & Categories*. Follow-up may include visiting a service, program, activity or home and interviewing the individual, staff and others involved. Contact with family members, physicians, and other professionals can be made as appropriate.

4.10 Facilitators, as appropriate, will follow-up with individual, families and their support networks to review and develop new individual support plans and safeguards. They may arrange for other supports when concerns are identified about the service provided, a new approach is needed, or when individuals may need to be moved as a result of a critical incident.

4.11 Documentation in the PARIS system by the analyst includes a scanned copy of the critical incident report, other pertinent formal reports, and a "Critical Incident Note", created in *Notes*, which outlines:

- The reasons provided about how the incident occurred;
- The names of each person involved (the individual, the service provider, other supported individuals in the resource or program at risk);
- What actions have been/will be taken including information about persons to contact;
- Identification of critical incident patterns and/or associated issues; and
- The outcome of the review and any recommendations that resulted from it including actions to prevent further incidents and suggested revisions to service delivery practices.
- Hard copies of the critical incident report and other pertinent formal reports must be placed on the Resource (RE) or Contract (CT) file.
- The Quality Service Manager responds to notifications in PARIS from analysts by reviewing notes and assigning "Critical Incident Review" work assignments.

4.12 Analysts coordinate investigations and, with support from Quality Service Managers, develop collaborative investigative procedures with agencies which have regulatory and investigative mandates such as Community Care Licensing and the local police. Community

Care Licensing leads the investigation of licensed facilities and CLBC staff must ensure that they do not inadvertently interfere with this process.

4.13 Analysts respond in a timely manner to calls from interested parties, e.g. an individual served, family, friends, service provider, advocacy group, the Advocate for Service Quality, Ombudsman, or other outside bodies concerned with safety and risk to the individuals receiving supports.

5. DOCUMENTATION

CLBC Critical Incident Report form
Incident Report for Community Care Facilities form (provided to licensed facilities by Community Care Licensing in each Health Region)

6. PRACTICE

6.1 Critical incident review and monitoring should be conducted within the overall intent of this policy as a safeguard process to protect the safety, well being, and rights of individuals receiving CLBC funded services.

6.2 Critical incident reporting is one component of the review of critical, serious or unusual incidents in conjunction with other linked policies which may require more in-depth follow up. Policies which pertain to abuse and neglect investigations, reporting of deaths, behaviour support planning and other policies or practice guidelines, relating to the incident, may necessitate additional review.

6.3 Timely critical incident reports from service providers, both verbally and in writing, are essential. Analysts should periodically review their liaison responsibilities noting where reporting is not being received or is slow in reaching them and then follow up with those service providers.

6.4 It is important that critical incident reports provide an accurate, complete description of the event(s) so that follow up can be helpful and any revision of the individual's safety plan or supports is based on correct assumptions. Analysts should clarify any incomplete or vague reports and actively question the approach being used if they have concerns.

6.5 Critical incident reports can be an indication that the individual's vulnerabilities/safety needs are not understood, the approach being used needs modification, or the supports are not adequate.

6.6 It is important that there is regular, meaningful consultation with individuals, families, support networks, service providers, other professionals and CLBC staff in situations where critical incident reports are frequent or severe. Staffing problems, training and other identified

follow-up needs can be reviewed. The analyst should ensure consultation leads to timely action by the service provider and involved professionals. If critical incident reports indicate ongoing issues, inadequate follow-up or a pattern of service provision concerns, then the analyst should consult with the Quality Service Manager to determine whether the contract should be continued, modified or terminated.

6.7 Analysts should consider informing MCFD After Hours when recurring critical incidents are of concern (e.g. runaways, aggression in the community, illicit drug use) and may bring an individual to the attention of community response systems. An overview of the situation, behaviour or response plan, and service provider contact information will be helpful.

6.8 When critical incidents continue to occur and the follow-up highlights disagreements on the causes or next steps, analysts may want to request an external review as a useful option to resolve the issues, address specific safeguard measures or suggest new approaches.

6.9 The documentation for each critical incident will vary, however it is important to thoroughly record information that may have an immediate or ongoing impact on an individual's health and safety or planning needs. Information relevant to resource monitoring and contract review should always be recorded.

6.10 When following up on critical incidents and patterns, analysts and service providers must balance the need for information with the need to be respectful of an individual's personal privacy, individual freedom and right to self-determination.

6.11 The review of critical incident reports involves a combination of policy adherence and realistic appraisal of an individual's needs and associated service safeguards. Follow-up planning requires the analyst to balance the "snapshot" nature of a critical incident report, the individual's needs, along with reasonable expectations for service providers.

7. REFERENCES

A Field Guide on Death and Dying
CLBC Adult Guardianship policy and procedures
CLBC Behaviour Support and Safety Planning policy
CLBC Critical Incident Report form
CLBC Critical Incidents: Service Provider Requirements
CLBC Investigations: Abuse and Neglect policy
CLBC Monitoring Guidelines policy
Incident Report for Community Care Facilities form
Responding to Vulnerability – A Discussion Paper about Safeguards & People with Developmental Disabilities

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Appendix One
Critical Incidents Definitions & Categories

The expanded definitions below correspond to the "Type of Incident" check boxes on the *CLBC Critical Incident Report* form. The reportable incident types are divided into events that analysts will **ALWAYS** follow up and those that **MAY** be followed up.

The initials "**CCL**" after a definition denote that this is a reportable event on the *Incident Report for Community Care Facilities* form used by the regional Health Authorities. A copy of each *Incident Report for Community Care Facilities form* is forwarded by the service provider to CLBC as the "Funding Agency".

THE FOLLOWING REPORTABLE CRITICAL INCIDENTS MUST ALWAYS BE REVIEWED AND FOLLOWED UP BY THE QUALITY SERVICE ANALYSTS:

Physical Abuse
Any excessive or inappropriate physical force directed at an individual by a person in a position of trust or authority. It may also include the use of excessive force or aggression by an individual who is not responsible for providing supports or services. (**CCL)**

Sexual Abuse
Any sexual behaviour directed at an individual by a staff member, volunteer or any other person in a position of trust or authority. May also include inappropriate, unsolicited or forced sexual attention from persons connected to an individual but not responsible for their services or supports. **(CCL)**

Emotional Abuse
Any act or lack of action that diminishes an individual's sense of well being, perpetrated by another person in a position of trust or authority. **(CCL)**

Financial Abuse
Abuse or misuse of an individual's funds and assets by a person in a position of trust or authority, e.g. obtaining property and funds without the individual's knowledge and full consent, or in the case of an incompetent person, not in their best interests. **(CCL)**

Neglect
Any deprivation of an individual's requirements for food, shelter, medical attention or supervision, which endangers the safety of the individual. **(CCL)**

Death
Any death of an individual. **(CCL)**

Poisoning
Any ingestion of poison by an individual. **(CCL)**

Suicide Attempt
Any attempt by an individual to take his or her own life. **(CCL)**

Sentinel Event
An unexpected occurrence involving death or serious injury that signals a need for immediate investigation.

Use or Possession of Weapons
A situation in which an individual receiving service has, uses, or threatens to use an object as a weapon. Also a situation in which a weapon is used by others to harm or threaten an individual receiving service. A weapon is any object being used to threaten, hurt or kill a person or destroy property. Weapons may be used to attack, defend, or threaten, and include loaded or unloaded firearms, knives, swords, mace, pepper spray, or their derivatives; and improper use of laser beams.

Use or Possession of Licit or Illicit Drugs
The misuse or overuse of a legal substance for a non-therapeutic or non-medical effect; such as the over-indulgence in and dependence on alcohol or a narcotic drug. Also covers any use of an illicit substance, or the use of a psychotropic drug without appropriate medical authorization.

NOTE: *There is no specific category of incidents for individuals who have had "contact with the law" e.g. stopped by the police, arrested or incarcerated, yet this can be a significant event that has implications for support requirements. Service providers should report with the category that coincides with the "precipitating" reason for the interaction such as possession of drugs, weapons, and aggression or, alternatively, with the "result" such as injury or disruption of service. If unsure about the need to report, the service provider can consult with the analyst.*

THE FOLLOWING TYPES OF REPORTABLE CRITICAL INCIDENTS MUST BE REVIEWED AND MAY REQUIRE FURTHER FOLLOW UP BY QUALITY SERVICE ANALYSTS DEPENDING ON THE SERIOUSNESS AND IMPACT OF THE EVENT:

Aggressive / Unusual Behaviour
Any aggressive or unusual behaviour on the part of an individual towards another person or persons. Each event does not need to be reported when a behaviour problem has been identified, appropriately assessed, a behaviour support – safety plan developed, approved and documented in the individual's support plan. (Also see the *Behaviour Support and Safety Planning* policy.) **(CCL)**

Fall
Any fall where the individual requires emergency care by a physician or transfer to hospital. **(CCL)**

Disease / Parasite Outbreak
Any outbreak of a communicable disease or parasites such as scabies, or any occurrence of a reportable disease in a residence or program. An outbreak is the occurrence of a disease beyond the normally expected incidence level. **(CCL)**

Unexpected Illness
Any unexpected illness of an individual who requires transfer of the individual to the hospital or emergency care by a physician. **(CCL)**

Medication Error
Any mistake in administering medication that adversely affects an individual or requires emergency care of an individual by a physician or transfer of the individual to hospital. **(CCL)**

NOTE: *Although not all medication errors require a report to and an immediate review by an Analyst, the number and type of medication errors made with respect to specific individuals or resources should be reviewed as an element of monitoring standards and contract requirements. (Service providers are also responsible for ensuring that any changes to medication are documented on an individual's health record.)*

Motor Vehicle Accident
Any motor vehicle accident where injuries occur to an individual while in the care or supervision of a service contractor. **(CCL)**

Missing / Wandering Person
Any unscheduled or unexplained absence of an individual from a residence or program, or while in the community under the care or supervision of a service provider. **(CCL)**

Other Injury
Any other injury to an individual that requires emergency transfer to hospital or emergency care by a physician. **(CCL)**

Disruption of Services/Service Delivery Problem
Any service disruption that affects the delivery of services to individuals; e.g., incarceration, planned hospitalization, fire, flood, labour action. **(CCL)**

Use of Restraint
Use of a physical, mechanical, chemical or other means to temporarily subdue or limit the freedom of movement of an individual. Includes containment, which is restraining a person's freedom of movement within a certain area e.g. half door that contains a person within one room; locked exits; or locking seatbelts in a vehicle. Restraint protocols must be part of an approved Behaviour Support – Safety Plan. Each incident must be reported and documented on an individual's file. (Also see the *Behaviour Support and Safety Planning* policy.) **(CCL)**

NOTE: *Where administration of a PRN is built into an individuals Health Care Plan or Protocol, this is not considered a 'chemical restraint' and is, therefore, not reportable as a Critical Incident.*

Use of Seclusion
Separation of an individual from normal participation and inclusion in an involuntary manner. The person is restricted to a segregated area and denied the freedom to leave it. Seclusion is different from containment in that the person is left alone. Each event does not need to be reported when a behaviour problem has been identified, appropriately assessed, and use of seclusion has been built into an approved Behaviour Support – Safety Plan that is documented on the individual's file. (Also see the *Behaviour Support and Safety Planning* policy.)

Use of Exclusionary Time Out
The removal of an individual from a positive reinforcing situation and environment, e.g., confinement in a room apart. It is used as a consequence of behaviour in order to assist an individual in learning more positive and appropriate behaviours. Each event does not need to be reported when a behaviour problem has been identified, appropriately assessed, and time-out has been built into an approved Behaviour Support – Safety Plan that is documented on the individual's file. (Also see the *Behaviour Support and Safety Planning* policy.)

Communicable Disease
Any occurrence of an illness caused by a micro organism (bacteria, virus or fungus, parasite) and transmissible from an infected person or animal to another person or animal. Transmission can be by direct or indirect contact with infected persons or with their excretions (e.g. blood, mucus, semen) in the air, water, food, or on surfaces or equipment. (Refer to *Incident Report for Community Care Facilities* form to determine what is reportable.)

Use of Infection Control
Implementation of policies and procedures to reduce the occurrence and spread of infections, especially in hospitals and health care facilities. (Refer to *Incident Report for Community Care Facilities* form to determine what is reportable.)

Bio hazardous Accident
An accident involving any material that can cause disease in humans or animals, or cause significant environmental or agricultural impact. Bio hazardous material includes viruses, fungi, parasites, and bacteria and their toxic metabolites; as well as blood, other body fluids, and human tissues, cells or cell culture. (Refer to *Incident Report for Community Care Facilities* form to determine what is reportable.)

Appendix Two
Critical Incidents Notification Chart

NATURE OF CRITICAL INCIDENT	WHO SHOULD BE NOTIFIED	TIMEFRAMES AND TYPE OF NOTIFICATION
Incidents involving death or serious injury	Quality Service Analyst notifies: ⇒ Local police (as appropriate) ⇒ Coroner's office (if a death has occurred) ⇒ Medical Health Officer (MHO) in licensed facilities ⇒ Quality Service Manager (QSM) ⇒ Provincial Medical Consultant ⇒ Ensures service provider contacts family ⇒ Facilitator Quality Service Manager notifies Director of Regional Operations Note: In licensed facilities, the Person in Charge is responsible under the CC&AL Act to notify the police, MHO, and Coroner.	Immediate notification by phone to QSM and Provincial Medical Consultant followed by an e-mail report within 48 hours to the Outlook "CLBC Hospitalization and Mortality Notification" distribution list
Reportable Critical Incidents that **require further review** and follow up as defined in the CLBC Critical Incidents policy	Quality Service Analyst notifies the QSM that a review will be conducted. Quality Service Analyst notifies facilitator and ensures service provider has contacted the family.	Response plan is developed within 24 hours of receipt of the report. Notification of plan to QSM is by phone or through PARIS depending on type and severity of incident.
Reportable Critical Incidents that **may require** further action as defined in the CLBC Critical Incidents policy	Quality Service Analyst reviews and responds to the critical incident as necessary, consulting with the QSM if it is determined that further action is required. Quality Service Analyst notifies facilitator and ensures service provider has contacted the family.	Incident is documented in the individual's PARIS file, with notification to the QSM, if further action is required.