TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

Submitting Risk Mitigation and Investigation Reports (RMIRs)

Regulatory Requirements

- Required for incident reports originally classified as critical or reclassified as critical.
- Sometimes completed for non-critical incident reports
  - based on the agency's policies and procedures
  - when requested
- Must meet requirements as specified in each waiver's regulations

Regulatory Requirements (cont'd)

For Michelle P and SCL

- RMIR regulatory requirements are outlined in section 11 of 907 KAR 1:835 and 907 KAR 12:010 :
  - Conduct an **IMMEDIATE** investigation **and involve the participant's case manager in the investigation.**
  - Prepare a report of investigation, which shall be recorded in the MWMA and shall include:
    - **a. Identifying information of the participant involved in the critical incident and the person reporting the critical incident.**
    - **b. Details of the critical incident:** and
    - c. Relevant participant information including:
      - (i) Diagnostic impressions and medical diagnoses based on the current version of the American Psychiatric Association Diagnostic and Statistical Manual of the Mental Disorders;
      - (ii) A listing of recent medical concerns;
      - (iii) **An analysis of causal factors; and**
      - (IV) **Recommendations for preventing future occurrences**

Regulatory Requirements (cont'd)

For ABI and ABI-LTC

- RMIR regulatory requirements are outlined in section 8 of 907 KAR 3:090 and 907 KAR 3:210:
  - Conduct an **IMMEDIATE** investigation and involve the participant's case manager in the investigation.
  - Prepare a report of investigation, which shall be recorded in the MWMA and shall include:
    - **a. Identifying information of the participant involved in the critical incident and the person reporting the critical incident.**
    - **b. Details of the critical incident:** and
    - c. Relevant participant information including:
    - (i) Axis I diagnosis or diagnoses;
    - (ii) Axis II diagnosis or diagnoses;
    - (iii) Axis III diagnosis or diagnoses;
    - (iv) A listing of recent medical concerns;
    - **(v) An analysis of causal factors**; and
    - **(vi) Recommendations for preventing future occurrences**

Regulatory Requirements (cont'd)

For HCB and Model II

- RMIR regulatory requirements are outlined in section 9 of 907 KAR 7:010 and section 7 of 907 KAR 1:595:
  - Conduct an **IMMEDIATE** investigation and involve the participant's case manager in the investigation.
  - Prepare a report of investigation, which shall be recorded in the MWMA and shall include:
    - **a. Identifying information of the participant involved in the critical incident and the person reporting the critical incident.**
    - **b. Details of the critical incident:** and
    - c. Relevant participant information including:
    - (i) A listing of recent medical concerns;
    - **(ii) An analysis of causal factors**; and
    - **(iii) Recommendations for preventing future occurrences**

Provider Actions - Notifications

- **Was everyone notified by required deadlines**?
  - This is where you would indicate late notifications to the CM, guardian, DCBS, and/or the regulating/operating agency (DDID/DMS/DAIL).
  - This is also where you would document if the incident report and/or RMIR was completed late due to a system outage. (i.e.- MWMA down due to maintenance.)
  - If there is an issue with the plan of care, the case manager may have to enter the incident, potentially causing a delay in reporting. This would be indicated here.

Person’s current status??

This is important, as it tells the person’s status at the time of the completion of the RMIR. (i.e.- If the person was taken to the hospital, this section may include information pertaining to the individual’s discharge date or that the individual remains in the hospital.)

Check Boxes in MWMA

- **Why did the incident occur?**
  - Should rarely check “unable to determine.”
- The answers in the checked boxes should agree with the narrative information provided later in the document.

Could the critical incident report have been prevented?

Oftentimes, this question is answered “no,” when most incidents can reasonably be prevented.

Look at the “root cause” to make this determination.

Staff Training?

- Think about this before responding. Could staff training/retraining help?
- If yes, which trainings? Be specific. Ensure you are truly capturing what you are doing here.

How many times has this kind of incident happened in your agency or with another provider, with this waiver participant in the past three months?

- The incident reports submitted can only be viewed by the service provider providing that service. (i.e.- The residential provider is only able to view incidents in MWMA that occurred in the residential setting.)
- The case manager can view incidents for ALL service settings.
- Involve the team to help answer this question, if necessary.

Provide DETAILED Narratives

- **What did you do to keep the waiver participant safe and well, following the incident?** (Take credit for what you did!)
  - Medical care?
  - Change in level of supervision?
  - Suspension of staff if abuse/neglect/exploitation is suspected?
  - Relocate if home is not habitable?
  - Initiate repairs or replace furniture or broken items, if this was deemed the cause of the incident.
  - Police involvement.

Provide DETAILED Narratives continued

- **What are investigating staff's recommendations for preventing future occurrences?**
  - These are the recommendations from the supervisory staff person completing the RMIR.
  - This should not be "N/A." Remember regulation requires the development of strategies to prevent recurrence.

Provide DETAILED Narratives continued

- **What were the waiver participant's guardian, case manager, and family members' recommendations to prevent the incident from reoccurring or concerns regarding the incident?**
  - Discuss the critical incident with these members of the team and capture their feedback.
  - This should never be "N/A." Please document who was contacted, what was discussed, and the outcome.
  - If a team meeting has occurred/has been scheduled, include information about that here.
  - Include recommendations from team members, even if the recommendation was not implemented/pursued at that time.

Provide DETAILED Narratives continued

- **What policies, procedures, or protocols were reviewed in order to prevent recurrence?**
  - These should be reviewed to determine if any agency systems were the causal factors for the incident that occurred. If the incident was the result of a system's failure of the agency, please document this and include the interventions in prevention section.
  - Please be specific. If you indicate a change to a policy is needed, please include what changes were made.

Findings

- After review, what are the agency's findings? (root cause)
- Capture identified causal factors- isolated occurrences are rare. Continue asking why…
- Clearly state what steps will be taken to prevent recurrence.
- Review the actions, abilities, needs or goals of the individual. This may also include a review of environmental circumstances that may had led to the critical incident. A resolution may result in a change to the individual's Peron-Centered Service Plan or a change in needed equipment.

Findings (Continued)

- Review the agency's systems. A resolution may result in additional training, increased staff supervision, termination of staff, increased number of staff or hours, change in staff, or update to policies and procedures. This may include a change in the agency's system(s) across the board, not just in this specific situation.
- Provide detail about current status (medical discharge orders, etc., how the individual is currently feeling). If uploading documents, this is where it would be referenced.
- If uploading information, please also provide a summary of supporting documentation in the narrative section (the system allows you to label all documentation).

Responsibility for Changes

- Who will be responsible for adjustments to policies, procedures, or protocols? (include effective or projected effective date of adjustments.)
- Who will be responsible for monitoring adjustments to policies, procedures, or protocols?

Factors to Consider When Completing an RMIR

- The importance of speaking with staff and/or the person that witnessed the incident, the individual (if applicable), and the individual's peers (if applicable), to get a clear picture of the incident details and provide the best and most beneficial interventions.
- Look at all the events leading up to the incident to see if any events are related.
- Ensure the interventions put into place are person-centered and benefit the individual first and foremost, and not necessarily just the agency.
- Remember MWMA allows a seven (7) day timeframe from the date a report is submitted to complete the RMIR. Do not rush the process if you are waiting for details. For example, if a team meeting is scheduled a day before the RMIR is due, you may wait for that team meeting to occur to include details of the meeting in the RMIR.
- Give yourself credit for what you and your team are doing. If all the information pertaining to the agency's internal investigation is not available by the (7) day deadline of the RMIR, you can indicate that in the RMIR. When the information is available, you can go back and add information to the RMIR as it is received.

Factors to Consider When Completing an RMIR

(continued)

- If the incident pertains to a medical issue, you may want to review all medical protocols (if applicable) and medical information pertaining to the medical diagnosis, leading up to the incident to ensure procedures were followed.
- If the incident pertains to a behavioral event, you may want to review the behavioral tracking information (if applicable) before completing the RMIR.
- The RMIR serves as a helpful tool for the agency to examine their systems to prevent issues from occurring again. It should not be considered punitive!
- You can reference staff (first initial, last name) and peers (initials only) in the RMIR, if that information pertains to the incident and/or RMIR.
- If the incident involves abuse, neglect, and/or exploitation, document if DCBS is investigating the incident and if so, what is their findings at the conclusion of the RMIR (if known).
- If uploading additional documentation in MWMA, documents must be in a PDF format.

Case Study

Sally Johnson is assigned the responsibility of completing the RMIR for the following critical incident report:

Bill and his housemate Tom were returning from a movie on 12/12/2022 at approximately 8:30 p.m. with residential staff, Danny.

Danny was walking in front of Bill and Tom going up the sidewalk to the home, so he could unlock the door. When Danny turned around, he found Bill lying on the sidewalk, face-down with blood coming from his head. Danny runs to Bill and uses his jacket to apply pressure to Bill's head, while advising Tom to call 911 from his cell phone.

The ambulance arrives and transports Bill to the local ER, where a CT scan demonstrated no internal head injuries. Bill received 10 sutures to his forehead and was released home.

Case Study (continued)

- While in the waiting room of the ER, staff Danny contacts his supervisor, Sally Johnson, to make her aware of the incident. Sally made the notifications to Bill's guardian and case manager and completed a critical incident report for Bill in MWMA.
- In the process of completing her internal investigation of this incident, Sally gathered and documented the following details of the incident and information regarding Bill:
  - Incident occurred at 8:30 p.m. on 12/12. Danny did not view the fall, only 'heard' Bill hit the concrete.
  - Bill received sutures in the ER and returned home in the early morning hours of 12/13. Bill is to return to the ER or his Primary Care Physician in one week to have the sutures removed. (per the ER discharge orders).
  - Bill's glasses were broken as a result of the incident and will need to be repaired. Bill's last vision exam was over 2 years ago.
  - Bill was diagnosed with Dementia in late June 2022.
  - This is the first fall Bill has experienced in the 5 years he has resided with this agency.
  - Jennifer, another residential staff, along with staff Danny report Bill has started exhibiting shuffling gait in the last month or so.

Analysis of Causal Factors:

- As a possible sign of progression of Dementia, Bill has started exhibiting shuffling gait that potentially caused Bill to lose his footing and fall.
- It has been over 2 years since Bill's last vision appointment and possible vision issues played a part in the fall.
- Discussed with case manager via email and she had no other suggestions other than discussing Bill's recent fall with his PCP for a possible introduction of a new medication for Dementia and/or a Physical Therapy referral.

Ways to prevent Recurrence:

- Follow up appointment scheduled with PCP on 12/19/2022 to have sutures removed and discuss the possibility of PT referral and progression of Dementia.
- Vision appointment scheduled for 12/16/2022 for exam and new glasses.

After the incident on 12/12/2022:

- Bill went for his follow up appointment with his PCP and an order for PT was received. Bill's PCP advised he did not want to pursue a medication addition for Dementia to Bill's regimen at that time.
- Bill received new glasses and his vision had only slightly regressed from his last exam.
- Bill sustained another fall approximately 2 weeks later, on the same sidewalk of his home returning from an evening concert with his housemate, Tom and staff Jennifer. This occurred approximately at 9:02 p.m. in the evening.

Additional details:

During the internal investigation of the second incident, the following information was gathered:

- Tom, Bill's housemate was interviewed and stated he had "tripped" several times in the same spot Bill had fallen on several occasions.
- Tom reported there used to be a light at the end of the sidewalk that lit the entire sidewalk from the driveway all the way to the house.
- Sally completed a visit to the home and noted a "chip" in the concrete, where both falls had occurred.
- The outside of the home is very dark and the outside light at the end of the walk was in need of repair. Staff were aware of the light needing to be fixed, but failed to mention it, as they believed this was not relevant to Bill's fall.

Causal factors and way to prevent recurrence

Causal factors:

- The “chip” in the concrete of the sidewalk poses a risk of falls and potentially was one of reasons Bill fell on two occasions, approximately 2 weeks apart.
- The outside front entrance of the home is not well lit and the light is in need of repair, which poses an additional risk of falls.

Ways to prevent recurrence:

- Maintenance has fixed the chip in the sidewalk and front entrance light.
- At the next “all” staffing meeting next month, the importance of communicating issues in the home that need repair through a maintenance work order will be discussed.

What did we learn?

- The importance of interviewing all witnesses of the incident if possible, to include peers and the individual.
- The importance of visiting the scene.
- How sometimes even though we complete what we believe to be thorough internal investigations, it may take several incidents to occur to actually make a determination that will ‘stick.’
- If an individual is having a pattern of incidents, always look at your past internal investigations to what you could do differently.

Example #1 – Behavioral Event

- **Causal factor**: Direct Support Staff did not follow preventative strategies in the positive behavior support plan.
- **Strategy to prevent recurrence**: Staff re-training on the preventative strategies

Example #2 – Behavioral Event

- **Causal factor:** Housemates do not get along/no longer want to live together.
- **Strategy to prevent recurrence:** Support one or both housemate(s) in seeking a move that includes compatibility.

Example #3 – Choking Event

- **Causal factor:** Unclear, as no prior choking episodes, no specialized diet texture.
- **Strategy to prevent recurrence:** Medical evaluation/discuss possibility of a swallow study with primary care physician

Example #4 – Aspiration Event

- **Causal factor:** Individual has a prescribed diet of pureed food with honey-thickened liquids. Experienced aspiration after having a milkshake. Ice cream/milkshakes are not a part of this prescribed diet.
- **Strategy to prevent recurrence:** Re-training of staff on diet texture/honey thickened liquids. Place dietary reminder guide in both residential and day program site books with MARs.

Example #5 – Fall with Injury

- **Causal factor:** Individual was wearing shoes that were "worn" and in need of replacement at the time of the event. In addition, it was determined that the sidewalk was chipped and in need of repair.
- **Strategy to prevent recurrence:** Purchased a new pair of shoes for individual and made needed repairs to the sidewalk.

Example #6 – Fall with Injury

- **Causal factor:** Individual became dizzy and lost balance.
- **Strategy to prevent recurrence:** Medical evaluation with primary care physician to rule out medical concerns.

Example #7 – Potential Exploitation

- **Causal factor:** Agency's policy for residential monitoring did not include a process for monitoring individual funds.
- **Strategy to prevent recurrence:** Revisions to residential monitoring policy, dismissal of direct support staff D. Smith, and a meeting with all direct support staff about ensuring accuracy with individual funds and reporting discrepancies.

Helpful Links

MWMA FAQ
https://chfs.ky.gov/agencies/dms/dca/Documents/mwmaupdates20FAQ.pdf

Incident Report Instructional Guide
https://chfs.ky.gov/agencies/dms/dca/Documents/irinstructionalguide.pdf

TRIS training materials: Incident Management Tasks, Incident Management Overview, and incident Management Workflow https://tris.eku.edu/MWMA/default.aspx

Regulations

- ABI 907 KAR 3:090
- ABI-LTC 907 KAR 3:210
- HCB 907 KAR 7:010
- Michelle P 907 KAR 1:835
- Model II 907 KAR 1:595
- SCL 907 KAR 12:010