

CENTRAL FAIRFAX SERVICES, INC.

(A part of Service Source Network)

SUMMARY OF CRITICAL INCIDENT REPORTS INVOLVING INDIVIDUALS SUPPORTED BY CFS FISCAL YEAR 2010 (07/01/09-06/30/10)

For the purposes of this report, critical incidents are defined as any event that occurs within the jurisdiction of CFS and results in one or more of the following:

- Death
- Emergency Care
- Fall
- Injury with Unknown Causes Requiring Medical Treatment
- Medication Error
- Report to Adult Protective Services
- Use of Restraints
- Vehicle Accident with Injuries

Deaths: During this reporting period, no deaths occurred within the jurisdiction of CFS.

Emergency Care: There were 27 incidents of individuals requiring emergency medical care, of which 25 incidents required activating the Emergency Medical System (911) and two required transporting individuals to urgent care. Out of the 25 incidents when CFS called 911, 19 were due to continuous seizure activity involving eight individuals, two were due to troubled breathing and abdominal/back pain involving same individual (this was followed with hospital stay and ultimately a discharge from CFS due to increased risk of cardiac arrest), two for falls involving two individuals, one for vomiting and irregular vital signs, and one for cyanosis. CFS nurses and/or other staff monitored and accompanied the individuals to the emergency room until they were joined by their primary caregiver. Two individuals were taken to urgent care; one because the individual was complaining of pain in the foot, later diagnosed as a fracture; and the other exhibiting excessive coughing and wheezing, later diagnosed with bronchitis.

Falls: There were 57 incidents of reported falls, most of which resulted in minor or no injuries. This is a reduction of 27% from last year (78). Seven of these 57 incidents were related to seizures. EMS was activated four times when individuals required additional medical treatment or monitoring in the emergency room. Six individuals had incidents of multiple falls (three or more) due to health/medical related reasons (i.e., syncope, seizure). Follow-up actions taken by CFS staff and therapists included adding, changing or modifying medical equipments (helmet, wheelchair, walker, and gait-belt); staff re-training in wheelchair transfers and Arjo-lift use; individual staff training in safe mobility and falls prevention protocols. Additional training occurred with an ARJO representative on May 24, 2010, regarding safety checks of slings prior to each use. The slings with the older clips were replaced for safer transfers, as per manufacturer's instruction.

Injuries with Unknown Causes: A total of 84 injuries with unknown causes were reported. Three of those incidents were reported to APS due to continued unexplained injuries, severity of the injuries, and/or injuries that were not consistent with the

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individual's self-injurious behavior. Most of the injuries were minor, requiring either first aid by CFS staff or no treatment. Nine of these incidents resulted in CFS nurses recommending further follow-up with medical attention. When injuries are reported, a review of the incident is conducted that includes assessment as to the possibility of self injury or the need for staff training or environmental modification to reduce the likelihood of such an event occurring in the future. Recommendations by the behavior analyst, nurse, and/or other clinical staff are carried out to enhance individual safety.

Medication Errors: Of a total of 24,135 daily medication administrations during the last fiscal year, a total of seven errors occurred. CFS was responsible for the two of the seven errors; in one case the individual refused to take the medication and in the other, a CFS nurse forgot to administer a PRN medication. The other five were due to improper actions by residential caregivers for reasons including medications not provided, CFS not being informed of prescriptions being discontinued, and late notification of changes in dosage or time of administration. None of the medication errors resulted in adverse reactions. All errors were documented and reported to primary caregivers and health care personnel as required.

Reports to Adult Protective Services: A total of 13 reports involving 13 individuals for allegations of abuse, neglect, exploitation, or consumer to consumer altercations were made by CFS. Three of the alleged incidents occurred at CFS of which two were investigated and one, involving a consumer to consumer altercation, was not investigated by APS. Of the two that were investigated, one was resolved with the individual no longer needing protective services due to the staff disciplinary action taken by CFS. The other incident was resolved by revising individual support plans, providing follow-up training, relocating involved staff, and following up on a Licensure compliance report. Ten reports involving 10 other individuals were made by CFS regarding alleged incidents that involved residential caregiver or family of the persons served, of which only 8 were investigated. All of the incidents mentioned above were also reported to the local and regional human rights advocates and the Virginia Department of Behavior Health and Developmental Services Licensure Specialist. Additionally, CFS submitted human rights reports involving incidents that occurred within the purview of CFS to the Human Rights Advocate.

Use of Restraints: CFS does not use seclusion. Mechanical restraints are mostly used for protective purposes. Two mechanical restraints are currently being used for behavioral purposes on a regular basis. Implementation of these restraints prevented one individual (back pack) from running out in the community, into the traffic; and the other from smearing himself and others with feces (body suit). Supporting data were presented to the local Human Rights Committee (LHRC) and the Behavior Management Committee (BMC) for approval; both the mechanical restraints were approved for regular use. Physical restraints, as defined by the Fairfax-Falls Church Community Services Board Behavior Management Committee, were used 61 times to prevent incidents of self-injurious behaviors, aggression to others, property destruction, or dangerous non-compliance. Of these, 28 incidents were related to one individual who has been diagnosed with dementia. The physical restraint for this aforementioned individual was approved by the BMC and LHRC and was applied to manage health and personal care of this individual due to progression of that disease.

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Last year the total number of physical restraints was 61, of which 22 were dementia related restraints involving two individuals. If dementia related incidents are taken out of the total incidents for both years, it will be found that a 15% reduction occurred in using physical restraints to manage behavior.

All restraints were reported to the designated Community Services Board, Intermediate Care Facilities, and Local Human Rights Committee. Proper techniques were used in most instances by trained staff to prevent injuries to the individual and/or others. Any staff using less than proper techniques for physical restraints was retrained. No injuries to consumers or staff were caused by using these restrictive procedures.

Staff training on the individual behavior plans and monitoring of the implementation of the behavior plans by the behavior analyst is ongoing.

Vehicle Accidents with Injuries: During this reporting period, no vehicular accident occurred involving individuals supported by CFS.

Questions or comments regarding this report may be addressed to Sutapa Ghosh, Quality Assurance Manager, at sghosh@ourpeoplework.org or 703-354-0900.

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