APS Healthcare

WV Traumatic Brain Injury (TBI) Waiver Program
effective February 1, 2012

Incident Reporting

During this time of transition, TBI Waiver Providers will not be issued a user account for the West Virginia Incident Management System (WVIMS). Until a user account is issued, TBI Waiver Providers are to use the following procedure.

The Incident Report form at the end of this document is to be completed by the provider agency when a simple or critical incident occurs or if there is evidence/suspicion of abuse, neglect, or exploitation. All incidents must be documented and tracked by the provider in order to identify trends and the need to improve/amend provider policies and procedures if necessary.

Please see Chapter 512: Traumatic Brain Injury Waiver Services Manual Section 512.7 for classifications of incidents involving members.

APS Healthcare, Inc. must receive the attached Incident Report for any incident involving a TBI Waiver member within **24** hours of the provider learning of the incident. Incident Reports are accepted by secure fax only to APS Healthcare, Inc. Fax number is**: 866-607-9903.**

The Provider Agency Director or Case Manager will immediately review each incident report. All critical Incidents must be investigated.

All incidents involving abuse, neglect and/or exploitation must be reported to Adult Protective Services, and the fact that the report has been made must be documented on the Incident Report form. The provider must also investigate allegations of abuse, neglect, and exploitation.

A follow-up Incident Report documenting the outcomes of the investigation must be completed and faxed to APS Healthcare, Inc. within **14** calendar days of the incident.

Incident Reports are accepted by secure fax only to APS Healthcare, Inc. Fax number is**: 866-607-9903.**

Instructions for Completing a WV TBI Waiver Program Incident Report

Section I: Member Information: to be completed by the person reporting the incident.

Section II: Description of Incident: to be completed and signed by the person reporting the incident. This should be a factual account of the incident. The incident must be reported to supervisory staff.

Section III: Incident Information: to be completed and signed by the agency personnel who immediately reviews each Incident Report Form and determines if the Incident is Simple, Critical, or Alleged Abuse, Neglect or Exploitation. The agency personnel will check all areas that apply under "Alleged Incident(s)".

Section IV: Incident Follow-Up: to be completed by Investigator who is assigned by the Agency Director/Administrator; must be signed by Investigator and Director/Administrator. A detailed description of the incident investigation must be documented with findings and conclusions; note all persons interviewed. Indicate which agencies/individuals were informed of the incident. Describe follow-up actions taken and any systemic action within the agency taken. Indicate any staff training that might be helpful in preventing further incidents, any recommendations for additional support of the TBI member, and any recommended modifications to the member's Service Plan.

Section V: Death: to be completed and signed by agency personnel when a member has died. If certain information is unknown, make a notation in the appropriate space.

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Incident Date: ____/____/_____
Time: _____am/pm

***SECTION I* – Member Information (completed by person reporting incident)**			
LAST:	FIRST:		
ADDRESS:	CITY:	STATE:	ZIP:
COUNTY:	DOB:	GENDER ☐ M ☐ F	

***SECTION II* – Description of Incident (completed & signed by person reporting incident)**

Describe in detail the reportable incident including other persons involved. Attach additional page(s) if necessary.

When was the Immediate Supervisor Notified? Date: _____/_____/_____ Time: _____

Supervisor's Name: _____

Signature of Person Reporting Incident: _____ Date: _____/_____/_____

***SECTION III* – Incident Information (completed by Designated Agency Personnel)**

INCIDENT TYPE: ☐ SIMPLE ☐ CRITICAL ☐ ALLEGED ABUSE, NEGLECT, EXPLOITATION

ALLEGED INCIDENTS(S) Check all that apply:				
ABUSE:	**☐ PHYSICAL**	**☐ SEXUAL**	**☐ VERBAL**	**☐ EMOTIONAL**
NEGLECT:	**☐ NUTRITIONAL**	**☐ MEDICAL**	**☐ SELF**	**☐ ENVIRONMENT**
EXPLOITATION	**☐ FINANCIAL**	**☐ THEFT**	**☐ DESTRUCTION OF PROPERTY**	
ACCIDENT/INJURY:	**☐ (REGUIRING TREATMENT BEYOND FIRST AID)**			
DEATH (Complete page 3)	**☐ ANTICIPATED**	**☐ UNANTICIPATED**	**☐ DATE DEATH _____**	
TREATMENT ERROR:	**☐ MEDICATION**	**☐ OTHER (DESCRIBE): _____**		
OTHER:	**☐ MISSING PERSON**	**☐ ABANDONMENT**	**☐ RIGHTS VIOLATION**	**☐ OTHER (DESCRIBE):**

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SECTION IV – Incident Follow-up (completed by Investigator; signed by Investigator & Agency Director/Administrator)

Member's Name (as reported in Section I): _____

Provide a detailed description of incident investigation. Attach additional page(s) if necessary.

_____ _____ _____
Signature Of Investigator **Title** **Date**

INDICATE WHICH OF THE FOLLOWING AGENCIES AND/OR INDIVIDUALS HAVE BEEN INFORMED

Legal Guardian?	**☐ YES ☐ NO**	**NAME: _____**	**DATE: _____**
Personal Attendant?	**☐ YES ☐ NO**	**NAME: _____**	**DATE: _____**
Case Manager?	**☐ YES ☐ NO**	**NAME: _____**	**DATE: _____**
Doctor?	**☐ YES ☐ NO**	**NAME: _____**	**DATE: _____**
Adult Protective Services/Child Protective Services	**☐ YES ☐ NO**	**NAME: _____**	**DATE: _____**
Coroner?	**☐ YES ☐ NO**	**NAME: _____**	**DATE: _____**
Police?	**☐ YES ☐ NO**	**NAME: _____**	**DATE: _____**

OTHER PROVIDER ☐ YES ☐ NO

If Yes, Note Below:

Describe follow-up actions taken and any systemic actions within the agency being taken to assure health and safety. Attach additional page(s) if necessary.

_____ _____
Signature of Agency Director/Administrator **Date**

_____ _____ _____
Signature of Investigator **Title** **Date**

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SECTION V – Death (completed & signed by agency personnel)

If incident is regarding the death of the member, please include the following information:

Member Information as Reported in Section I.

Member's Name _____

Incident Date: _____/_____/_____ Incident Time: _____

1. Date of Death: Time of Death:

2. Place of Death:

☐ HOME
☐ HOSPITAL
☐ OTHER SETTING (PLEASE EXPLAIN/DESCRIBE):

3. Describe all life-saving measures, if any were applicable, that were attempted at the time of death (i.e., CPR administered, 911 called, transport to hospital, etc.), if known:

4. Circumstance immediately preceding the death, if known:

5. If no life-saving measures were taken, please explain why not (i.e., was there a no-code status, do not resuscitate (DNR) or, etc.). if known:

_____ _____ _____
Signature Title Date