

WV Traumatic Brain Injury (TBI) Waiver Program
Incident Management Reporting Requirements – Personal Options

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.

For *Personal Options*, the Resource Consultant must report any incidents to APS Healthcare as well as notify the Case Manager, using the Incident Report form at the end of this document, within **the next business day** of learning of the incident. All incidents involving abuse, neglect and/or exploitation must be reported to Adult Protective Services or Child Protective Services, but also must be reported to APS Healthcare. If the Case Manager becomes aware of an incident before the Resource Consultant the Case Manger must report the incident to the Resource Consultant. APS Healthcare reviews each incident, investigates and reports the outcomes of the investigation within 14 calendar days of the incident.

Please see Chapter 512: Traumatic Brain Injury Waiver Services Manual Section 512.4 for classifications of incidents involving a program participant.

At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, APS Healthcare shall immediately notify Adult Protective Services per WV Code §9-6-9 or Child Protective Services per WV Code §49-6A-2.

Section I: Program Participant 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: This is to be completed by APS. 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 taken. Indicate any staff training that might be helpful in preventing further incidents, any recommendations for additional support of the program participant, and any recommended modifications to the program participant’s Service Plan.

Section V: Death: to be completed and signed by Resource Consultant when a program participant has died. If certain information is unknown, make a notation in the appropriate space. The Resource Consultant must also complete the TBIW Mortality Notification form and submit to APS Healthcare.

West Virginia Medicaid Traumatic Brain Injury Waiver Program

INCIDENT REPORT

Confidential

Page 1

Incident Date: ___/___/_____

Time: _____am/pm

SECTION I – Program Participant Information (completed by person reporting incident)

LAST: _____ FIRST: _____ MIDDLE INITIAL: _____

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 Resource Consultant Notified? Date: ___/___/_____ Time: _____

Resource Consultant’s Name: _____

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

SECTION III – Incident Information

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

ALLEGED INCIDENTS(S) Check all that apply:

ABUSE, NEGLECT, OR EXPLOITATION

ABUSE:	<input type="checkbox"/> PHYSICAL	<input type="checkbox"/> SEXUAL	<input type="checkbox"/> VERBAL	<input type="checkbox"/> EMOTIONAL	<input type="checkbox"/> OTHER:
NEGLECT:	<input type="checkbox"/> NUTRITIONAL	<input type="checkbox"/> MEDICAL	<input type="checkbox"/> SELF	<input type="checkbox"/> ENVIRONMENT	<input type="checkbox"/> FAILURE OF TBIW STAFF**
EXPLOITATION:	<input type="checkbox"/> FINANCIAL	<input type="checkbox"/> THEFT	<input type="checkbox"/> DESTRUCTION OF PROPERTY	<input type="checkbox"/> OTHER:	

CRITICAL INCIDENTS

<input type="checkbox"/> ATTEMPTED SUICIDE, SUICIDAL THREAT/GESTURES	<input type="checkbox"/> CRIMINAL ACTIVITY	<input type="checkbox"/> UNUSUAL EVENT REQUIRING MEDICAL INTERVENTION	<input type="checkbox"/> SIGNIFICANT INTERRUPTION OF MAJOR UTILITY	<input type="checkbox"/> ENVIRONMENTAL/ STRUCTURAL PROBLEM
<input type="checkbox"/> FIRE IN HOME	<input type="checkbox"/> UNSAFE PHYSICAL ENVIRONMENT	<input type="checkbox"/> DISRUPTION OF DELIVERY OF TBIW SERVICES w/o COMPROMISE TO HEALTH/SAFETY	<input type="checkbox"/> MEDICATION ERROR	<input type="checkbox"/> DISRUPTION OF PLANNED SERVICES THAT COMPROMISES HEALTH/SAFETY
<input type="checkbox"/> FAILURE OF TBIW STAFF**		<input type="checkbox"/> OTHER		

SIMPLE INCIDENTS

<input type="checkbox"/> FALL OR OTHER INCIDENT NOT REQUIRING FIRST AID OR MEDICAL TREATMENT	<input type="checkbox"/> MINOR INJURIES OF UNKNOWN ORIGIN WITH NO DETECTABLE PATTERN	<input type="checkbox"/> DIETARY ERRORS WITH MINIMAL OR NO NEGATIVE OUTCOME	<input type="checkbox"/> OTHER:
--	--	---	---------------------------------

* Refer to 512.4 Incident Management for a description of incident types

**A report to the local DHHR office by phone and written is required

West Virginia Medicaid Traumatic Brain Injury Waiver Program

INCIDENT REPORT

Confidential

Page 2

SECTION IV – Incident Follow-up (completed by APS HEALTHCARE, INC.)

Program Participant’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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME: _____	DATE: _____	OTHER PROVIDER <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, Note Below:
Personal Attendant?	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME: _____	DATE: _____	
Case Manager?	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME: _____	DATE: _____	
Doctor?	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME: _____	DATE: _____	
Adult Protective Services/Child Protective Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME: _____	DATE: _____	
Coroner?	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME: _____	DATE: _____	
Police?	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME: _____	DATE: _____	

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 Investigator Title Date

West Virginia Medicaid Traumatic Brain Injury Waiver Program
INCIDENT REPORT
Confidential
Page 3

SECTION V – Death (completed & signed by Resource Consultant) Must also complete the Mortality Notification Form

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

Program Participant'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 know:

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