WV Traumatic Brain Injury (TBI) Waiver Program

Incident Management Reporting Requirements

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 (TBIW) Manual Section 512.4 for classifications of incidents involving a program participant.

KEPRO must receive the attached Incident Report for any incident involving a person on the TBI Waiver within **the next business day** learning of the incident. Incident Reports are accepted by secure fax only to KEPRO. 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 or Child Protective Services and to KEPRO 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 KEPRO within **14** calendar days of learning the incident.

Instructions for Completing a WV TBI Waiver Program Incident Report

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: 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 program participant, and any recommended modifications to the program participant's Service Plan.

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

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Page 1 Incident Date: ____/____/_____
Time: _____am/pm

***SECTION I* – Program Participant 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, NEGLECT, OR EXPLOITATION

ABUSE:	☐ PHYSICAL	☐ SEXUAL	☐ VERBAL	☐ EMOTIONAL	☐ OTHER:
NEGLECT:	☐ NUTRITIONAL	☐ MEDICAL	☐ SELF	☐ ENVIRONMENT	☐ FAILURE OF TBIW STAFF**
EXPLOITATION:	☐ FINANCIAL	☐ THEFT	☐ DESTRUCTION OF PROPERTY		☐ OTHER:

CRITICAL INCIDENTS

☐ ATTEMPTED SUICIDE, SUICIDAL THREAT/GESTURES	☐ CRIMINAL ACTIVITY	☐ UNUSUAL EVENT REQUIRING MEDICAL INTERVENTION	☐ SIGNIFICANT INTERRUPTION OF MAJOR UTILITY	☐ ENVIRONMENTAL/ STRUCTURAL PROBLEM
☐ FIRE IN HOME	☐ UNSAFE PHYSICAL ENVIRONMENT	☐ DISRUPTION OF DELIVERY OF TBIW SERVICES **W/O** COMPROMISE TO HEALTH/SAFETY	☐ MEDICATION ERROR	☐ DISRUPTION OF PLANNED SERVICES THAT COMPROMISES HEALTH/SAFETY
☐ FAILURE OF TBIW STAFF**		☐ OTHER		

SIMPLE INCIDENTS

☐ FALL OR OTHER INCIDENT NOT REQUIRING FIRST AID OR MEDICAL TREATMENT	☐ MINOR INJURIES OF UNKNOWN ORIGIN WITH NO DETECTABLE PATTERN	☐ DIETARY ERRORS WITH MINIMAL OR NO NEGATIVE OUTCOME	☐ 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

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

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?	☐ 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) Must also complete Mortality Notification Form

If incident is regarding the death of a 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 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