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 KEPRO 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 KEPRO. If the Case Manager becomes aware of an incident before the Resource Consultant the Case Manger must report the incident to the Resource Consultant. KEPRO 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, KEPRO 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 KEPRO. 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 KEPRO.

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

***SECTION I* – Member 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:	☐ 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 KEPRO)

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 Investigator **Title** **Date**

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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