Print Form

CRITICAL INCIDENT REPORT

(CAP/DA, CAP/Choice, CAP/DA/MFP, CAP/Choice/MFP)

CONFIDENTIAL

Instructions: Complete and submit this form to the Division of Medical Assistance, CAP/DA Unit (fax *(919) 715-0052*) within 5 business days of learning of the incident or after hospital discharge. If requested information is unavailable, provide an explanation on the form and report the additional information as soon as possible. **Please complete all pages.**

Recipient Information

Recipient's Name _____ Recipient's MID _____

Recipient's Age _____ Recipient's County Name _____

Recipient's Gender ☐ Male ☐ Female Recipient's Ethnicity _____ _____

Recipient's Primary Diagnosis (name, not number) _____

***Check*:** ☐ CAP/DA ☐ CAP/Choice ☐ CAP/DA/MFP ☐ CAP/Choice/MFP

Incident Information

Date of Incident (if known) _____ Date you became aware of incident ____

Location of Incident _____

Individual/Staff Involved: _____

Was the recipient under the direct care of a CAP/DA Waiver Service at the time of the incident?
☐ Yes ☐ No

- If **yes**: Was incident due to staff's error? ☐ Yes ☐ No
- If **yes**: Did the personnel respond appropriately to the incident? ☐ Yes ☐ No

TYPE OF INCIDENT

Check all that apply.

☐ Death, (see"**Notification of Death**" section on last page)

☐ Missing Person _____

☐ Use of Restraint or Seclusion _____

☐ Theft(s) _____

☐ Injury, due to _____ _____, that required a change in the plan of care.

☐ Abuse, Neglect, or Exploitation (Incident MUST BE REPORTED to Department of Social Service APS)

☐ Admitted to facility. Choose type: _____ _____

☐ Health, Safety and Well-being cannot be met due to: ____

☐ Medication Error, due to _____ _____ that threatened the patient's health or safety. (even if the error was made by the recipient or family).

☐ Hospitalization _____ _____
Date of Discharge_____

☐ Other, please specify _____

Note: Incident reports are confidential quality assurance documents.. Do not file incident reports in the Recipient's service record. Confidentiality of recipient information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR, parts 160 and 164

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INCIDENT DESCRIPTION

***Describe what happened, in detail, including any events leading up to or resulting from it**. Attach additional pages if needed.* _____

RECIPIENT'S RESPONSE

Describe how the CAP/DA – CAP/Choice Recipient Responded to the incident: _____

Information (Continued)

ACTION TAKEN / PREVENTION / DISPOSITION

Describe how this type of incident may be prevented in the future and any corrective measures that have been or will be put in place as a result of this incident *Check all that apply. Attach additional pages if needed.*

☐Caregiver/staff teaching/training ☐Change in hours ☐New FL-2 revision
☐Change in medication regimen ☐Change in level of in-home staff ☐POC
☐Change in treatment regimen ☐Referral to other services/supports ☐CIS Assessment
☐Infection control measures ☐Termination
☐Admitted to a facility as a result of abuse/neglect or exploitation.
☐Other, _____

***Please describe the change and the specific Disposition of the Incident*:** _____

NOTIFICATIONS/REPORTED TO

Indicate authorities or persons incident was reported to (as applicable).

☐CAP-DA Case Manager /Care Advisor
Name _____ Contact Info _____

☐Home Health/Home Care Agency
Name _____ Contact Info _____

☐Physician
* must be notified for medication errors
Name _____ Contact Info _____

☐Law enforcement

☐EMS

☐Adult Protective Services
* must be notified for alleged or actual abuse, neglect, or exploitation
Name _____ Date Of Report _____
Type of Report_____ _____

Did DSS accept the referral? ☐ Yes ☐ No

☐DMA HCC Section
Name _____ Contact Info _____

☐DHSR – Home Care complaints
Name _____ Contact Info **-800-624-3004**

☐Board of Nursing
Name _____ Contact Info **919 782 3211**

☐Program Integrity
Home Care Section:**919 647 8000**

☐Health Care Personnel Registry
Name _____ Contact Info **919 855 3968**

☐Other, _____
Name _____ Contact Info _____

Name _____ Contact Info _____

Were the appropriate persons or agencies notified? ☐ Yes ☐ No

Comments: _____

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	REPORTED BY
Reporting Information	Name/title of person documenting incident _____ Name of the person or entity that reported the incident to the Lead Agency: _____ Local Lead Agency _____ County _____ Signature _____ Date _____
	CONSULTANT'S SECTION
	Name of Consultant reviewing incident _____ Date Consultant Received Report _____
	STATE'S REMEDIATION/FOLLOW-UP PLAN
Explanation: _____ Signature _____ Date: _____	

NOTIFICATION OF DEATH

Does Recipient have Guardian? ☐ Yes ☐No

Does Recipient have P.O.A.? ☐Yes ☐No If yes what type? ☐ Health ☐Financial

Date Consent was obtained: _____

Information on Death:

Date of death: _____

Date notified of death _____

Date of this report:_____ (5 business days of learning of the incident)

Death: due to _____ _____

Location of Death:☐ Home ☐ Assisted Living ☐ Hospital ☐ Nursing Facility ☐ Other:_____

Risks Present last 6 months: ☐ None
☐ Health/Welfare ☐Behavior ☐Frailty ☐Substance use/abuse
☐Smoking ☐Obesity ☐ Infectious disease ☐Other:_____

Number of Falls in the last 6 months:_____

Injuries from Falls in the last 6 months: ☐ None ☐ Hit Head ☐ Concussion

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☐ Skin Tear ☐Fracture/Site: _____ ☐_ Bruising ☐ Hematoma

☐Abrasion/Contusion ☐Other: _____

Medical Services Receiving at Death**:** ☐ None

☐ HHC Agency: _____ Start Date: _____ DC Date: _____

☐ Hospice Agency:_____ Start Date:_____ DC Date: _____

☐ PT ☐ OT ☐ SLP ☐ Dialysis ☐ Behavior Health

Describe client's activities 24 hours prior to death (NA when in NF/hospital)_____

Hospitalizations in the past 6 months:

Date in and Out	Reason

Medications: Include prescription and non-prescription usage.

Medication/Dosage/Frequency		**Medication/Dosage/Frequency**

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