Print Form

North Carolina Department of Health and Human Services – Division of Medical Assistance

CONFIDENTIAL **CRITICAL INCIDENT REPORT** *CONFIDENTIAL*

COMMUNITY ALTERNATIVES PROGRAM FOR CHILDREN (CAP-C)

Instructions: Complete and submit this form to the Division of Medical Assistance, Home Care Initiatives Unit (fax (919) 715-9025) within 5 business days of learning of the incident. If requested information is unavailable, provide an explanation on the form and report the additional information as soon as possible. **Please complete all pages.** * = Required

Beneficiary Information

*Beneficiary's Name _____ *Beneficiary's MID _____-_____-_____ _____

Beneficiary's Date of Birth _____/_____/_____ Beneficiary's county name _____

Beneficiary's Gender ☐ Male ☐ Female Beneficiary's Ethnicity

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

Incident Overview

*Person Reporting Incident _____

Incident Date _____/_____/_____ Incident Time __:__ ☐ AM ☐ PM
Date you became aware of incident _____/_____/_____

*Incident Location , if "Other", please specify _____

*Was the beneficiary under the direct care of the CAP/C waiver service provider at the time of the incident?
☐ Yes ☐ No If yes, specify service: , if "Other", please specify _____
Name of Provider Agency _____
Specific Name of Provider Staff, if known _____

*Type of Incident

☐alleged or actual self abuse by beneficiary	☐alleged or actual abuse by others	☐beneficiary self neglect	☐neglect by informal caregivers
☐theft of medication or supplies	☐theft of beneficiary/informal caregivers' household possessions or money	☐exploitation other than theft	☐beneficiary left unattended
☐wandering/elopement	☐fall(s)	☐choking or other problem with ingestion	☐unsafe interruption of services or neglect by service provider
☐unsafe provision of services	☐equipment malfunction/failure	☐vehicular accident or breakdown	☐vandalism
☐unsafe home environment other than vandalism	☐failure/defect in residence threatening beneficiary health/safety	☐ other, specify	

Additional Information _____

*Cause of Incident

☐nonadherence to medications	☐nonadherence to diet	☐nonadherence to other treatment plan	☐medication error
☐equipment user error	☐improper equipment placement or setup	☐improper equipment maintenance	☐lack of motivation/interest by beneficiary
☐lack of knowledge about caregiving by service provider	☐lack of knowledge about caregiving by informal supports	☐inadequate informal caregivers	☐inadequate level of services
☐improper/inadequate home maintenance	☐lack of proper home security	☐inappropriate resource utilization	☐lack of caregiver finances
☐lack of oversight or monitoring	☐expected course of disease/diagnosis	☐other, specify	

Additional Information

Note: Incident reports are confidential quality assurance documents, protected by GS 122 C-30, 122 C-191, and 122 C-192. Do not file incident reports in the beneficiary's service record. Confidentiality of beneficiary information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR, parts 160 and 164

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Incident Witnesses

Last Name	First Name	Relationship to Beneficiary	Home Phone	Office Phone	Additional Information
_____	_____	_____	(___) ___ - ____	(___) ___ - ____ ext _____	_____
_____	_____	_____	(___) ___ - ____	(___) ___ - ____ ext _____	_____

Incident Description

(Include any events leading up to or resulting from the incident.)

*_____

Incident Remediation

Describe the steps taken to resolve this incident and prevent it from happening again.

*Summary _____

Task	Proposed Initiation Date	Target Resolution Date	Person Responsible	Title	Agency	Actual Completion Date
*_____	__/__/____	__/__/____	_____	_____	_____	__/__/____
_____	__/__/____	__/__/____	_____	_____	_____	__/__/____
_____	__/__/____	__/__/____	_____	_____	_____	__/__/____

Comments _____

Incident Notifications

☐ **CAP Case Manager**
Name _____ Contact Info _____ Date _____

☐ **CAP Home Health/Home Care Agency**
Name _____ Contact Info _____ Date _____

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

☐ **Law Enforcement**
Name _____ Contact Info _____ Date _____

☐ **Child Protective Services**
* must be notified for alleged or actual abuse, neglect, or exploitation
Name _____ Contact Info _____ Date _____

☐ **Parent/Guardian**
Name _____ Contact Info _____ Date _____

☐ **NC DFS Complaint Unit**
Name _____ Contact Info 1 800 624 3004 Date _____

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

☐ **Program Integrity**
Name _____ Contact Info 919 647 8000 Date _____

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

☐ **Other**, _____
Name _____ Contact Info _____ Date _____

Certification

Name of RN reviewing incident _____
(REQUIRED for incidents of medical nature)

Contact Info _____ Date __/__/____

Comments _____

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Waiver Assurance Issues		HCBS Quality Framework Issues	
Administrative Authority	☐	Participant Access	☐
Level of Care	☐	Participant Centered Service Planning and Delivery	☐
Participant Centered Service Planning and Delivery	☐	Provider Capacities and Capabilities	☐
Provider Qualifications	☐	Participant Health and Safety	☐
Financial Accountability	☐	Participant Rights and Responsibilities	☐
Health and Welfare	☐	Participant Outcomes and Satisfaction	☐

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Review and Follow-up

Name of Individual Reviewing Incident _____
Date Report Reviewed _____

Was the critical incident reported to DMA within the required time frame? ☐ Yes ☐ No
Was the critical incident report reviewed within the required time frame? ☐ Yes ☐ No
If there was a Child Protective Services (CPS) or At Risk Case Management (ARCM) investigation, was the plan of care updated to address the needs identified? ☐ Yes ☐ No
Did the case manager responded appropriately by determining the cause of the incident and taking measures to prevent its recurrence? ☐ Yes ☐ No

DMA Follow-up _____

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