

DHHS Incident and Death Report

Provider Agency Name _____

Consumer's Name _____

LME Client Record Number. _____

This form is used to report Level II and Level III incidents, including deaths and restrictive interventions, involving any person receiving publicly funded mental health, developmental disabilities and/or substance abuse (MH/DD/SA) services. Facilities licensed under G.S. 122C (except hospitals) and unlicensed providers of community-based MH/DD/SA services must submit the form, as required by North Carolina Administrative Code 10A NCAC 27G .0600, 26C .0300, and 27E .0104(e)(18). Failure to complete this form may result in administrative actions against the provider's license and/or authorization to receive public funding. This form may also be used for internal documentation of Level I incidents, if required by provider policy or LME contract. Effective May 1, 2010, this form replaces the *DHHS Incident and Death Report (Form QM02, Revised April, 2009)*.

Instructions: Complete and submit this form to the local and/or state agencies responsible for oversight within 72 hours of learning of the incident (See page 3 for details). Report deaths of consumers that occur within 7 days of restraint or seclusion **immediately**.
 If requested information is unavailable, provide an explanation on the form and report the additional information as soon as possible.
Page 1-2 Instructions: The staff person who is most knowledgeable about the incident should complete pages 1-2 of this form as soon as possible after learning of the incident and submit to their supervisor or other staff as directed by agency policy) for review and approval.

Date of Incident: _____ Time of Incident: _____ a.m. p.m. Unknown

CONSUMER INFORMATION

Consumer's Date of Birth: _____

Consumer's Gender: Male Female

All Diagnoses: _____

Consumer enrolled in Methadone maintenance program? Yes

Consumer enrolled in one of the following CAP/MR-DD

Consumer adjudicated incompetent? Yes No

Waiver services? **Check all that apply:**

Consumer has TBI (Traumatic Brain Injury)? Yes No

Comprehensive Waiver

Consumer receiving ICF-MR/DD Services? Yes No

Supports Waiver

Money Follows the Person

Innovations

RACE:

Hispanic/Latino Native American White/Anglo

Black/African American Mixed Race Other

LOCATION OF INCIDENT

Community Consumer's legal residence Day Treatment Family's home Friend's home Hospital

Provider premises Unknown Other (specify) _____

DESCRIPTION OF INCIDENT

Name / title of first staff person to learn of incident _____

Was the consumer under the care of the reporting provider at the time of the incident? Yes No

Was the consumer treated by a licensed health care professional for the incident? Yes No Date: _____

Was the consumer hospitalized for the incident? Yes No Date: _____

NOTE: Incident reports are quality assurance documents. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected. Use the form according to confidentiality requirements in NC General Statutes and Administrative Code and the Code of Federal Regulations.

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Provider Agency Name _____	Consumer's Name _____	LME Client Record Number. _____
TYPE OF INCIDENT	Briefly describe the incident, including Who, What, When, Where, and How. <i>Do not provide another consumer's name or identifying information.</i>	
	CONSUMER DEATH	
	Level II death due to: <input type="checkbox"/> Terminal illness/natural causes	
	Level III death due to: <input type="checkbox"/> SUICIDE <input type="checkbox"/> ACCIDENT <input type="checkbox"/> HOMICIDE / VIOLENCE <input type="checkbox"/> UNKNOWN CAUSE	
	Did death occur within 7 days of the restrictive intervention? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, immediately submit this form to your supervisor.</i>	
	DETAILS OF DEATH REPORTABLE TO NC DEPARTMENT OF HEALTH & HUMAN SERVICES	
	<i>Complete this section only for deaths from <u>suicide</u>, <u>accident</u>, <u>homicide/violence</u>, <u>unknown cause</u> or <u>occurring within 7 days of restrictive intervention</u>.</i>	
	Address where consumer died: _____ County _____	
	Physical illnesses / conditions diagnosed prior to death: _____	
	Dates of last two (2) medical exams: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None	
Date of most recent <u>admission</u> to a hospital for physical illness: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None		
Date of most recent <u>discharge</u> from a hospital for physical illness: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None		
Date of most recent <u>admission</u> to an inpatient mh/dd/sas facility: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None		
Date of most recent <u>discharge</u> from an inpatient mh/dd/sas facility: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None		
Height: ____ ft ____ in <input type="checkbox"/> Unknown Weight: _____ lbs <input type="checkbox"/> Unknown		
RESTRICTIVE INTERVENTION		
Did death occur within 7 days of the restrictive intervention? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, immediately submit this form to your supervisor.</i>		
(Number in order of use) ____ Physical Restraint	Is the use of restrictive intervention part of the consumer's Individual Service Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
____ Isolation	Was the restrictive intervention administered appropriately? <input type="checkbox"/> Yes <input type="checkbox"/> No	
____ Seclusion	Did the use of restrictive intervention(s) result in discomfort, complaint, or require treatment by a licensed health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Attach a <u>Restrictive Intervention Details Report</u> (Form QM03) or a provider agency form with comparable information.</i>		

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OTHER INCIDENT		
<p style="text-align: center;">INJURY</p> <p style="text-align: center;"><i>Report injuries requiring treatment by a licensed health professional</i></p> <p style="text-align: center;"><i>(Check only <u>one</u>)</i></p> <p>Injury due to:</p> <input type="checkbox"/> Assault <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/> Self-injury <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Trip or fall <input type="checkbox"/> Other (specify) _____	<p style="text-align: center;">ABUSE ALLEGATION</p> <p style="text-align: center;"><i>(Check <u>all</u> that apply)</i></p> <input type="checkbox"/> Alleged abuse of a consumer (includes sexual abuse) <input type="checkbox"/> Alleged neglect of a consumer <input type="checkbox"/> Alleged exploitation of a consumer <input type="checkbox"/> Alleged sexual abuse of a consumer	<p style="text-align: center;">MEDICATION ERROR</p> <p style="text-align: center;"><i>Report errors that threaten health or safety</i></p> <p style="text-align: center;"><i>(Check <u>all</u> that apply)</i></p> <input type="checkbox"/> Wrong dose administered <input type="checkbox"/> Wrong medication administered <input type="checkbox"/> Wrong time (<i>administered more than one hour before or after prescribed time</i>) <input type="checkbox"/> Missed dose <input type="checkbox"/> Refused dose <input type="checkbox"/> Medication given to wrong consumer <input type="checkbox"/> Other
<p style="text-align: center;">CONSUMER BEHAVIOR <i>(Check all that apply)</i></p> <input type="checkbox"/> Aggressive behavior <input type="checkbox"/> Destructive behavior <input type="checkbox"/> Illegal act <input type="checkbox"/> Inappropriate or illegal sexual behavior (consumer is victim, not perpetrator) <input type="checkbox"/> Unplanned consumer absence of more than 3 hours over the time specified in person- centered plan <input type="checkbox"/> Diversion of drugs <input type="checkbox"/> Other (specify) _____		<p style="text-align: center;">OTHER INCIDENT</p> <p style="text-align: center;"><i>(Check only <u>one</u>)</i></p> <input type="checkbox"/> Suspension of a consumer from services Number of days suspended _____ <input type="checkbox"/> Expulsion of a consumer from services <input type="checkbox"/> Fire that threatens or impairs a consumer's health or safety
Name/title of staff person documenting incident <i>(Please print)</i> : _____ Phone (____) _____ Signature _____ Date _____ Time _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		
<p>Supervisor's Instructions: <i>The supervisor of the service should review pages 1-3 of this form, complete page 3 and 4 and submit to required agencies in the required timeframes.</i></p>		
PROVIDER INFORMATION	Facility / Unit _____ Facility /Unit Director: _____ Service address: _____ City: _____ County _____ Facility /Unit Phone Number: (____) _____ IPRS Billing No. or National Provider ID No.: _____ Service being provided at <u>time of incident</u> : <input type="checkbox"/> Residential <input type="checkbox"/> Licensed Residential License No _____ <input type="checkbox"/> Non-residential (<i>specify</i>) _____ Was a 122C-Licensed service being provided at the time of the incident? <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>License No.</i>) _____ <i>If <u>yes</u>, note reporting instructions for Level III below.</i>	
LEVEL OF INCIDENT	<input type="checkbox"/> Level II (Moderate) Send this form to the host LME (LME responsible for geographic area where service is provided) within 72 hours. If required by contract, also report to the consumer's home LME.	<input type="checkbox"/> Level III (High) Immediately report verbally to the host LME. Convene an incident review committee within 24 hours if services were being actively provided at time of incident or the incident occurred on the provider's premises. Send this form within 72 hours to: <ul style="list-style-type: none"> ▪ host LME (see bottom of page) ▪ consumer's home LME ▪ NC Division of MH/DD/SAS, Quality Management Team, 3004 MSC, Raleigh, NC 27699-300 Voice: (919) 733-0696 Fax: (919) 508-0986 <p>NOTE: Report deaths that occur within 7 days of seclusion or restraint <u>immediately</u> to the host LME and DMH/DD/SAS Advocacy Team (919) 715-3197.</p> <p>NOTE: If a licensed G.S.122C service was being provided at time of the Level III incident, use the same deadlines to report <u>death from suicide, accident, homicide/violence, and death occurring within 7 days of restraint or seclusion</u>, to the NC Division of Health Service Regulation, Complaint Intake Unit, 2711 MSC, Raleigh, NC 27699-2711. Voice: 1-800-624-3004 Fax: 919-715-7724</p> <p style="text-align: center;"><u>Do not report deaths of unknown cause to DHSR.</u></p>

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PROVIDER RESPONSE	Describe the <u>cause of the incident</u> ; why did the incident occur?			
	Describe <u>how this type of incident may be prevented</u> in the future and any <u>corrective measures</u> that have been or will be put in place as a result of the incident			
REPORTING INFORMATION	Indicate <u>authorities or persons</u> notified of the incident (as applicable):			
	Agency / Person	Contact Name	Phone or FAX	Notification Date
	<input type="checkbox"/> Host LME _____	_____	() _____	_____
	<input type="checkbox"/> Home LME _____	_____	() _____	_____
	<input type="checkbox"/> Law enforcement	_____	() _____	_____
	<input type="checkbox"/> DSS County: _____	_____	() _____	_____
<input type="checkbox"/> NC DMH/DD/SAS QM Team	_____	() _____	_____	
<input type="checkbox"/> NC DHSR Complaint Unit	_____	() _____	_____	
<input type="checkbox"/> NC DHSR Health Care Personnel Registry	_____	() _____	_____	
<input type="checkbox"/> Service Plan Team/Clinical Home	_____	() _____	_____	
<input type="checkbox"/> Parent / Guardian	_____	() _____	_____	
<input type="checkbox"/> Other	_____	() _____	_____	
Name/ <u>title</u> of supervisor authorizing report and completing page 3. <i>(Please print)</i> : _____				
_____ Phone () _____				
Signature _____ Date _____ Time _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m				
E-mail address: _____				

Direct questions to: ContactDMHQuality@ncmail.net Phone: (919) 733-0696

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