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: _____

All Diagnoses: _____

Consumer adjudicated incompetent? ☐ Yes ☐ No

Consumer has TBI (Traumatic Brain Injury)? ☐ Yes ☐ No

Consumer receiving ICF-MR/DD Services? ☐ Yes ☐ No

Consumer's Gender: ☐ Male ☐ Female

Consumer enrolled in Methadone maintenance program? ☐ Yes

Consumer enrolled in one of the following CAP/MR-DD Waiver services? Check all that apply:

☐ **Comprehensive Waiver**
☐ **Supports Waiver**
☐ **Money Follows the Person**
☐ **Innovations**

RACE:

☐ **Hispanic/Latino** ☐ **Native American** ☐ **White/Anglo**
☐ **Black/African American** ☐ **Mixed Race** ☐ **Other**

DESCRIPTION OF INCIDENT

LOCATION OF INCIDENT

☐ Community ☐ Consumer's legal residence ☐ Day Treatment ☐ Family's home ☐ Friend's home ☐ Hospital
☐ Provider premises ☐ Unknown ☐ Other *(specify)* _____

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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Briefly describe the incident, including Who, What, When, Where, and How. *Do not provide another consumer's name or identifying information.*

TYPE OF INCIDENT

CONSUMER DEATH

Level II death due to: ☐ Terminal illness/natural causes

Level III death due to: ☐ SUICIDE ☐ ACCIDENT ☐ HOMICIDE / VIOLENCE ☐ UNKNOWN CAUSE

Did death occur within 7 days of the restrictive intervention? ☐ Yes ☐ No ***If yes, immediately submit this form to your supervisor.***

DETAILS OF DEATH REPORTABLE TO NC DEPARTMENT OF HEALTH & HUMAN SERVICES

Complete this section only for deaths from suicide, accident, homicide/violence, unknown cause or occurring within 7 days of restrictive intervention.

Address where consumer died: _____ County_____

Physical illnesses / conditions diagnosed prior to death: _____

Dates of last two (2) medical exams: _____ _____ ☐ Unknown ☐ None

Date of most recent admission to a hospital for physical illness: _____ ☐ Unknown ☐ None

Date of most recent discharge from a hospital for physical illness: _____ ☐ Unknown ☐ None

Date of most recent admission to an inpatient mh/dd/sas facility: _____ ☐ Unknown ☐ None

Date of most recent discharge from an inpatient mh/dd/sas facility: _____ ☐ Unknown ☐ None

Height: _____ ft _____ in ☐ Unknown **Weight**: _____ lbs ☐ Unknown

RESTRICTIVE INTERVENTION

Did death occur within 7 days of the restrictive intervention? ☐ **Yes** ☐ **No If yes, immediately submit this form to your supervisor.**

(Number in order of use)

_____ Physical Restraint

_____ Isolation

_____ Seclusion

Is the use of restrictive intervention part of the consumer's Individual Service Plan? ☐ Yes ☐ No

Was the restrictive intervention administered appropriately? ☐ Yes ☐ No

Did the use of restrictive intervention(s) result in discomfort, complaint, or require treatment by a licensed health professional? ☐ Yes ☐ No

Attach a Restrictive Intervention Details Report (Form QM03) or a provider agency form with comparable information.

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OTHER INCIDENT

INJURY

Report injuries requiring treatment by a licensed health professional

(Check only one)

Injury due to:

- ☐ Assault
- ☐ Motor vehicle accident
- ☐ Self-injury
- ☐ Suicide attempt
- ☐ Trip or fall
- ☐ Other (specify) _____

ABUSE ALLEGATION

(Check all that apply)

- ☐ Alleged abuse of a consumer (includes sexual abuse)
- ☐ Alleged neglect of a consumer
- ☐ Alleged exploitation of a consumer
- ☐ Alleged sexual abuse of a consumer

Report any alleged or suspected case of abuse, neglect or exploitation of a consumer, as required by law, to the county Dept. of Social Services and the DHSR Healthcare Personnel Registry (if a staff is accused).

MEDICATION ERROR

Report errors that threaten health or safety

(Check all that apply)

- ☐ Wrong dose administered
- ☐ Wrong medication administered
- ☐ Wrong time *(administered more than one hour before or after prescribed time)*
- ☐ Missed dose ☐ Refused dose
- ☐ Medication given to wrong consumer
- ☐ Other

CONSUMER BEHAVIOR *(Check all that apply)*

- ☐ Aggressive behavior
- ☐ Destructive behavior
- ☐ Illegal act
- ☐ Inappropriate or illegal sexual behavior (consumer is victim, not perpetrator)
- ☐ Unplanned consumer absence of more than 3 hours over the time specified in person- centered plan
- ☐ Diversion of drugs
- ☐ Other (specify) _____

OTHER INCIDENT

(Check only one)

- ☐ Suspension of a consumer from services

Number of days suspended

- ☐ Expulsion of a consumer from services
- ☐ Fire that threatens or impairs a consumer's health or safety

Name/title of staff person documenting incident *(Please print)*:

_____ Phone ( ) _____

Signature _____ Date _____ Time _____ ☐ a.m. ☐ p.m.

Supervisor's Instructions: The supervisor of the service should review pages 1-3 of this form, complete pagse 3 and 4 and submit to required agencies in the required timeframes.

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 time of incident: ☐ Residential ☐ Licensed Residential *License No*_____ ☐ Non-residential (*specify)*

_____

Was a 122C-Licensed service being provided at the time of the incident? ☐ No ☐ Yes *(License No.)* _____ ***If yes, note reporting instructions for Level III below.***

LEVEL OF INCIDENT

☐ **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.

☐ **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:

- *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***

NOTE: *Report deaths that occur within 7 days of seclusion or restraint immediately to the host LME and DMH/DD/SAS Advocacy Team (919) 715-3197.*

NOTE: *If a licensed G.S.122C service was being provided at time of the Level III incident, use the same deadlines to report death from suicide, accident, homicide/violence, and death occurring within 7 days of restraint or seclusion, 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***

Do not report deaths of unknown cause to DHSR.

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PROVIDER RESPONSE

Describe the cause of the incident; why did the incident occur?

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 the incident

REPORTING INFORMATION

Indicate authorities or persons notified of the incident ***(as applicable)***:

Agency / Person	Contact Name	Phone or FAX	Notification Date
☐ Host LME _____		( )	
☐ Home LME _____		( )	
☐ Law enforcement		( )	
☐ DSS County:_____		( )	
☐ NC DMH/DD/SAS QM Team		( )	
☐ NC DHSR Complaint Unit		( )	
☐ NC DHSR Health Care Personnel Registry		( )	
☐ Service Plan Team/Clinical Home		( )	
☐ Parent / Guardian		( )	
☐ Other		( )	

Name/title of supervisor authorizing report and completing page 3. *(Please print)*:

_____ Phone ( ) _____

Signature _____ Date _____ Time _____ ☐ a.m. ☐ p.m

E-mail address:.

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

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