How to report a Critical Incident for Qualified Service Providers

Qualified Service Providers (QSPs) are required by federal law to report all critical incidents involving people they care for.

A critical incident is "any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant.[1]"

Incidents that need to be reported are:

- Abuse (physical, emotional, sexual), neglect, or exploitation;
- Rights violations through omission or commission, the failure to comply with the rights to which an individual is entitled as established by law, rule, regulation, or policy;
- Serious injury or medical emergency, which would not be routinely provided by a primary care provider;
- Wandering or elopement;
- Restraint violations;
- Death of client and cause (including death by suicide);
- Report of all medication errors or omissions; and
- Any event that could harm client's health, safety or security if not corrected.

❖ If an incident involves abuse, neglect or exploitation, a provider must report to Vulnerable Adult Protective Services (VAPS). To file a report, there are two options:

- **Option 1:**
  - Use the online reporting system.
  - Using Internet Explorer, visit: https://fw2.harmonyis.net/NDLiveIntake/
  - To add the client, scroll down to the bottom of report and choose "Add."
- **Option 2:**
  - Fill out SFN 1607 (Report of Vulnerable Adult, Abuse, Neglect, or Exploitation), online at www.nd.gov/eforms/Doc/sfn01607.pdf
  - A copy of the form is included (Attachment 1).

❖ Critical Incident Reporting Requirements:

- Any QSP who is with a client and is involved, witnessed or responded to an event that is a reportable incident, is required to report it.
- When a provider finds out about a critical incident, follow these steps:
  - **Step 1**
    - Report it to the Home and Community Based Services (HCBS) case manager and
  - **Step 2**
    - Fill out an incident report (SFN 53601 – Risk Management Medical Services Incident Report) from the HCBS case manager or online at https://www.nd.gov/eforms/Doc/sfn53601.pdf.

[1] In accordance with the North Dakota Medicaid Waiver for Home and Community Based Services under the authority of §1915(c) of the Social Security Act, ND Century Code 50-25.2-03(4)

- A copy of the form is included (Attachment 2).
  - Contact the HCBS case manager if you need help filling out the form.
  - The completed SFN 53601 needs to be sent to the HCBS case manager within 24 hours of the incident.
  - The HCBS case manager will forward it to the North Dakota Department of Human Services Aging Services Division.
  - If the HCBS case manager has first-hand knowledge of a critical incident, he or she will forward the completed SFN 53601 to the Aging Services Division within 24 hours.

- Example 1
  - If a client falls while a provider is in the room, but the client didn't have an injury or need medical attention, a critical incident report is not required.

- Example 2
  - If a family member tells the HCBS case manager that a client is in the hospital due to a stroke, a critical incident report is not required because neither the HCBS case manager or provider saw or responded to the event.

- Example 3
  - If a provider comes to a client's home and the client is on the floor and 911 is called for medical attention, a critical incident report is required because the client required medical attention AND the provider responded to the event (fall).

Attachment 1

REPORT OF VULNERABLE ADULT ABUSE, NEGLECT, OR EXPLOITATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES
SFN 1607 (9-2018)

Clear Fields

Report Date

REPORTER INFORMATION

Name	Telephone Number	Email Address	
Agency	Title or Relationship to Victim		
Address	City	State	ZIP Code

ALLEGED VICTIM INFORMATION

Name			Telephone Number	
Address		City	State	ZIP Code
Gender ☐ Male ☐ Female	Date of Birth	Age	Victim Currently ☐ At Home ☐ In Facility ☐ Pending Discharge ☐ Whereabouts Unknown	
Marital Status ☐ Single ☐ Married ☐ Widow/Widower ☐ Divorced/Separated ☐ Unknown				

PERSON SUSPECTED OF CAUSING ABUSE, NEGLECT OR EXPLOITATION (if known)

Name	Relationship to Victim	Telephone Number	
Address	City	State	ZIP Code

LEGAL REPRESENTATIVE

Check One ☐ POA-Durable ☐ POA-Other ☐ Guardian/Conservator ☐ Other ☐ None ☐ Unknown			
Name		Telephone Number	
Address	City	State	ZIP Code

COLLATERAL CONTACT (Case Manager, Family, Friend, etc.)

Name	Relationship to Victim	Telephone Number
Name	Relationship to Victim	Telephone Number

Reason for Referral (Who, What, When, Where, Why, How Often)

Reason for Referral (*continued*)

Email Completed Form Here
(by clicking this button, the form is emailed to carechoice@nd.gov)

or FAX the form to 701-328-8744.

Attachment 2

RISK MANAGEMENT MEDICAL SERVICES INCIDENT REPORT

OMB - RISK MANAGEMENT DIVISION
SFN 53601 (9-2011)

Department Location Code

☐ Incident
☐ Near Miss
☐ Claim Form Requested

Name:	ID Number:	☐ Client ☐ Outpatient ☐ Inpatient ☐ Employee ☐ Visitor ☐ Volunteer			
Address:		City:		State:	ZIP Code:
Date of Incident:	Time of Incident:	Sex: ☐ Female ☐ Male	Date of Birth:		Telephone Number:
Service Area:	Ward:		Notification: ☐ Medical ☐ Family		Workers Compensation Filed: ☐ Yes ☐ No
Witness:	Telephone Number:		Address:		
City:	State:	ZIP Code:	Date Reviewed by Loss Control:		Property DMG. ☐ State ☐ Other What:

OCCURRENCE CATEGORY: (Select one only)

MEDICATION
- ☐ Incorrect Day/Time
- ☐ Incorrect Dose
- ☐ Incorrect Medication
- ☐ Wrong Patient
- ☐ Incorrect Route
- ☐ Omitted
- ☐ Refusal
- ☐ Self-Med
- ☐ Given Without Order
- ☐ Other: _____

FALLS
- ☐ To/From Bed
- ☐ To/From Chair/Equipment
- ☐ Fall While Walking ☐ Assist ☐ Unassist
- ☐ Ice Fall
- ☐ Elevated Fall
- ☐ Other: _____

TREATMENT/PROCEDURE
- ☐ Infection-Related
- ☐ Surgery
- ☐ Testing-Related
- ☐ Treatment-Related
- ☐ Other: _____

TRAUMA
- ☐ Altercation/Hostility
- ☐ Burn
- ☐ Caught by Object
- ☐ Self Abuse
- ☐ Recreation Injury
- ☐ Scratched
- ☐ Struck
- ☐ Struck An Object
- ☐ Struck By Object
- ☐ Suicide/Attempted
- ☐ Swallowed Inedible
- ☐ Other: _____

MISCELLANEOUS
- ☐ Altercation/Hostility
- ☐ Complaint
- ☐ Confidentiality Breach
- ☐ Elopement/Leave without Notification
- ☐ Improper Clt/Clt Contact
- ☐ Improper Emp/Clt Contact
- ☐ Med. Record/Doc.
- ☐ Property Damage
- ☐ Equipment/Product Related
- ☐ Computer Security
- ☐ Unknown

PART OF BODY INJURED:

Body Part Injured ☐ Bilateral ☐ Left ☐ Lower ☐ Middle ☐ Right ☐ Unknown ☐ Upper

TYPE OF BODILY INJURY:
- ☐ Abrasion/Scrapes
- ☐ Amputation
- ☐ Anoxia/Resp Distress
- ☐ Bite ☐ Intact Skin ☐ Broken Skin
- ☐ Blister
- ☐ Burns ☐ 1st ☐ 2nd ☐ 3rd
- ☐ Contusion/Bruise
- ☐ Damaged Teeth
- ☐ Death
- ☐ Decubitis Ulcer
- ☐ Edema/Swelling
- ☐ Nosebleed
- ☐ Fracture/Dislocation
- ☐ Infection
- ☐ Laceration ☐ Major ☐ Minor
- ☐ None Evident
- ☐ Reddened
- ☐ Rash
- ☐ Sprain/Strain
- ☐ Wound Disruption
- ☐ Other: _____

AREA OF OCCURRENCE:
- ☐ Administration Area
- ☐ Bathroom/Shower
- ☐ Bedroom
- ☐ Dining Area
- ☐ Exam Room
- ☐ Grounds
- ☐ Hallway/Waiting Room
- ☐ Kitchen
- ☐ Lab
- ☐ Living Area
- ☐ Med. Room
- ☐ Medical Records
- ☐ Nursing Station
- ☐ Off Premises
- ☐ Pharmacy
- ☐ Parking Area
- ☐ Recreational Facility
- ☐ Seclusion
- ☐ Stairs
- ☐ Surgery
- ☐ Tunnel
- ☐ Storage
- ☐ Vehicle
- ☐ Voc Program
- ☐ Unknown
- ☐ X ray
- ☐ Other: _____

PROCESS:
- ☐ Bathroom
- ☐ Behavior
- ☐ Day Program
- ☐ Exam
- ☐ Home Visit
- ☐ Household Duties
- ☐ Hygiene/Grooming
- ☐ Interpersonal Altercation
- ☐ Job/Work
- ☐ Leisure
- ☐ Left Premises Unattended
- ☐ Lifting Client
- ☐ Lifting Object
- ☐ Meal/Snack
- ☐ Med. Administration
- ☐ Other Daily Cares
- ☐ Rest/Sleep
- ☐ Scheduled Appointment
- ☐ Trauma by: Patient # ☐ Client/Patient ☐ Staff ☐ Self ☐ Other ☐ Seizure ☐ Seclusion/Restraint ☐ Stress Test
- ☐ Surgery
- ☐ Therapeutic Intervention
- ☐ Therapeutic Outing
- ☐ Transporting
- ☐ X ray
- ☐ Other: _____

Description of Incident:

Individual Preparing Report: (Name and Title)	Date:	Additional Sign-Off:	Date:
Department Head/Supervisor: (Name and Title)	Date:	Risk Management Review:	Date:

* Pursuant to N.D.C.C. Sec. 32-12.2-11, this report is privileged and exempt from the open records law as long as disclosure could prejudice any pending or reasonably predictable claim.

TO BE COMPLETED BY DEPARTMENT HEAD/SUPERVISOR

Describe policies and procedures in effect that relate to this incident.
Were policies and procedures followed? ☐ Yes ☐ No - Explain

List all causes of the incident (equipment, procedure, environment, behavior)

Action Taken

a. Has corrective action been initiated? ☐ Yes ☐ No
If yes, what corrective action is being taken?
If no, when will corrective action be taken?

b. Work Order Submitted ☐ Yes ☐ No

c. What safety equipment/training could have prevented this injury?

Comments and/or Diagram

GENERAL INSTRUCTIONS

1. Use ink. Place a bold "X" or "Check Mark" where necessary.
2. The employee who discovers the incident or to whom the incident is reported, shall complete the form. As you complete this form:
   a. Be objective and factual.
   b. Make appropriate notes in the patient/client record, but do not refer to incident report.
   c. Use complete record number for patient/client (ID number section). For others, print name, address, city, state, zip, and telephone number in designated section.
   d. Note the time of the incident (not the time of reporting).
   e. Witness: List the witness name, address, and telephone number, and indicate whether the witness is an employee. List additional witnesses on a separate piece of paper. Attach to Incident Report.
3. If an individual with Developmental Disabilities is involved in an accident, please complete notification box. The family must be notified if the incident involves the client's serious illness, serious accident or death, in order to comply with AC requirements.
4. The complete report is forwarded to the Risk Management designee, within 24 hours of the incident.

ANY INCOMPLETE REPORTS WILL BE RETURNED FOR COMPLETION