

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 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 both pages.**

Recipient Information	Recipient's Name _____	Recipient's MID _____-_____-_____
	Recipient's Date of Birth ____/____/____	Recipient's county name _____
	Recipient's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Recipient's Ethnicity <u>-SELECT-</u> _____
	Recipient's Primary Diagnosis (name, not number) _____	
Incident Information	Date of Incident (if known) ____/____/____	
	Date you became aware of incident ____/____/____	
	Location of Incident <u>-SELECT-</u>	
	Was the recipient under the direct care of the CAP/C nurse or nurse aide at the time of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes: Was incident due to nurse or nurse aide error? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes: Did the nurse or nurse aide respond appropriately to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	TYPE OF INCIDENT	
	<input type="checkbox"/> Death, due to <u>-SELECT-</u>	
	<input type="checkbox"/> Injury, due to <u>-SELECT-</u> _____, that required a change in the plan of care.	
	<input type="checkbox"/> Alleged or Actual Abuse, Neglect, or Exploitation <u>-SELECT-</u>	
<input type="checkbox"/> Medication Error, due to <u>-SELECT-</u> , that threatened the patient's health or safety or resulted in an adverse reaction (even if the error was made by the recipient or family).		
<input type="checkbox"/> Significant and repetitive pattern (3or more times in 12 months) of		
<input type="checkbox"/> provider withdrawal of services <input type="checkbox"/> difficulty staffing <input type="checkbox"/> recipient or family refusal of care		
<input type="checkbox"/> misuse or abuse of services, such as family not coming home on time to relieve staff		
<input type="checkbox"/> Theft of medication or supplies		
<input type="checkbox"/> Other, please specify _____		
<input type="checkbox"/> ED visit		
Name of Hospital _____ Was patient <input type="checkbox"/> discharged to home, or <input type="checkbox"/> admitted to hospital?		
Was this incident a true emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did the patient see or contact their physician about the problem prior to going to the ED? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did the physician instruct the patient to go to the ED? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the patient been seen in the emergency room for this or any other problem within the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes, for: _____		
<input type="checkbox"/> Unplanned Hospitalization		
Name of Hospital _____ Length of Stay _____		
Was patient seen in the emergency room prior to hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete 'ED visit' section above.		
Has the patient had any other unplanned hospitalization, for this or any other reason, within the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes, for: _____		

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 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

Recipient's Name _____

Recipient's MID _____ - _____ - _____

Incident Information, continued	INCIDENT DESCRIPTION													
	<p><i>Describe what happened, in detail, including any events leading up to or resulting from it. Attach additional pages if needed.</i> _____</p>													
Provider Response	INCIDENT CAUSE													
	<p><i>Describe the cause of the incident. Check all that apply. Attach additional pages if needed.</i></p> <p> <input type="checkbox"/> non-adherence to medication, dietary, or treatment regimen or precautions <input type="checkbox"/> lack of adequate supervision <input type="checkbox"/> inappropriate resource utilization <input type="checkbox"/> expected course of disease <input type="checkbox"/> lack of knowledge <input type="checkbox"/> inadequate supports <input type="checkbox"/> other, _____ </p> <p>Please describe the specific cause: _____</p>													
	INCIDENT PREVENTION													
	<p><i>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.</i></p> <p> <input type="checkbox"/> caregiver or staff teaching/training <input type="checkbox"/> change in hours <input type="checkbox"/> new FL-2 <input type="checkbox"/> change in medication regimen <input type="checkbox"/> change in level of in-home staff <input type="checkbox"/> POC revision <input type="checkbox"/> change in treatment regimen <input type="checkbox"/> referral to other services/supports <input type="checkbox"/> infection control measures <input type="checkbox"/> other, _____ </p> <p>Please describe the specific change: _____</p>													
Reporting Information	NOTIFICATIONS													
	<p><i>Indicate authorities or persons aware of the incident (as applicable).</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> CAP-C Case Manager Name _____ Contact Info _____ </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Parent/Guardian Name _____ Contact Info _____ </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> CAP-C Home Health/Home Care Agency Name _____ Contact Info _____ </td> <td style="vertical-align: top;"> <input type="checkbox"/> NC DFS Complaint Unit Name _____ Contact Info <u>1 800 624 3004</u> </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> Physician <small>* must be notified for medication errors</small> Name _____ Contact Info _____ </td> <td style="vertical-align: top;"> <input type="checkbox"/> Board of Nursing Name _____ Contact Info <u>919 782 3211</u> </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> Law enforcement Name _____ Contact Info _____ </td> <td style="vertical-align: top;"> <input type="checkbox"/> Program Integrity Name _____ Contact Info <u>919 647 8000</u> </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> Child Protective Services <small>* must be notified for alleged or actual abuse, neglect, or exploitation</small> Name _____ Contact Info _____ </td> <td style="vertical-align: top;"> <input type="checkbox"/> Health Care Personnel Registry Name _____ Contact Info <u>919 855 3968</u> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> <input type="checkbox"/> Other, _____ Name _____ Contact Info _____ </td> </tr> </table>		<input type="checkbox"/> CAP-C Case Manager Name _____ Contact Info _____	<input type="checkbox"/> Parent/Guardian Name _____ Contact Info _____	<input type="checkbox"/> CAP-C Home Health/Home Care Agency Name _____ Contact Info _____	<input type="checkbox"/> NC DFS Complaint Unit Name _____ Contact Info <u>1 800 624 3004</u>	<input type="checkbox"/> Physician <small>* must be notified for medication errors</small> Name _____ Contact Info _____	<input type="checkbox"/> Board of Nursing Name _____ Contact Info <u>919 782 3211</u>	<input type="checkbox"/> Law enforcement Name _____ Contact Info _____	<input type="checkbox"/> Program Integrity Name _____ Contact Info <u>919 647 8000</u>	<input type="checkbox"/> Child Protective Services <small>* must be notified for alleged or actual abuse, neglect, or exploitation</small> Name _____ Contact Info _____	<input type="checkbox"/> Health Care Personnel Registry Name _____ Contact Info <u>919 855 3968</u>	<input type="checkbox"/> Other, _____ Name _____ Contact Info _____	
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REPORTED BY														
Name/title of person documenting incident _____ Contact Info _____ Signature _____ Date ____/____/____	Name of RN reviewing incident _____ <small>(optional, but recommended if incident was medical in nature)</small> Contact Info _____ Signature _____ Date ____/____/____													

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