

Software for Realizing Care's Potential

Delaware Division of Health Care Quality (DHCQ) Acute Care Provider Incident Management User Guide

1-855-WELLSKY <u>WellSky.com</u>



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Introduction | Incident Management User Guide

The Division of Health Care Quality (DHCQ) has three main sections providing oversight to long-term care (LTC) facilities and acute/ambulatory (outpatient) facilities licensing and certification, and investigations. The Division provides the following services: Adult Abuse Registry; Background Check Center; the Certified Nursing Assistant (CNA) Registry; Incident Reporting Center; Licensing/Certifying Health Care Agencies and Facilities; Promulgating and Enforcing Regulations; and Investigating Allegations of Abuse, Neglect, Mistreatment, and Financial Exploitation. DHCQ conducts incident management processes for its 300+ acute care providers and for its LTC providers. DHCQ has a dedicated investigation unit.

Learning Objectives for Incident Management User Guide

- Incident Reporting Form
 - Provider/Facility
 - o MCO
 - o Member of the public
- Logging into Wellsky
- Provider submits 30 day follow-up

Chapter 1 Incident Reporting Form

The Online Incident Reporting form is used to report complaints, reportable incidents, and alleged abuse, neglect, mistreatment or financial exploitation (including rights complaints, HIPAA violations, etc.) of an individual supported by the following agencies:

- Division of Developmental Disabilities Services (DDDS)
- Division of Health Care Quality (DHCQ)
- Division of Medicaid & Medical Assistance (DMMA)
- Division of Substance Abuse and Mental Health (DSAMH)

This guide will cover how DHCQ will utilize the form for submission of their division's incident reports.

Completing the DE DHSS Online Incident Reporting Form

The Incident Workflow begins with the discovery of a reportable incident. The online incident reporting form can be used by anyone and does not require a login.

Role = Reporter of Incident (Provider, Citizen, Parent, Anonymous)

Open a web browser, such as Edge or Chrome, and navigate to

1. The DE DHSS Incident Reporting Form is (Prod site): <u>https://hssdedhssprod.wellsky.com/assessments/?WebIntake=9A2</u> <u>787C9-BDCF-449A-BFD7-59B32DD77BE7</u> 2. The Online Incident report form appears. The information at the top describes the purpose of the page. Required fields will be indicated in red until they are populated, at which point they change to green. Reporters are encouraged to provide as much information as possible even if the field is not required.

INCIDENT REPORTING SY	'STEM
Please use this form to report complain (including rights complaints, HIPAA viol	its, reportable incidents, and alleged abuse, neglect, mistreatment or financial exploitation ations, etc.) of an individual supported by the following agencies:
 Division of Health Care Quality (DH Division of Developmental Disabili Division of Medicaid & Medical Ass Division of Substance Abuse and M 	ICQ) ties Services (DDDS) istance (DMMA) Aental Health (DSAMH)
If in doubt, please submit a report.	
Staff will review the report and address help us follow-up quickly and assure th	the issue as soon as possible. Please provide as much factual information as possible to e safety and wellbeing of those we serve.
If you include your email address in the your records.	e report, you will receive an email confirmation message that you can print and retain for
You may be contacted by a representat personal identifying information will or	ive if additional information is needed to best route the issue to the proper authority. Your Iy be used by the investigating staff and otherwise will remain confidential as required.
Incident Online Submi	ssion Form
Some fields below are <mark>required</mark> . Please remem	ber that the more information you provide the better we will be able to investigate.
Are you a: required	
Unanswered	○ Member of the general public/service recipient ○ Provider/Facility
○ МСО	
Is this report for: required	
Unanswered	

- 3. The Reporter first selects whether they are a member of the general public or a Provider. Depending on the choice, the questions vary slightly to match the target audience. They then select the Agency they are reporting to.
- 4. If you are a Provider or Facility, skip to this step *Provider/Facility*.
- 5. Of you are a MCO, skip to this step, MCO.
- 6. If you are a member of the public, continue to the next step.

Member of the public

7. Select Member of the general public/service recipient & then select the DHCQ Acute option.

ome fields below are <mark>required</mark> . Please remember th	at the more information you provide the better we will	be able to investigate.
Are you a: required		
O Unanswered	Member of the general public/service recipient	O Provider/Facility
⊙ мсо		
s this report for: required		
O Unanswered	A person with developmental or intellectual disabilities (living in a residential setting, receiving supported living services, attending a day program or receiving supported employment services) (Division of Developmental Disabilities Services)	A person receiving Mental Health or Substant Use Disorder Services (mental health group home, PROMISE services, opioid treatment services, or other substance use disorder services) (Division of Substance Abuse and Mental Health)
A person in an Acute Care Facility or in an Outpatient Healthcare Facility/Agency (e.g. Adult Day Care Center, Home Health Agency, Hospice, Hospital, Dialysis, etc.) (Division of Health Care Quality Acute)	A person in a Long Term Care (LTC) Facility (e.g., Nursing Home, Assisted Living, ICF-IID, Group Home, Neighborhood Home, Family Care Home, Home for people with AIDS, Rest [Residential Home])(Division of Health Care Quality ITC)	 A person receiving Medicaid who does not fai under the other categories listed

- 8. Questions appear asking for the Reporter name, relationship and address.
 - a. You can also select if you would like to remain anonymous.

Incident Management

Reporter Information		
Reporter's Relationship to Victim (DHCQ) required Select the item that best identifies your relationship to the alie	ed victim.	
Unanswered	 Agency 	O Facility
O Friend/Caregiver	 Medical staff 	O Ombudsmen
O Relative	O Self	O Other
Reporters First Name required		
Enter response		
Reporters Last Name required		
Enter response		
Include agency name if appropriate Enter response Address 2		
Enter response		
City Start typing the name of the city, make a selection from the dro the drop-down list. Enter response	p-down list. If your city does not popu	late on the drop down, choose the next geographically closest city on
State Enter response		
Zip Code Enter response		
Reporter's Phone Enter response		
Reporter's Email Please include an email address so we can send you confirmatic Enter response	n of the report and verification annea	ation for your records.
Would you like to remain anonymous?		

9. Enter the Date of Occurrence, Description of Incident, and Incident Type.

Date of Occurrence	required	
Enter date as MMDDYY	M. If approximate or unknown, enter closest date and explain in "Description of incident" field.	
Enter resp	onse	
Time of Occurrence		
• Enter resp	onse	
Incident Discovered	Date	
When the Reporter bec	ame aware of the incident	
Enter resp	onse	
Police Contacted?		
Unanswered	O Yes O No O Unknown	
Description of Incide	ant required	
HOW.	o, or what the problem is, with as much detail as possible, include details or any injuries in applicable, include which where, where, where and	
Carso concensor o		
enter response		
-		
Is this an ongoing pi	oblem?	
Is this an ongoing p	oblem?	
Is this an ongoing pi	oblem? O Yes O No	
Is this an ongoing portion of the second sec	oblem? O Yes O No aken:	
Is this an ongoing pu Unanswered What actions were t include steps such as: a	oblem? O Yes O No aken: ssessment of Immediate medical needs, steps to make the victim feel safe and protect them from further incident/harm, removal of the alleged	
Is this an ongoing pu Unanswered What actions were t include steps such as: a perpetrator's access to	o Yes No aken: sessament of Immediate medical needs, steps to make the victim feel safe and protect them from further incident/harm, removal of the alleged the victim, as well as any notifications made. include the action, who, the date and the time for each.	
Is this an ongoing pr Unanswered What actions were t include steps such as: a perpetrator's access to Enter response	oblem? O Yes No aken: sessment of Immediate medical needs, steps to make the victim feel safe and protect them from further incident/harm, removal of the alleged the victim, as well as any notifications made. Include the action, who, the date and the time for each.	
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is this an ongoing pr i Unanswered What actions were t Mat actions were t Incident Site Type (Incident Site Type (Incident where the Incident where the Incident	oblem? O Yes No aken: ssessment of immediate medical needs, steps to make the victim feel safe and protect them from further incident/harm, removal of the alleged the victim, as well as any notifications made. Include the action, who, the date and the time for each. DHCQ Acute) required dent took place.	
Is this an ongoing privation of the second s	vblem? Ves No aken: ssessment of immediate medical needs, steps to make the victim feel safe and protect them from further incident/harm, removal of the alleged the victim, as well as any notifications made. Include the action, who, the date and the time for each. b DHCQ Acute) required dent took place.	
Is this an ongoing pr	vblem? Ves No aken: ssessment of immediate medical needs, steps to make the victim feel safe and protect them from further incident/harm, removal of the alleged the victim, as well as any notifications made. Include the action, who, the date and the time for each. b DHCQ Acute) required dent took place.	
Is this an ongoing pr	vblem? Ves No aken: ssessment of Immediate medical needs, steps to make the victim feel safe and protect them from further incident/harm, removal of the alleged the victim, as well as any notifications made, include the action, who, the date and the time for each. b DHCQ Acute) required demt took place. ed Image: State of the sta	
Is this an ongoing pr	voblem? Yes No aken: ssessment of Immediate medical needs, steps to make the victim feel safe and protect them from further incident/harm, removal of the alleged the victim, as well as any notifications made, include the action, who, the date and the time for each. DHCQ Acute) required dent took place. ed te provider, including the specific office name or location name. If applicable	
Is this an ongoing pr	oblem? O Yes No aker: Sessment of Immediate medical needs, steps to make the victim feel safe and protect them from further incident/harm, removal of the alleged the victim, as well as any notifications made. include the action, who, the date and the time for each. b OHCQ Acute) required dent took place. ed Image: Constraint of the specific office name or location name if applicable	
Is this an ongoing pr	oblem? o Yes No aker: Sessment of Immediate medical needs, steps to make the victim feel safe and protect them from further incident/harm, removal of the alleged the victim, as well as any notifications made. include the action, who, the date and the time for each. b DHCQ Acute) required dent took place. ed Image: Compare the specific office name or location name if applicable	

10. Click on the **+New** box to add the Alleged Victim, Alleged Perpetrator(s) and Witness/Other Participants. Note that at least one Alleged Victim must be entered.

you have clicked th						
·	e "+ New" link below and the p	age doesn't not open, disat	le the Pop-up blocke	r.		
lleged Victim requ	ired Last Name	First Name	Street	City	Home Phone	Cell Phone
rou have clicked th eged Perpetrato ou wish to enter tw	re "+ New" link below and the p ir(s) vo or more alleged perpetrators,	age doesn't not open, disat	ole the Pop-up blocke same abuse, neglect, a	r. or exploitation	incident of the alleged victim	
you have clicked th leged Perpetrato you wish to enter tw + New	ie "+ New" link below and the p ir(s) vo or more alleged perpetrators, Last Name	age doesn't not open, disat they must be related to the First Name	ole the Pop-up blocke same abuse, neglect, t Street	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone
you have clicked th Ileged Perpetrato you wish to enter tw + New	ie "+ New" link below and the p or(s) Last Name	age doesn't not open, disat they must be related to the First Name	ole the Pop-up blocke same abuse, neglect, a Street	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone
you have clicked th Ileged Perpetrato you wish to enter th + New	ie "+ New" link below and the p or(s) Last Name	age doesn't not open, disat they must be related to the First Name	ole the Pop-up blocke same abuse, neglect, n Street	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone
you have clicked th Ileged Perpetrato you wish to enter tw • New you have clicked th	ie "+ New" link below and the p pr(s) vo or more alleged perpetrators, Last Name a "+ New" link below and the pa	age doesn't not open; disat they must be related to the First Name ge doesn't not open, disable	ile the Pop-up blocke same abuse, neglect, t Street the Pop-up blocker.	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone
you have clicked th lleged Perpetrato you wish to enter th New you have clicked th Vitness/Other Pai	e "+ New" link below and the p pr(s) vo or more alleged perpetrators, Last Name e "+ New" link below and the pa ticipant(s)	age doesn't not open, disat they must be related to the First Name ge doesn't not open, disable	ele the Pop-up blocke same abuse, neglect, i Street the Pop-up blocker.	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone

11. Complete all required fields and as much information as possible.

	1 0			
First Name required Please type "unknown" if you do not know the	Alleged Victim's first name.			
Jane				
Last Name required				
lease type "unknown" if you do not know the	Alleged Victim's last name.			
Parker				
Alias				
lease provide any nicknames, alternate name	s, or any former last names.			
Enter response				
Date of Birth				
Date of Birth inter date as MMDDYYYY - no slashes				
Date of Birth Enter date as MMDDYYYY - no slashes Enter response				
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Sender				
Date of Birth Inter date as MMDDYYYY - no slashes III Enter response Sender O Unanswered Female	Male			
Date of Birth inter date as MMDDWYY - no slashes III Enter response Sender O Unanswered Female O Gender Identity	Male			
Date of Birth inter date as MMDDWYY - no slashes III Enter response Sender Unanswered Female O Sender Identity Unanswered	Male O Female		⊖ Male	
Date of Birth Inter date as MMDDYYY - no slashes III Enter response Sender Unanswered Female Unanswered Unanswered Non-Binary	Male O Female O Other		 Male Transgender Female 	
Date of Birth inter date as MMDDWYY - no slashes iii Enter response Sender Unanswered • Female • Unanswered Non-Binary Transgender Male	Male O Female O Other O Declined to Answer	Ş	 ○ Male ○ Transgender Female 	

12. Click **OK** at the bottom of the form

mail 🔓	
Enter response	
Perpetrator a State Worker?	
● Unanswered ○ Yes ○ No ○ Unknown	
	•
	Cancel OK

13. Enter any additional information needed and click **Submit**.

is and an ongoin	g problem?					
Unanswere	d 🔿 Yes 🔿 No					
Is there anything	else you would like us	to know?				
🧿 Unanswere	d 🔿 Yes 🔿 No					
Upload/attach e	ectronic documents rel	ated to this web intake report				
Browse	No files selected					×
Fhank you for	completing the Inc	ident Report.				
3y clicking Sub	mit you attest that	this information is true,	accurate and complete	e to the best of you	ir knowledge. We take	every
				the second se	CALIFORNIA A CONCEPTION OF THE PROPERTY OF	(a) (a)

14. A confirmation screen will appear with the Incident ID. The Incident is now submitted to DHCQ staff to review.



Provider/Facility

15. Select "Provider/Facility" & "Division of Health Care Quality Acute"



- 16. Additional questions appear which only apply to Provider/Facility reports. Proceed with entering the Reporter's details including the Full name of the person submitting the form if different from reporter, the Relationship to the alleged victim, as well as the Reporter's First & Last Name.
 - a. You can also select if you would like to remain anonymous.

Reporter Informatio	n		
Full name of person submitting this report Enter response	rt, if different from reporter:		
Reporter's Relationship to Victim (DHCQ) Select the item that best identifies your relations	required hip to the ageged victim.		
Unanswered	O Agency	O Facility	
O Friend/Caregiver	O Medical staff	O Ombudsmen	
O Relative	 Self 	O Other	
Reporters First Name required			
leporters Last Name required			
Reporter's Phone required			
Reporter's Email required Please include an email address so we can send y	ou confirmation of the report and verification notification	for your records.	
Enter response			

17. Enter the all Incident details, such as Date of Occurrence, Description of Incident, Incident Type, etc.

Incident Details
Date of Occurrence required Enter date as MMDDYYYY. If approximate or unknown, enter closest date and explain in "Description of Incident" field.
enter responde
Time of Occurrence required
Enter response
Incident Discovered Date required When the Reporter became aware of the Incident
Enter response
Police Contacted? required
Unanswered O Yes O No C Unknown
Description of Incident: required Description of Incident: required Descripte what happened, or what the problem is, with as much detail as possible. Include details of any injuries if applicable. Include WHO, WHAT, WHERE, WHEN, WHY and HOW. Enter response
Is this an ongoing problem? required Unanswered O Yes O No
What actions were taken: required Include steps such as, assessment of immediate medical needs, steps to make the victim feel safe and protect them from further incident/harm, removal of the alleged perpetrator's access to the victim, as well as any notifications made. Include the action, who, the date and the time for each. Enter response
Incident Type required
Incident Site Type (DHCQ Acute) required Indicate where the Incident took place.
Provider ID required Enter response
Provider Name required Enter the full name of the provider, including the sp-cific office name or location name if applicable Enter response
Where did the incident occur? required Provide complete address if known, including up to more if applicable

18. Click on the +New field to add the Alleged Victim, Alleged Perpetrator(s) and Witness/Other Participants. Note that at least one Alleged Victim must be entered.

you have clicked t	ie "+ New" link below and the pa	age doesn't not open, disa	ble the Pop-up blocke	er.		
Heged Victim requ	ired Last Name	First Name	Street	City	Home Phone	Cell Phone
ou have clicked th eged Perpetrate	ne "+ New" link below and the pa pr(s) wo or more alleged perpetrators,	age doesn't not open, disa they must be related to the	ble the Pop-up blocke same abuse, neglect,	er.	incident of the alleged victim	
u have clicked th ged Perpetrate u wish to enter th New	ne "+ New" link below and the pa or(s) vo or more alleged perpetrators,	age doesn't not open, disa they must be related to the First Name	ble the Pop-up blocke same abuse, neglect, - Street	r. or exploitation City	incident of the alleged victim	Cell Phone
ou have clicked th eged Perpetrato ou wish to enter th + New	he "+ New" link below and the pa or(s) Last Name	age doesn't not open, disa they must be related to the First Name	ble the Pop-up blocke same abuse, neglect, - Street	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone
ou have clicked til eged Perpetrate ou wish to enter the New	he "+ New" link below and the p. or(s) wo or more alleged perpetrators, Last Name	age doesn't not open, disa they must be related to the First Name	ble the Pop-up blocke same abuse, neglect, Street	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone
you have clicked the leged Perpetrate you wish to enter the New	he "+ New" link below and the pr or(s) wo or more alleged perpetrators, Last Name	age doesn't not open, disa they must be related to the First Name	ble the Pop-up blocke same abuse, neglect, Street	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone
you have clicked the second se	e "+ New" link below and the pu or(s) wo or more alleged perpetrators, Last Name e "+ New" link below and the pag	age doesn't not open, disa they must be related to the First Name ge doesn't not open, disabl	ble the Pop-up blocke same abuse, neglect, - Street e the Pop-up blocker,	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone
you have clicked ti lleged Perpetrat you wish to enter ti New you have clicked th fitness/Other Pa	e "+ New" link below and the p. or(s) wo or more alleged perpetrators, Last Name e "+ New" link below and the pag ticipant(s)	age doesn't not open, disa they must be related to the First Name ge doesn't not open, disabl	ble the Pop-up blocke same abuse, neglect, Street e the Pop-up blocker.	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone

19. Complete all required fields and as much information as possible and click OK at the bottom of the form.

First Name required	Allowed Wetten's first in sea			
lane	alleged vicums inschame.			
Jane				
ast Name required				
lease type "unknown" if you do not know the	Alleged Victim's last name.			
Parker				
Alias				
lease provide any nicknames, alternate name	5, or any former last names.			
Enter response				
Enter response				
Enter response Date of Birth Enter date as MMDDYYYY - no slashes				
Enter response Date of Birth Inter date as MMDDYYYY - no slashes Enter response				
Enter response Date of Birth Inter date as MMDDYYYY - no slashes III Enter response				
Enter response Date of Birth Inter date as MMDDYYYY - no slashes III Enter response Gender				
Enter response Date of Birth Inter date as MMDDYYYY - no slashes III Enter response Sender O Unanswered Female O	Male			
Enter response Date of Birth Inter date as MMDDYYYY - no slashes Enter response Gender Unanswered Female	Male			
Enter response Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender Unanswered Female Unanswered Unanswered	Male		⊖ Male	
Enter response Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender Unanswered Female Unanswered Unanswered Unanswered	Male O Female		⊖ Male	
Enter response Date of Birth Inter date as MMDDYYYY - no slashes Enter response Gender Unanswered Non-Binary	Male O Female O Other	↓	 Male Transgender Female 	
Enter response Date of Birth Inter date as MMDDYYYY - no slashes III Enter response Sender Unanswered Female Unanswered Non-Binary Transgender Male	Male O Female O Other O Declined to Answer		○ Male ○ Transgender Female	

Incident Management

mail	2					
Enter respo	75e					
Perpetrator	State Worker?					
🔘 Unanswe	red O Yes O	No (🔿 Un <mark>known</mark>			
						ŧ

20. Enter any additional information needed and click Submit.

Auditio	al Information
Is this an on	oing problem?
Unansi	ered O Yes O No
Is there anyt	ing else you would like us to know?
🔘 Unansi	ered 🔿 Yes 🔿 No
Upload/atta	a electronic documents related to this web intake report
Browse	No files selected
Thank you	or completing the Incident Report.
By clicking	ubmit you attest that this information is true, accurate and complete to the best of your knowledge. We take ever nd inquiry seriously and thanks you for reporting this event for assessment and, if necessary, investigation and

21.A confirmation screen will appear with the Incident ID. The Incident is now submitted to DHCQ staff to review.

Success!	
Success! The incident was	submitted successfully.
Please keep this reference	e number for your records: 10008
Return to DHSS website	A Print

MCO

22. Select "MCO" & "Division of Health Care Quality Acute"

Incident Online Submiss	ion Form		
Some fields below are required . Please remember t	hat the more information you provide the better we will	be able to investigate.	
Are you a: required Unanswered MCO	\bigcirc Member of the general public/service recipient	O Provider/Facility	
Is this report for: required			-
○ Unanswered	 Division of Developmental Disabilities Services 	 Division of Substance Abuse and Mental Health 	
Division of Health Care Quality Acute	O Division of Health Care Quality LTC	O Division Of Medicaid and Medical Assistance	
Which MCO are you reporting on behalf of? required			
Unanswered	O AmeriHealth Caritas Delaware	O Delaware First Health	
O Highmark Health Options	O Other/Not an MCO		

- 23. Additional questions appear which only apply to MCO reports. Proceed with entering the Reporter's details including the Full name of the person submitting the form if different from reporter, the Relationship to the alleged victim, as well as the Reporter's First & Last Name.
 - a. You can also select if you would like to remain anonymous.

Reporter Information		
Full name of person submitting this report, if dif	ferent from reporter:	
Reporter's Relationship to Victim (DHCQ) required Select the item that best identifies your relationship to th	ne alleged victim.	
Unanswered	O Agency	O Facility
○ Friend/Caregiver	 Medical staff 	O Ombudsmen
⊖ Relative	⊖ Self	⊖ Other
Reporters First Name required Enter response		
Reporters Last Name required		
Reporter's Phone Enter response		
Reporter's Email required Please include an email address so we can send you confi	rmation of the report and verification notific	ation for your records.
Enter response		
Would you like to remain anonymous?		

24. Enter the all Incident details, such as Date of Occurrence, Description of Incident, Incident Type, etc.

Incident Details	
Date of Occurrence required Enter date as MMDDPYYY. If approximate or unknown, enter closest date and explain in "Description of incident" field. Image: Enter response	
Time of Occurrence required	
Incident Discovered Date When the Reporter became aware of the Incident.	
Enter response	
Police Contacted? O Yes O No O Unknown	
Description of Incident: required Describe what happened, or what the problem Is, with as much detail as possible. Include details of any injuries if applicable. Include WHO, WHAT, WHERE, WHEN, WHY and HOW. Enter response	
Is this an ongoing problem? required Unanswered Units CONO What actions were taken: Include steps such as: assessment of immediate medical needs, steps to make the Victim feel safe and protect them from further incident/harm, removal of the alleged perpetrator's access to the victum, as well as any notifications made. Include the action, who, the date and the time for each.	
Enter response	
Incident Type required	~
Incident Site Type (DHCQ Acute) required Indicate where the Incident took place.	~
Provider Name required Enter the full name of the provider, including the specific office name or location name if applicable Enter response	
Where did the incident occur? required Provide complete address if known, including unit or room if applicable Enter response	

25. Click on the +New field to add the Alleged Victim, Alleged Perpetrator(s) and Witness/Other Participants. Note that at least one Alleged Victim must be entered.

you have clicked t	ne "+ New" link below and the pa	age doesn't not open, disa	ble the <mark>Pop-up bloc</mark> ke	r.		
lleged Victim req	lired					
+ New	Last Name	First Name	Street	City	Home Phone	Cell Phone
you have clicked t leged Perpetrate you wish to enter t	he "+ New" link below and the pa pr(s) wo or more alleged perpetrators,	age doesn't not open, disa	ble the Pop-up blocke same abuse, neglect,	r. or exploitation	incident of the alleged victim	
you have clicked t Ileged Perpetrat you wish to enter t + New	he "+ New" link below and the pa or(s) Last Name	ige doesn't not open, disa they must be related to the First Name	ble the Pop-up blocke same abuse, neglect, Street	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone
f you have clicked t Ileged Perpetrat f you wish to enter t Yew	ne "+ New" link below and the pa or(s) Last Name	age doesn't not open, disa they must be related to the First Name	ble the Pop-up blocke same abuse, neglect, - Street	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone
Fyou have clicked t Very Clicked Perpetrat Fyou wish to enter t A New	ne "+ New" link below and the pa or(s) Last Name = "+ New" link below and the page	age doesn't not open, disa they must be related to the First Name	ble the Pop-up blocke same abuse, neglect, Street	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone
f you have clicked t Veged Perpetrat you wish to enter t + New f you have clicked th Vitness(/Other Pa	ne "+ New" link below and the pa pr(s) wo or more alleged perpetrators, ' Last Name e "+ New" link below and the pag ticinant(s)	age doesn't not open, disa they must be related to the First Name ge doesn't not open, disabl	ble the Pop-up blocke same abuse, neglect, Street e the Pop-up blocker,	r. or exploitation City	incident of the alleged victim Home Phone	Cell Phone

26. Complete all required fields and as much information as possible and click OK at the bottom of the form.

in this section, please provide as indenti	normation as possible about the alleged victim		
First Name required	llagar Victim's first name		
Jane			
ast Name required	lieged Victim's last name.		
Parker		/	
Alias			
	or any former last names		
Please provide any nicknames, alternate names	, or any former laschames.		
Please provide any nicknames, alternate names Enter response Date of Birth			
Please provide any nicknames, alternate names Enter response Date of Birth Inter date as MMDDYYYY - no slashes III Enter response			
Please provide any nicknames, alternate names Enter response Date of Birth Inter date as MMDDYYYY - no slashes III Enter response Sender			
Ilease provide any nicknames, alternate names Enter response Date of Birth Inter date as MMDDYYYY - no slashes III Enter response Sender O Unanswered I Female O 1	Aale		
Ilease provide any nicknames, alternate names Enter response Date of Birth inter date as MMDDYYYY - no slashes III Enter response Sender O Unanswered Female 1 Gender Identity	Aale		
<pre>ilease provide any nicknames, alternate names Enter response Date of Birth inter date as MMDDYYYY - no slashes iii Enter response Sender O Unanswered Female 1 Gender Identity O Unanswered</pre>	Male O Female	⊖ Male	
lease provide any nicknames, alternate names Enter response Date of Birth Inter date as MMDDYYYY - no slashes Enter response Sender Unanswered Unanswered Non-Binary	Aale O Female O Other	 Male Transgender Female 	

Incident Management

mail 🕹			
Enter response.			
s Perpetrator a Sta	ite Worker?		
Unanswered	🔾 Yes 🛛 No	O Unknown	
			ł

27. Enter any additional information needed and click Submit.

is this an ongoing problem?		
Unanswered O Yes	O No	
Is there anything else you would	like us to know?	
Unanswered O Yes	O No	
Upload/attach electronic docum	ents related to this web intake report	
Browse No files selected	d	×
Thank you for completing t	he Incident Report.	
By clicking Submit you atte	st that this information is true, accurate and complete to the best of your knowledge. We tal	ke every
complaint and inquiry seric	ously and thanks you for reporting this event for assessment and, if necessary, investigation	and

28.A confirmation screen will appear with the Incident ID. The Incident is now submitted to DHCQ staff to review.



Chapter 2 Getting Started: Logging into Wellsky

- 1. Log into the Prod Environment using your username and password
- 2. Delaware DHSS Production URL: https://hssdedhssprod.wellsky.com/humanservices/

Home Solutions Support	la construction de la constructi	
	WellSky Huma Service Belavere PH35 Sandbex (502.014) Venion: E.B.4.1.8779	
	Username	
	Password	
	Change password Forgot password?	
	Log In	
	opyrigint o 2024 Wellsky, All rights reserved. Therms of use (vatents (virvacy po	ucy

a. System will default to the My Work screen

WellSky Human Services			My Work Incidents Provider	s Reports 🌲 Q \varTheta
INCIDENTS		PROVIDERS	TASKS	
Disposition	۲		My Management	
Complaint Pending Review	1		Ticklers Due	
Notes	0		Event Ticklers	
Pending	3		Alart Notes	
Alert Notes - Intakes	0			
Unread Alert Notes	0			
v8.841				About

Chapter 3 Provider 30 Day Follow Up

Role: DHCQ Acute Provider

1. Monitor My Work dashboard for incoming Pending notes.

KellSky Huma	n Services				My Work	Incidents	Providers	۰	۹ (9
File										
	INCIDENTS		PROVIDERS		TA	sks				
Disposition		۲		My Management						
Complaint Pending Review		1		Ticklers Due						
No Action Needed		1		Event Ticklers						
Review in Progress		1		Alert Notes						
Survey In Progress		1								
My Incident Ticklers		۲								
Ticklers		1								
Notes		۲								
Complete		1								
Pending		2								

- 2. Review the Pending Note and navigate to appropriate incident.
- 3. Navigate to the **Documentation** subpage and from the **File** menu, select **Add Documentation**.
- 4. Select the **DHCQ 30 Day Follow Up Report** and complete the documentation form.

WellSky Human Services		Incident Tracking ID = 10131 - Clyde Davis Documentation 10/22/2024 7:00 PM
File		
Please Select Type: DHCQ OHFLC 30 Day Follow Up -		
An asterisk (*) indicates a required field		
Forms		
Review Date *	10/22/2024	
Evaluator *	Sharp, Mandi 🗸	
Status *	Draft	
Victim *	Davis, Clyde 🗸	
	_	
Incident Description		
Persons Involved		
Date	MM/DD/YYYY	
Time	· · · ·	
Location of the incident		2
Relevant information from the client's record		
Description of the client's injury		
Name(s) of staff involved in the incident		
Written statements by all persons with knowledge of the	ne incident	

- 5. From the File menu, select Save Documentation.
- 6. This will make the Status editable.
 - a. Update Status = Submitted.

WellSky Human Services	
File	
DHCQ OHFLC 30 Day Follow Up	(
An asterisk (*) indicates a required field	4
Forms	4
Review Date *	10/22/2024
Documentation *	DHCQ OHFLC 30 Day Follow Up
Evaluator *	Tarzwell, Dawn
Status *	Submitted V
Victim *	Davis, Clyde 🗸
and a second and the second and a	ولاسطى بالاستطيبي سنواد المسي بستتصبوعي المسي بوالسبي

- 7. From the File menu, select Save and Close Documentation.
- 8. If additional participants have been identified, navigate to the **Notes** subpage.
- 9. From the File menu, select Add Note.

WellSky Human Services	Incident Tracking ID = 10131 - 10/22/2024 7:42 PM	Clyde Davis Not	es
File			
Add Note Print Add Note Documentation Notes Print Part Part Part Part Part Part Part Par			

- a. Note Type = Notifications
- b. Note Subtype = Provider
- c. Note Details = Enter the participants that need to be added to the incident.
- d. Status = Complete
- e. Recipient = DHCQ Acute Staff

Note Date *	10/22/2024	
Note By *	Sharp, Mandi	
Note Type *	Notifications	
Note Sub-Type	Provider V	
Note Details		<i>i</i> t
Status *	Pending_~	
Attachments		
Add Attachment		
Attachments Grid		
Document	Description	Category
here are no attachments to display	1	
Notes Recipients		
Add Note Recipient:	Lookup Clear	
Note Recipients Grid	2	

- 10. From the File menu, select Save and Close Note.
- 11. If additional information is needed, from the **File** menu, select **Add Note**.
 - a. Note Type = Provider Additional Notes
 - b. Status = Pending
 - c. Recipient = DHCQ Acute Staff

WellSky Human Services		
File Tools		
An asterisk (*) indicates a required field		
Division *	DHCQ	
Note Date *	10/29/2024	
Note By *	Sharp, Mandi	
Note Type *	Provider Additional Notes	
Note Details		
Status *	Pending 🗸	
Attachments		
Add Attachment		
Attachments Grid		
Document	Description	Category
There are no attachments to display	1	
Notes Recipients	1	
Add Note Recipient:	Lookup Clear	

12. From the File menu, select Save and Close Note.