



Software for Realizing Care's

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

1-855-WELLSKY

WellSky.com

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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.

DHCQ LTC will utilize WellSky to identify, track, investigate, and monitor critical incidents and their resolution per DHSS policy.

Learning Objectives for Incident Management User Guide

- Completing the Incident Reporting Form
 - Provider/Facility
 - MCO
 - Member of the public
- Logging into WellSky
- Provider completes 5 day follow up

Chapter 1 Incident Reporting Form

While there are other methods of reporting an Incident, the individual could have called in or the incident could have been redirected from another division. However, the primary focus in this document will be the Online 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):
<https://hssdedhssprod.wellsky.com/assessments/?WebIntake=9A2787C9-BDCF-449A-BFD7-59B32DD77BE7>

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 SYSTEM

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

If in doubt, please submit a report.

Staff will review the report and address the issue as soon as possible. Please provide as much factual information as possible to help us follow-up quickly and assure the safety and wellbeing of those we serve.

If you include your email address in the report, you will receive an email confirmation message that you can print and retain for your records.

You may be contacted by a representative if additional information is needed to best route the issue to the proper authority. Your personal identifying information will only be used by the investigating staff and otherwise will remain confidential as required.

Incident Online Submission Form

Some fields below are **required**. Please remember 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

MCO

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 or a Facility](#).
5. If 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 LTC option.

Incident Online Submission Form

Some fields below are **required**. Please remember 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

MCO

Is this report for: *required* ✓

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 Substance 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 LTC)

A person receiving Medicaid who does not fall 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.

Reporter Information

Reporter's Relationship to Victim (DHCQ) required
Select the item that best identifies your relationship to the alleged victim.

<input checked="" type="radio"/> Unanswered	<input type="radio"/> Agency	<input type="radio"/> Facility
<input type="radio"/> Friend/Caregiver	<input type="radio"/> Medical staff	<input type="radio"/> Ombudsmen
<input type="radio"/> Relative	<input type="radio"/> Self	<input type="radio"/> Other

Reporters First Name required
Enter response...

Reporters Last Name required
Enter response...

Address 1
Include agency name if appropriate
Enter response...

Address 2
Enter response...

City
Start typing the name of the city, make a selection from the drop-down list. If your city does not populate on the drop down, choose the next geographically closest city on the drop-down list.
Enter response...

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 confirmation of the report and verification notification for your records.
Enter response...

Would you like to remain anonymous?
 Yes No

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

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 response...

Time of Occurrence

Enter response...

Incident Discovered Date
When the Reporter became aware of the incident

Enter response...

Police Contacted?

Unanswered Yes No 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?

Unanswered Yes No

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 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 LTC) 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...

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.

Address of Occurrence (Provide complete address if known)
Enter response...

If you have clicked the "+ New" link below and the page doesn't not open, disable the Pop-up blocker.

Alleged Victim *required*

+ New	Last Name	First Name	Street	City	Home Phone	Cell Phone

If you have clicked the "+ New" link below and the page doesn't not open, disable the Pop-up blocker.

Alleged Perpetrator(s)
If you wish to enter two or more alleged perpetrators, they must be related to the same abuse, neglect, or exploitation incident of the alleged victim.

+ New	Last Name	First Name	Street	City	Home Phone	Cell Phone

If you have clicked the "+ New" link below and the page doesn't not open, disable the Pop-up blocker.

Witness/Other Participant(s)

+ New	Last Name	First Name	Relationship	Phone

Additional Information

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

In this section, please provide as much information as possible about the alleged victim.

First Name *required* ✓
Please type "unknown" if you do not know the Alleged Victim's first name.
Jane

Last Name *required* ✓
Please type "unknown" if you do not know the Alleged Victim's last name.
Parker

Alias
Please provide any nicknames, alternate names, or any former last names.
Enter response...

Date of Birth
Enter date as MMDDYYYY - no slashes
Enter response...

Gender ✓
 Unanswered Female Male

Gender Identity ✓
 Unanswered Female Non-Binary Other Male Transgender Female
 Transgender Male Declined to Answer

Street Address ✓
Please provide an approximate location/address if the street address is not known.
123 Main Street

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

Enter response...

Email 

Enter response...

Is Perpetrator a State Worker?

Unanswered Yes No Unknown

Cancel OK

A black arrow points to the OK button.

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

Additional Information


Is this an ongoing problem?

Unanswered Yes No

Is there anything else you would like us to know?


Unanswered Yes No

Upload/attach electronic documents related to this web intake report

Browse... No files selected 

Thank you for completing the Incident Report.

By clicking Submit you attest that this information is true, accurate and complete to the best of your knowledge. We take every complaint and inquiry seriously and thanks you for reporting this event for assessment and, if necessary, investigation and resolution.



14. 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 number for your records: 10008

Provider or a Facility

15. Select “Provider/Facility” & “Division of Health Care Quality LTC”

Incident Online Submission Form

Some fields below are **required**. Please remember 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**

MCO

Is this report for: **required** ✔

Unanswered Division of Developmental Disabilities Services Division of Substance Abuse and Mental Health

Division of Health Care Quality Acute **Division of Health Care Quality LTC** Division Of Medicaid and Medical Assistance

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 Reporters First & Last Name, phone & email.
- You can also select if you would like to remain anonymous.

Reporter Information

Full name of person submitting this report, if different from reporter:
Enter response...

Reporter's Relationship to Victim (DHCQ) required
Select the Item that best identifies your relationship to the alleged victim.

Unanswered Agency Facility

Friend/Caregiver Medical staff Ombudsmen


Relative Self Other

Reporters First Name required
Enter response...

Reporters Last Name required
Enter response...











Reporter's Phone required
Enter response...

Reporter's Email required
Please include an email address so we can send you confirmation of the report and verification notification for your records.
Enter response...

Would you like to remain anonymous? 

Yes No

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

Incident Details	
Date of Occurrence <small>required</small>	
<small>Enter date as MMDDYYYY. If approximate or unknown, enter closest date and explain in "Description of Incident" field.</small>	
	<small>Enter response...</small>
Time of Occurrence <small>required</small>	
	<small>Enter response...</small>
Incident Discovered Date <small>required</small>	
<small>When the Reporter became aware of the incident</small>	
	<small>Enter response...</small>
Police Contacted? <small>required</small>	
<input checked="" type="radio"/> Unanswered <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Description of Incident: <small>required</small>	
<small>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.</small>	
	<small>Enter response...</small>
Is this an ongoing problem? <small>required</small>	
<input checked="" type="radio"/> Unanswered <input type="radio"/> Yes <input type="radio"/> No	
Describe any changes in the behavior of the resident <small>required</small>	
<small>If applicable</small>	
	<small>Enter response...</small>
What actions were taken: <small>required</small>	
<small>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.</small>	
	<small>Enter response...</small>
Incident Type <small>required</small>	
	
Incident Site Type (DHCQ LTC) <small>required</small>	
<small>Indicate where the incident took place.</small>	
	
Provider ID <small>required</small>	
	<small>Enter response...</small>
Provider Name <small>required</small>	
<small>Enter the full name of the provider, including the specific office name or location name if applicable</small>	
	<small>Enter response...</small>
Where did the incident occur? <small>required</small>	
<small>Provide complete address if known, including unit or room if applicable</small>	

18. 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.

Address of Occurrence (Provide complete address if known)

Enter response...

If you have clicked the "+ New" link below and the page doesn't not open, disable the Pop-up blocker.

Alleged Victim required

+ New Last Name First Name Street City Home Phone Cell Phone

If you have clicked the "+ New" link below and the page doesn't not open, disable the Pop-up blocker.

Alleged Perpetrator(s)

If you wish to enter two or more alleged perpetrators, they must be related to the same abuse, neglect, or exploitation incident of the alleged victim.

+ New Last Name First Name Street City Home Phone Cell Phone

If you have clicked the "+ New" link below and the page doesn't not open, disable the Pop-up blocker.

Witness/Other Participant(s)

+ New Last Name First Name Relationship Phone

Additional Information

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

In this section, please provide as much information as possible about the alleged victim.

First Name required ✓
Please type "unknown" if you do not know the Alleged Victim's first name.
Jane

Last Name required ✓
Please type "unknown" if you do not know the Alleged Victim's last name.
Parker

Alias
Please provide any nicknames, alternate names, or any former last names.
Enter response...

Date of Birth
Enter date as MMDDYYYY - no slashes
 Enter response...

Gender ✓
 Unanswered Female Male

Gender Identity ✓
 Unanswered Female Male
 Non-Binary Other Transgender Female
 Transgender Male Declined to Answer

Street Address ✓
Please provide an approximate location/address if the street address is not known.
123 Main Street

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



Enter response...

Email

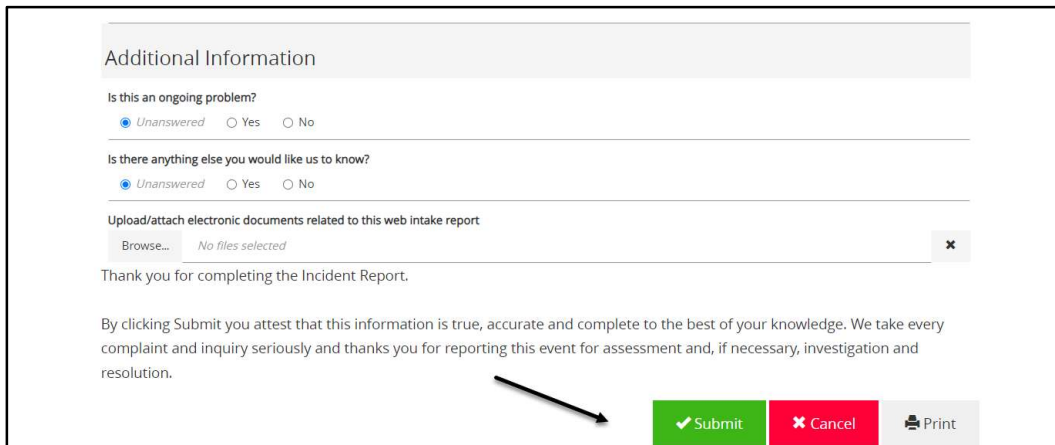
Enter response...

Is Perpetrator a State Worker?

Unanswered Yes No Unknown

Cancel OK

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



Additional Information

Is this an ongoing problem?

Unanswered Yes No

Is there anything else you would like us to know?

Unanswered Yes No

Upload/attach electronic documents related to this web intake report

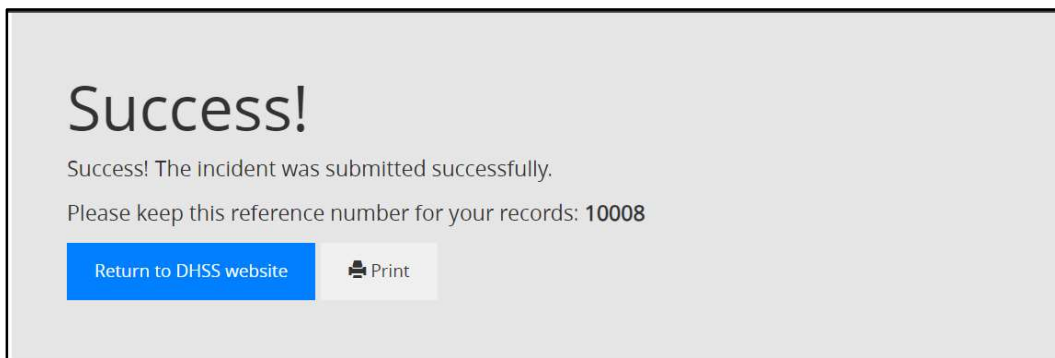
Browse... No files selected

Thank you for completing the Incident Report.

By clicking Submit you attest that this information is true, accurate and complete to the best of your knowledge. We take every complaint and inquiry seriously and thanks you for reporting this event for assessment and, if necessary, investigation and resolution.

Submit Cancel Print

22. 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 number for your records: 10008

Return to DHSS website Print

MCO

23. Select “MCO” & “Division of Health Care Quality LTC”

Incident Online Submission Form

Some fields below are **required**. Please remember 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

MCO

Is this report for: *required*

Unanswered Division of Developmental Disabilities Services Division of Substance Abuse and Mental Health

Division of Health Care Quality Acute **Division of Health Care Quality LTC** Division Of Medicaid and Medical Assistance

Which MCO are you reporting on behalf of? *required*

Unanswered AmeriHealth Caritas Delaware Delaware First Health

Highmark Health Options Other/Not an MCO

24. 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 Reporters First & Last Name, phone & email.
- a. You can also select if you would like to remain anonymous.

Reporter Information

Full name of person submitting this report, if different from reporter:
Enter response...

Reporter’s Relationship to Victim (DHCQ) *required*
Select the item that best identifies your relationship to the alleged victim.

Unanswered Agency Facility

Friend/Caregiver Medical staff Ombudsmen

Relative Self Other

Reporters First Name *required*
Enter response...

Reporters Last Name *required*
Enter response...

Reporter’s Phone *required*
Enter response...

Reporter’s Email *required*
Please include an email address so we can send you confirmation of the report and verification notification for your records.
Enter response...

Would you like to remain anonymous?

Yes No

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

Incident Details

Date of Occurrence required
Enter date as MMDDYYYY. If approximate or unknown, enter closest date and explain in "Description of Incident" field.

Time of Occurrence required

Incident Discovered Date
When the Reporter became aware of the incident:

Police Contacted?
 Unanswered Yes No 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.

Is this an ongoing problem? required
 Unanswered Yes No

Describe any changes in the behavior of the resident required
If applicable

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 victim, as well as any notifications made. Include the action, who, the date and the time for each.

Incident Type required

Incident Site Type (DHCQ LTC) 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

Where did the incident occur? required
Provide complete address if known, including unit or room if applicable

26. 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.

Address of Occurrence (Provide complete address if known)
Enter response...

If you have clicked the "+ New" link below and the page doesn't not open, disable the Pop-up blocker.

Alleged Victim required

+ New Last Name First Name Street City Home Phone Cell Phone

If you have clicked the "+ New" link below and the page doesn't not open, disable the Pop-up blocker.

Alleged Perpetrator(s)

If you wish to enter two or more alleged perpetrators, they must be related to the same abuse, neglect, or exploitation incident of the alleged victim.

+ New Last Name First Name Street City Home Phone Cell Phone

If you have clicked the "+ New" link below and the page doesn't not open, disable the Pop-up blocker.

Witness/Other Participant(s)

+ New Last Name First Name Relationship Phone

Additional Information

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

In this section, please provide as much information as possible about the alleged victim.

First Name required ✓
 Please type "unknown" if you do not know the Alleged Victim's first name.
 Jane

Last Name required ✓
 Please type "unknown" if you do not know the Alleged Victim's last name.
 Parker

Alias
 Please provide any nicknames, alternate names, or any former last names.
Enter response...

Date of Birth
 Enter date as MMDDYYYY - no slashes
 Enter response...

Gender ✓
 Unanswered Female Male

Gender Identity ✓
 Unanswered Female Male
 Non-Binary Other Transgender Female
 Transgender Male Declined to Answer

Street Address ✓
 Please provide an approximate location/address if the street address is not known.
 123 Main Street

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



Enter response...

Email 

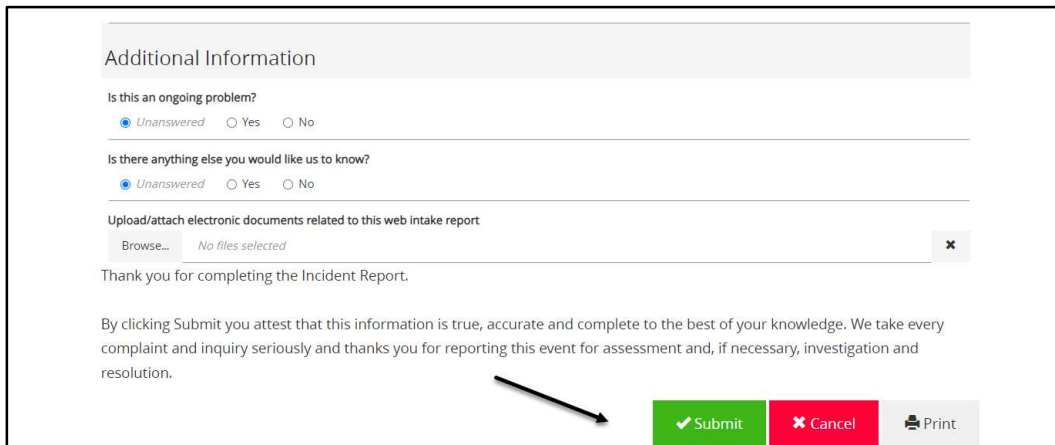
Enter response...

Is Perpetrator a State Worker?

Unanswered Yes No Unknown

Cancel OK

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



Additional Information

Is this an ongoing problem?

Unanswered Yes No

Is there anything else you would like us to know?

Unanswered Yes No

Upload/attach electronic documents related to this web intake report

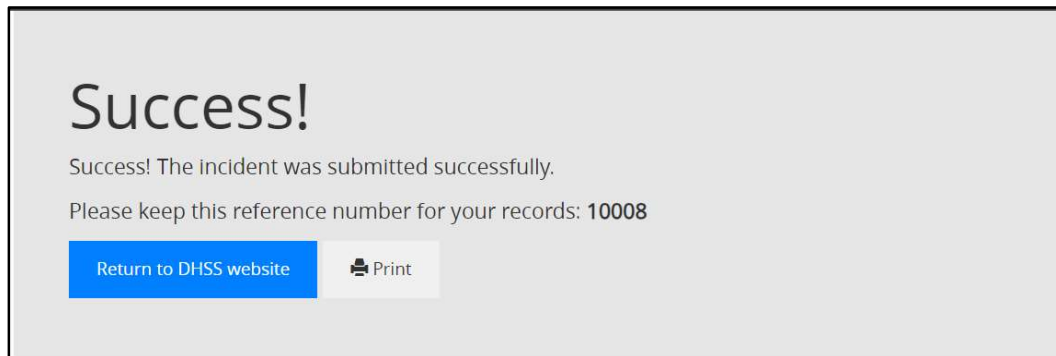
Browse... No files selected

Thank you for completing the Incident Report.

By clicking Submit you attest that this information is true, accurate and complete to the best of your knowledge. We take every complaint and inquiry seriously and thanks you for reporting this event for assessment and, if necessary, investigation and resolution.

Submit Cancel Print

30. 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 number for your records: **10008**

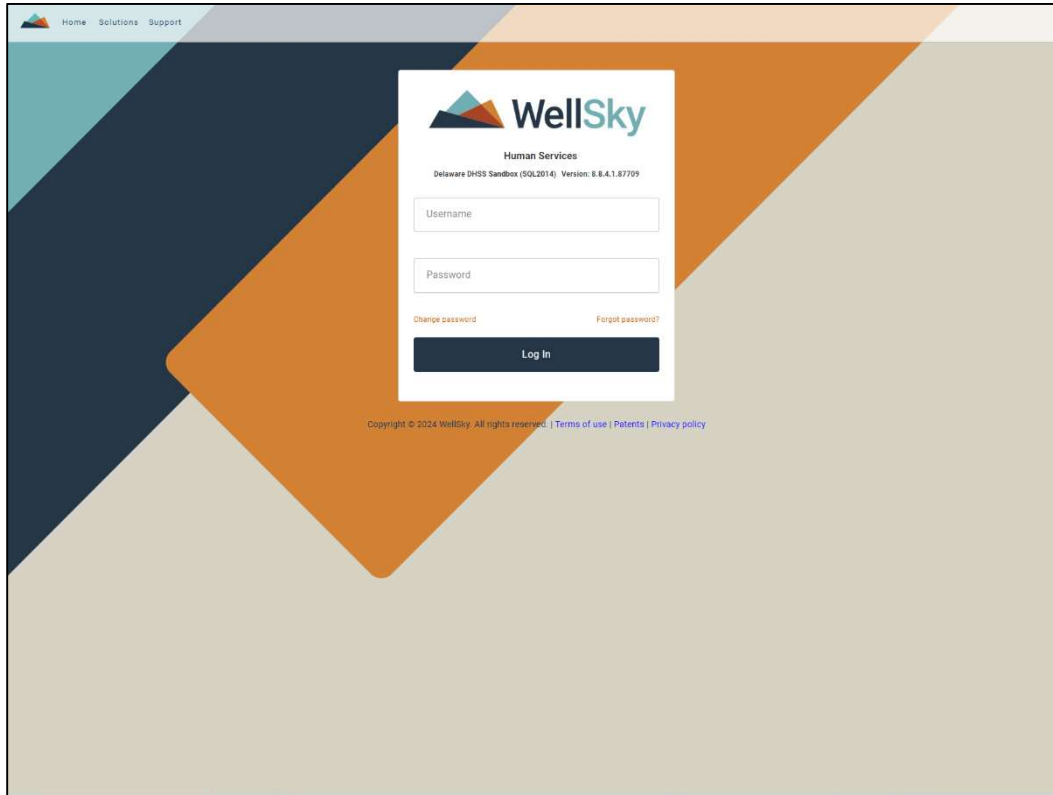
Return to DHSS website Print

Chapter 2 Getting Started: Logging into WellSky

1. Log into the Prod Environment using your username and password.

Delaware DHSS Production URL:

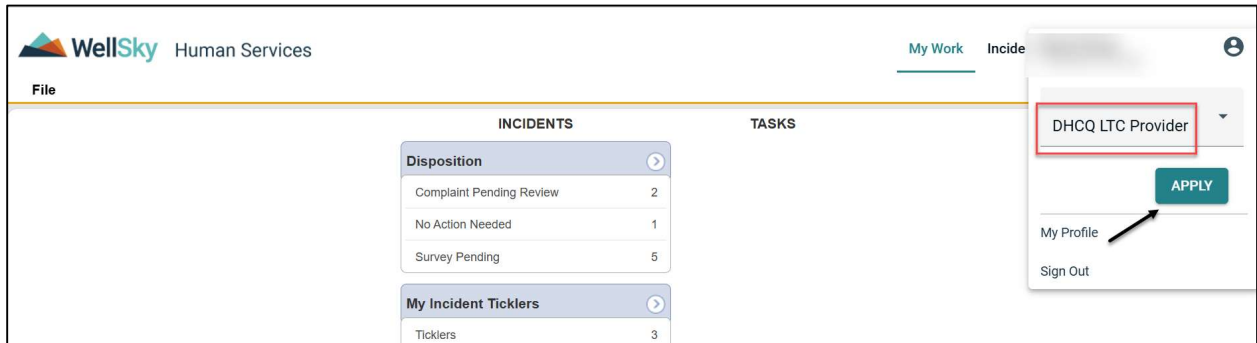
<https://hssdedhssprod.wellsky.com/humanservices/>



2. System will default to the My Work screen



3. Click the Person Icon in the upper right portion of the screen to view the default role. If you have multiple Roles assigned to you, you can select a new Role from the dropdown then click Apply

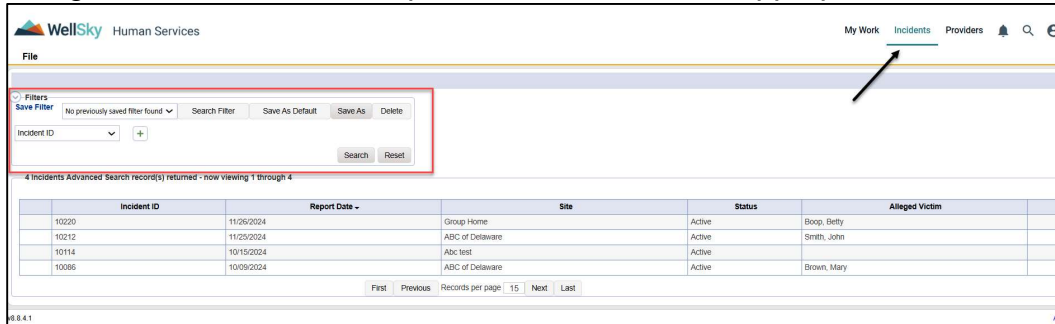


4. This will refresh the user's Role and the system will automatically return to the My Work page.

Chapter 3 Provider Completes 5 Day Follow Up

Role: DHCQ LTC Provider

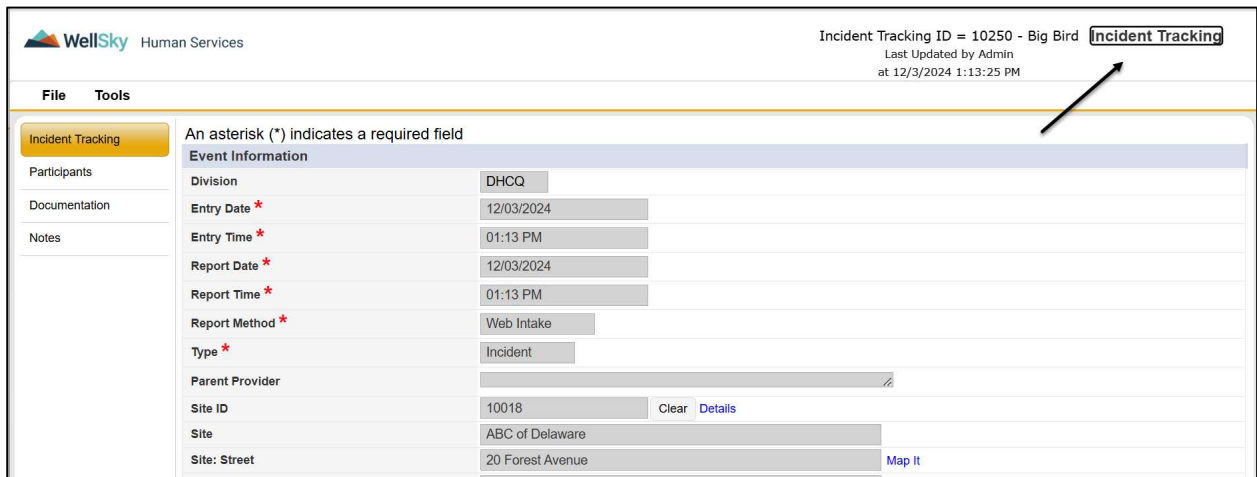
1. Navigate to the Incident Chapter and search for the appropriate incident.



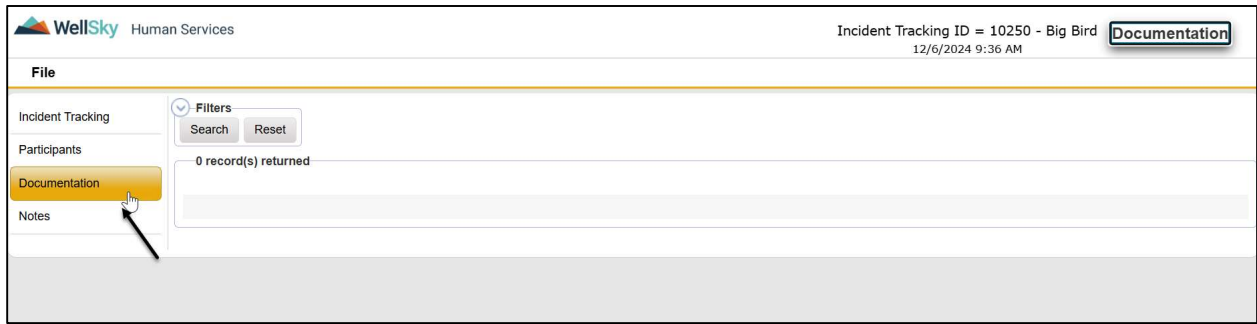
2. To select the Incident, click anywhere on the row.



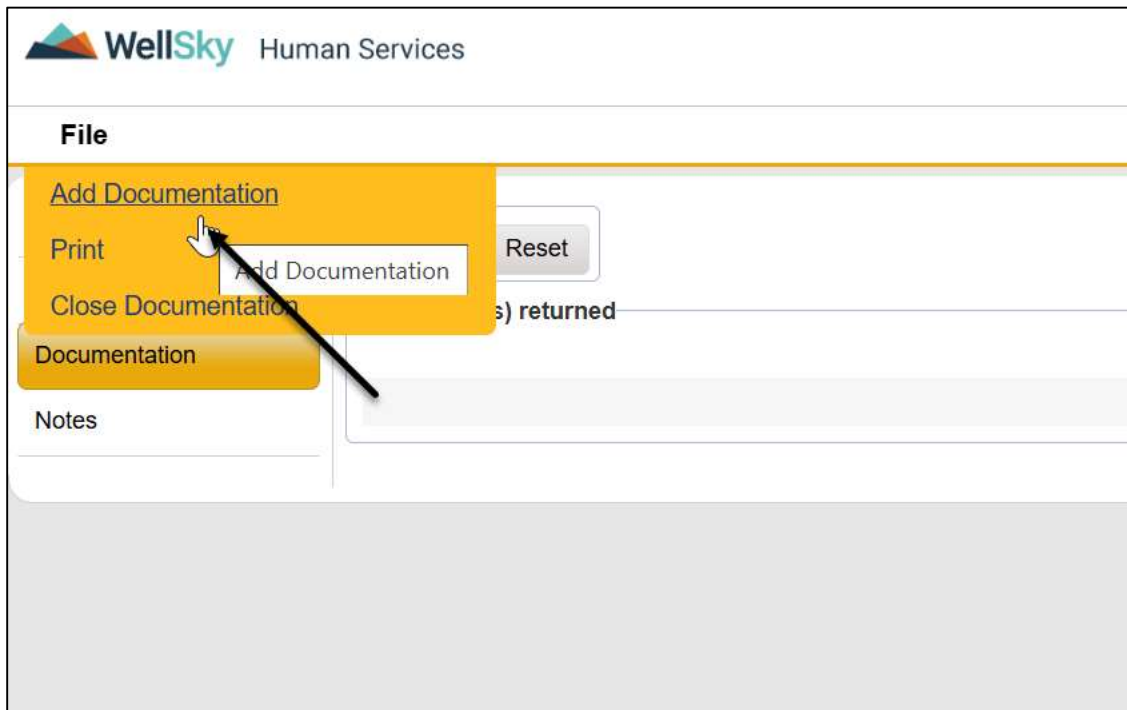
3. When the Incident pulls up, it directs you to the Incident Tracking page.



4. Navigate to the **Documentation** subpage.



5. From the **File** menu, select **Add Documentation**.



6. Select the **DHCQ FRI 5 Day Follow Up Report** and complete the documentation form.
 - a. Select the Victims name.
 - b. Complete all required fields.

WellSky Human Services Incident Tracking ID = 10250 - Big Bird Documentation
12/6/2024 9:39 AM

File

Please Select Type: **DHCQ FRI 5 Day Follow Up Report** ▼

An asterisk (*) indicates a required field

Forms

Review Date *

Entered By *

Document Status *

Victim *

1. Additional/Updated Information Related to the Reported Incident. Provide a brief description of any additional information and/or updates, if applicable

Describe any additional outcomes to the resident(s), identifying/describing any physical and mental harm *

2. Steps taken to investigate the allegation. Provide a detailed summary of ALL steps taken to investigate allegation

Summary of interview(s) with the alleged victims and/or the victim's responsible party, if applicable. Indicate any visual cues from the resident of psychosocial distress and harm and the resident's perspective on incurred psychological harm and distress *

Summary of interview(s) with witness(es), what the individual observed or knowledge of the alleged incident or injury *

Summary of interview(s) with the alleged perpetrator(s) (staff, resident, visitor, contractor, etc.) *

Summary of interview(s) with staff responsible for oversight and supervision of the location where the alleged victim resides *

Summary of interview(s) with staff responsible for oversight and supervision of the alleged perpetrator, if staff or a resident *

Provide summary information from the investigation related to the incident from the resident's clinical record. If a resident to resident altercation occurred, provide any relevant details that may have caused the alleged perpetrator's behavior *

If available within the five business day timeframe, provide summary information of other documents obtained, such as hospital/medical progress notes/orders and discharge summaries, law enforcement reports, and death reports as applicable *

3. Notifications

7. Facility Investigator

Name of person(s) investigating allegation *

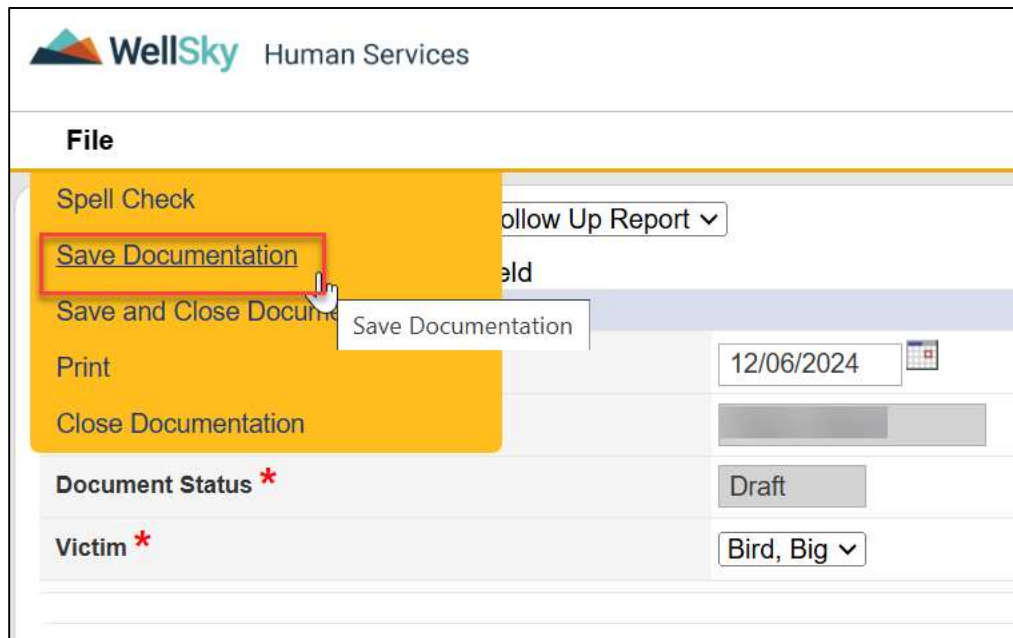
8. Submitted By

Name of administrator/designee *

Contact Number for follow up *

Email for follow up *

7. From the **File** menu, select **Save Documentation**.



8. This will make the Status editable. You can continue to make edits to the document if it is in a Draft or Pending status.
- Draft = Auto-populated when the document is first created.
 - Pending = Used when the document is still being edited and not ready to submit.
 - Submitted = All edits are complete and marks the form as read only.

File

DHCQ FRI 5 Day Follow Up Report

An asterisk (*) indicates a required field

Forms

Review Date *	12/06/2024
Documentation *	DHCQ FRI 5 Day Follow Up Report
Entered By *	
Document Status *	Pending
Victim *	

- Draft
- Pending
- Submitted

1. Additional/Updated Information Related to Incident. Provide a brief


- 9. Once the document is complete, update Status = Submitted.
- 10. From the **File** menu, select **Save and Documentation**.

File

History	
Spell Check	
Save Documentation	
Save and Close Documentation	
Print	
Close Documentation	

Document Status *	Submitted
Victim *	Bird, Big

11. This marks the form a read only and can no longer be edited.

 WellSky Human Services Incident Tracking ID = 10250 - Big Bird Documentation

File

DHCQ FRI 5 Day Follow Up Report

An asterisk (*) indicates a required field

Forms

Review Date *	12/06/2024
Documentation *	DHCQ FRI 5 Day Follow Up Report
Entered By *	
Document Status *	Submitted
Victim *	Bird, Big

1. Additional/Updated Information Related to the Reported Incident. Provide a brief description of any additional information and/or updates, if applicable

Describe any additional outcomes to the resident(s), identifying/describing any physical and mental harm *

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2. Steps taken to investigate the allegation. Provide a detailed summary of ALL steps taken to investigate allegation

Summary of interview(s) with the alleged victims and/or the victim's responsible party, if applicable. Indicate any visual cues from the resident of psychosocial distress and harm and the resident's perspective on

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12. End of Workflow.