

Software for Realizing Care's

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

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



Table of Contents

Introduction Incident Management User Guide	3
Learning Objectives for Incident Management User Guide	3
Chapter 1 Incident Reporting Form	4
Member of the public	6
Provider or a Facility	11
MCO	15
Chapter 2 Getting Started: Logging into WellSky	19
Chapter 3 Provider Completes 5 Day Follow Up	21

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
 - o 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

 the DE DHSS Incident Reporting Form is (Prod site): <u>https://hssdedhssprod.wellsky.com/assessments/?WebIntake=9A2787C9-BDCF-</u> <u>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 REPORTIN	IG SYSTEM
	omplaints, reportable incidents, and alleged abuse, neglect, mistreatment or financial exploitation PAA violations, etc.) of an individual supported by the following agencies:
Division of Medicaid & Med	Disabilities Services (DDDS)
If in doubt, please submit a rep	ort.
	address the issue as soon as possible. Please provide as much factual information as possible to ssure the safety and wellbeing of those we serve.
If you include your email addre your records.	ss in the report, you will receive an email confirmation message that you can print and retain for
	esentative if additional information is needed to best route the issue to the proper authority. Your n will only be used by the investigating staff and otherwise will remain confidential as required.
Incident Online Su	Ibmission Form
Some fields below are <mark>required</mark> . Plea	se 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
○ 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 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.

ome fields below are <mark>required</mark> . Please remember th	at the more information you provide the better we will	be able to investigate.
re 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 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 fal 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) requir		
Select the Item that best identifies your relationship to Unanswered	C Agency	O Facility
O Friend/Caregiver	O Medical staff	O Ombudsmen
O Relative	O Self	O Other
Reporters First Name required		
Enter response		
Reporters Last Name required		
Enter response		
Enter response City Start typing the name of the city, make a selection from the drop-down list. Enter response State Enter response	n the drop-down list. If your city does not populate	on the drop down, choose the next geographically closest city on
Zip Code Enter response		
Reporter's Phone		
Enter response		
Reporter's Email Please include an email address so we can send you co	firm an of the report and verification notification	n for your records.
Enter response		
Would you like to remain anonymous? O Yes O No		

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

ncid	ent Details
	Occurrence required
	e as MMDDYYYY. If approximate or unknown, enter closest date and explain in "Description of incident" field.
	Enter response
Time of	Occurrence
O	Enter response
	Discovered Date Reporter became aware of the incident
ш	Enter response
Police C	ontacted?
● Ur	answered 🔿 Yes 🔿 No 🔿 Unknown
	tion of Incident: required 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
Entei	response
	answered 🔿 Yes 🔿 No
Include s	tions were taken: teps 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 tor's access to the victim, as well as any notifications made. Include the action, who, the date and the time for each.
Entei	response
Incident	Type required
Incider	it Site Type (DHCQ LTC) required
	where the incident took place.
	r Name required full name of the provider, including the specific office name or location name if applicable
Enter	response
	iid the incident occur? required
cntel	r 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.

•	he "+ New" link below and the p	oage doesn't not open, disa	ible the <mark>Pop-up bloc</mark> ke	er.		
lleged Victim req	Last Name	First Name	Street	City	Home Phone	Cell Phone
lleged Perpetrat	he "+ New" link below and the p or(s) wo or more alleged perpetrators	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			incident of the alleged victim	
lleged Perpetrat	or(s)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			n incident of the alleged victim Home Phone	Cell Phone
lleged Perpetrat	or(s) wo or more alleged perpetrators	, they must be related to the	same abuse, neglect,	or exploitation		
vou wish to enter t	or(s) wo or more alleged perpetrators	, they must be related to the First Name	same abuse, neglect, Street	or exploitation		
Ileged Perpetrat you wish to enter t New	or(s) Last Name	, they must be related to the First Name	same abuse, neglect, Street	or exploitation		

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

First Manage				
First Name required Please type "unknown" if you do not know the	Alleged Victim's first name.			
Jane	1992 - 1999 - U.S. 1998 - H.L. (1994 - L. (1994 - 1997 - 199			
Last Name required				
Please type "unknown" if you do not know the	Alleged Victim's last name.			
Parker		5	/	
Alias		/		
Please provide any nicknames, alternate name	s, or any former last names.			
Enter response				
Date of Birth Enter 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 Gender	Male			
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender O Unanswered @ Female O	Male			
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender O Unanswered @ Female O	Male O Female		⊖ Male	
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender Olnanswered • Female O Gender Identity	20200	<u>_</u>	 Male Transgender Female 	
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender O Unanswered Female O Gender Identity O Unanswered) Female	5	0	

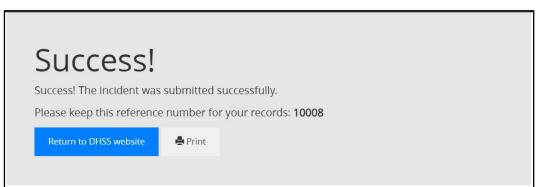
12. Click **OK** at the bottom of the form

mail	5					
Enter res	sponse					
Perpetrat	tor a State V	Vorker?				
Unans	swered (🔾 Yes 🛛 No	O Unknown			
						ł

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

Is this an ongoing problem?				
Is there anything else you would like us t	o know?			
O Unanswered ○ Yes ○ No				
Upload/attach electronic documents rela	ted to this web intake report			
Browse No files selected				×
Thank you for completing the Inci	dent Report.			
Du dicking Cubook you attact that	this information is true accur	ate and complete to the h	ast of your lessues	dae Metalia avea
By clicking Submit you attest that complaint and inquiry seriously a		A	~	
complaine and inquiry seriously a	id thanks you for reporting th	is event for assessment a	nu, in necessary, in	vesugation and

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



Provider or a Facility

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

Incident Online Submis	sion Form	
Some fields below are <mark>required</mark> . Please remembe	r that the more information you provide the better we will	be able to investigate.
Are you a: required		
O Unanswered	O Member of the general public/service recipient	Provider/Facility
⊖ мсо		
Is this report for: required		
○ Unanswered	 Division of Developmental Disabilities Services 	 Division of Substance Abuse and Mental Health
O 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. Procced 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 diff	erent from reporter:		
Reporter's Relationship to Victim (DHCQ) required Select the Item that best identifies your relationship to the	alleged victim.		
Unanswered	 Agency 	O Facility	
O Friend/Caregiver	O Medical staff	O Ombudsmen	
O Relative	O Self	O Other	
Reporters First Name required			
Reporters Last Name required			
Reporter's Phone required Enter response			
Reporter's Email required Please include an email address so we can send you confir	nation of the report and verification notificatio	n for your records.	

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

Incid	ent Details	
	Occurrence required	
Enter da	te as MMDDYYYY. If approximate or unknown, enter closest date and explain in "Description of Incident" field. Enter response	
Time of O	Occurrence required Enter response	
	t Discovered Date required Reporter became aware of the incident.	
	Enter response	
Police C	iontacted? required	
🖲 Ui	nanswered O Yes O No O Unknown	
Describe HOW.	tion of Incident: required 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 r response	
III UI	n ongoing problem? required nanswered O Yes O No be any changes in the behavior of the resident required	
If appilo		
Include s perpetra	ctions were taken: required teps 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 tor's access to the victim, as well as any notifications made. Include the action, who, the date and the time for each. r response	
Inciden	t Type required	~
	nt Site Type (DHCQ LTC) required e where the incident took place.	~
	er ID required er response	
Enter the	r Name required Full name of the provider, including the specific office name or location name if applicable	
Ente	r response	
Where	did the incident occur? required	

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.

you have clicked t	to "+ Naw" link bolow and the s	and doorn't not open dis	able the Pep up blocks			
lleged Victim req	he "+ New" link below and the p	age doesn't not open, dis	able the rop-up blocke			
+ New	Last Name	First Name	Street	City	Home Phone	Cell Phone
lleged Perpetrat					incident of the alleged victim	
lleged Perpetrat					i incident of the alleged victim Home Phone	Cell Phone
lleged Perpetrat	or(s) wo or more alleged perpetrators,	, they must be related to th	e same abuse, neglect,	or exploitation		
Ileged Perpetrat you wish to enter t New	or(s) wo or more alleged perpetrators,	, they must be related to th First Name	e same abuse, neglect, Street	or exploitation		
vou wish to enter t	or(s) wo or more alleged perpetrators, Last Name he "+ New" link below and the pa	, they must be related to th First Name	e same abuse, neglect, Street	or exploitation City		

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

First Manage				
First Name required Please type "unknown" if you do not know the	Alleged Victim's first name.			
Jane	nezz zeden un Ponezz in anno 11 metro de 1994 prezz			
Last Name required				
Please type "unknown" if you do not know the	Alleged Victim's last name.			
Parker		5	/	
Alias		/		
Please provide any nicknames, alternate name	s, or any former last names.			
Enter response				
Date of Birth Enter 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 Gender	Male			
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender O Unanswered @ Female O	Male			
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender O Unanswered @ Female O	Male O Female		⊖ Male	
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender Olnanswered • Female O Gender Identity	20200	<u>_</u>	 Male Transgender Female 	
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender O Unanswered Female O Gender Identity O Unanswered) Female	<i>[</i> ₂	0	

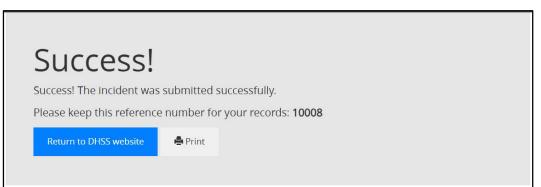
20. Click **OK** at the bottom of the form

mail 💫	
Enter response	
Perpetrator a State Worker?	
Unanswered O Yes O No O Unknown	

21. Enter any additional information needed and click Submit.

Is this an ongoing problem				
Unanswered O Y	:s ○ No			
Is there anything else you	vould like us to know?			
💿 Unanswered 🛛 🔿 Y	es 🔿 No			
Upload/attach electronic d	ocuments related to this web intake report			
Browse No files se	lected			
Thank you for complet	ing the Incident Report.			
, ,	attest that this information is true, a		~	
complaint and inquiry	seriously and thanks you for reportin	ng this event for assessme	ent and, if necessary,	investigation and

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



MCO

23. Select "MCO" & "Division of Health Care Quality LTC"

Incident Online Submis	sion Form	
Some fields below are <mark>required</mark> . Please remembe	er that the more information you provide the better we will	be able to investigate.
Are you a: required		
Unanswered MCO	O Member of the general public/service recipient	O Provider/Facility
Is this report for: required		
O Unanswered	 Division of Developmental Disabilities Services 	 Division of Substance Abuse and Mental Health
O Division of Health Care Quality Acute	Division of Health Care Quality LTC	O Division Of Medicaid and Medical Assistan
Which MCO are you reporting on behalf of? requir	red	
Unanswered	O AmeriHealth Caritas Delaware	 Delaware First Health
O 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 diff	erent from reporter:		
Reporter's Relationship to Victim (DHCQ) required Select the item that best identifies your relationship to th	alleged victim.		
Unanswered	O Agency	O Facility	
O Friend/Caregiver	O Medical staff	O Ombudsmen	
O Relative	O Self	O 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 confir <i>Enter response</i>	nation of the report and verification notificatio	an for your records.	
Would you like to remain anonymous?			

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

Incident Details		
Date of Occurrence required		
And the second success of the second s	wn, enter closest date and explain in "Description of Incident" field.	
Time of Occurrence required		
Enter response		
Incident Discovered Date When the Reporter became aware of the incident:		
Enter response		
Police Contacted?		
Unanswered O Yes O No	O Unknown	
Description of Incident: required		
	vith as much detail as positible. Include details of any injuries if applicable. Include WHO, WHAT, WHERE, WHEN, WHY and	
Enter response		
a tradición de las consectos de las defensiones		
s this an ongoing problem? required		
Describe any changes in the behavior of the If applicable	le resident required	
Enter response		
What actions were taken:		
Include steps such as: assessment of immediate m	edical 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 no Enter response	tifications made. Include the action, who, the date and the time for each.	
Litter responses		
Incident Type required		200
Incident Site Type (DHCQ LTC) required		
Indicate where the incident took place.		
		×
Provider Name required Enter the full name of the provider, including the s	sarifir effect mana se bentian mana if apolicable	
Enter the full hame of the provider, including the a Enter response	evin, voive mene vi lucatum name il applicatue	
Where did the incident occur? required		
where did the incident occur? required	r room if applicable	
Enter response		

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.

•	he "+ New" link below and the p	oage doesn't not open, disa	ible the <mark>Pop-up bloc</mark> ke	er.		
lleged Victim req	Last Name	First Name	Street	City	Home Phone	Cell Phone
lleged Perpetrat	he "+ New" link below and the p or(s) wo or more alleged perpetrators	1 11 1 1			incident of the alleged victim	
lleged Perpetrat	or(s)	1 11 1 1			n incident of the alleged victim Home Phone	Cell Phone
lleged Perpetrat	or(s) wo or more alleged perpetrators	, they must be related to the	same abuse, neglect,	or exploitation		
vou wish to enter t	or(s) wo or more alleged perpetrators	, they must be related to the First Name	same abuse, neglect, Street	or exploitation		
Ileged Perpetrat you wish to enter t New	or(s) Last Name	, they must be related to the First Name	same abuse, neglect, Street	or exploitation		

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

First Manage				
First Name required Please type "unknown" if you do not know the	Alleged Victim's first name.			
Jane	nezz zeden un Ponezz in anno 11 metro de 1994 prezz			
Last Name required				
Please type "unknown" if you do not know the	Alleged Victim's last name.			
Parker		5	/	
Alias		/		
Please provide any nicknames, alternate name	s, or any former last names.			
Enter response				
Date of Birth Enter 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 Gender	Male			
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender O Unanswered @ Female O	Male			
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender O Unanswered @ Female O	Male O Female		⊖ Male	
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender Olnanswered • Female O Gender Identity	20200	<u>_</u>	 Male Transgender Female 	
Date of Birth Enter date as MMDDYYYY - no slashes Enter response Gender O Unanswered Female O Gender Identity O Unanswered) Female	5	0	

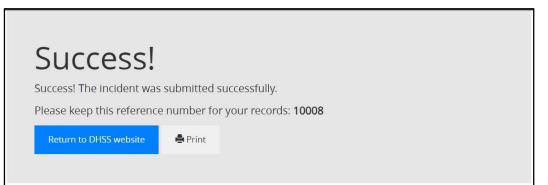
28. Click **OK** at the bottom of the form

mail 😞	
Enter response	
Perpetrator a State Worker?	
● Unanswered ○ Yes ○ No ○ Unknown	
	Cancel

29. Enter any additional information needed and click Submit.

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 v	eb intake report		
Browse No files selected			×
Thank you for completing the Incident Repo	t.		
By clicking Submit you attest that this infor	ation is true, accurate and complete	to the best of your know	ledge. We take every
complaint and inquiry seriously and thanks	23 A		0
resolution.	1 0		0

30. 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.

Delaware DHSS Production URL:

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

Home Solutions Support		
	Human Services Human Services Disease 5H55 Sandbox (502.014) Vension: 8.8.4.1.87795	
	Password Charge assessed Forgot password Log In	
	Copyright © 2024 WellSky All rights reserved. Terms of use Patents Privacy policy	

2. System will default to the My Work screen

WellSky Human Services			My Work Incidents Providers Repo	orts 🏚 Q 😝
INCIDENTS		PROVIDERS	TASKS	
Disposition	0		My Management	۲
Complaint Pending Raview	1		Tickless Duo	
Notes	<u>o</u>		Event Ticklers	
Pending	1		Alert Notes	
Alert Notes - Intakes Unread Aleri Notes	0			
v8.84.1				Altour

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

WellSky Human Services				My Work	Incide -		Θ
File	INCIDENTS		TASKS		-	DHCQ LTC Provider	-
	Disposition	\bigcirc					
	Complaint Pending Review	2				APF	PLY
	No Action Needed	1				My Profile	
	Survey Pending	5				Sign Out	
	My Incident Ticklers	\bigcirc					
	Ticklers	3					

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.

				1
No previously saved filter found 🗸	Search Filter Save As Default Save As Delete			/
D	Search Reset ed - now viewing 1 through 4			
		Site	Status	Alleged Victim
ents Advanced Search record(s) retur	ed - now viewing 1 through 4		Status	Alleged Victim Boop, Betty
ents Advanced Search record(s) retur	ed - now viewing 1 through 4 Report Date -	Group Home A		
ents Advanced Search record(s) return Incident ID 10220	red - now viewing 1 through 4 Report Date - 11/25/2024	Group Home A ABC of Delaware A	tive	Boop, Betty

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

		Search Reset		
5 Incidents Advanced Search reco	rd(s) returned - now viewing 1 through 5			
Incident ID	Report Date 🗸	Site	Status	Alleged Victim
10250	12/03/2024	ABC of Delaware from	Active	Bird, Big
10220	11/26/2024	Group Home	Active	Boop, Betty
10212	11/25/2024	ABC of Delaware	Active	Smith John

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

WellSky Hu	uman Services			Incident Tracking ID = 10250 - Big Bird Incident Tracking Last Updated by Admin at 12/3/2024 1:13:25 PM
File Tools				
Incident Tracking	An asterisk (*) indicates a required	d field		
	Event Information			
Participants	Division	DHCQ		
Documentation	Entry Date *	12/03/2024		
Notes	Entry Time *	01:13 PM		
	Report Date *	12/03/2024		
	Report Time *	01:13 PM		
	Report Method *	Web Intake		
	Type *	Incident		
	Parent Provider			1.
	Site ID	10018	Clear Details	
	Site	ABC of Delaware		
	Site: Street	20 Forest Avenue		Map It
		and story and story		

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

WellSky Hur	nan Services	Incident Tracking ID = 10250 - Big Bird 12/6/2024 9:36 AM
Incident Tracking Participants Documentation Notes	Search Reset 0 record(s) returned	

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

📥 WellSky	Human Services		
File			
Close Documenta	d Documentation	Reset s) returned	
Documentation Notes			

- 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.

MellSky 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				
Forms				
Review Date *	12/06/2024			
Entered By *	Sharp, Mandi			
Document Status *	Draft			
Victim *	Bird, Big 🗸			
1. Additional/Updated Information Related to the Reported Incident	. Provide a brie	ef description of any additional information and	l/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 sum	mary of ALL st	eps 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 phychological harm and distress *				
Summary of interview(s) with witness(es), what the individual observed or knowledge of the alleged incident or injury \bigstar				
Summary of interview(s) with the alleged perpetrator(s) (staff, resident, visitor, contractor, etc.) \clubsuit				
Summary of interview(s) with staff responsible for oversight and supervision of the location where the alleged victim resides \bigstar				
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 *			16	4
If available within the five business day timeframe, provide summary information of other documents obtained, such as hospitalimedical progress notes/orders and discharge summaries, law enforcement reports, and death reports as applicable *			<i>h</i>	
3 Notifications				
				-
7. Facility Investigator				
Name of person(s) investigating allega	tion *			k
8. Submitted By				
Name of administrator/designee *				(
Contact Number for follow up *		x(xxx)xxx-xxxx		
Email for follow up *	Email for follow up *			
and a second and a s	and a second second	and a find and a second	and the second second	Server and a for a former of the server

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

File	
Spell Check	ollow Up Report 🗸
Save Documentation	∍ld
Save and Close Docume Save	Documentation
Print	12/06/2024
Close Documentation	The second se
Document Status *	Draft
Victim *	Bird, Big 🗸

- 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.
 - a. Draft = Auto-populated when the document if first created.
 - b. Pending = Used when the document is still being edited and not ready to submit.
 - c. Submitted = All edits are complete and marks the form as read only.

WellSky Human Services	
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 V
Victim *	
	Draft
	Pending
1. Additional/Updated Information Related to	Submitted a brief

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

WellSky Human Services	
File	
History	ort
Spell Check	∍ld
Save Documentation	
Save and Close Documentation	12/06/2024
Save and Clo	DHCQ FRI 5 Day Follow Up Report
Close Documentation	and the second se
Document Status *	Submitted V
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 *	(And And And And And And And And And And
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),	test
identifying/describing any physical and mental harm *	<i>H</i>
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	test
any visual cues from the resident of psychosocial	
the victim's responsible party, if applicable. Indicate	test (//

12. End of Workflow.