



Software for Realizing Care's Potential

# Delaware Division of Health Care Quality (DHCQ) Acute Care

## Provider Incident Management User Guide

1-855-WELLSKY

[WellSky.com](https://www.wellsky.com)

# Incident Management

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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
  - MCO
  - 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):  
<https://hssdedhssprod.wellsky.com/assessments/?WebIntake=9A2787C9-BDCF-449A-BFD7-59B32DD77BE7>

## Incident Management

- 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

- 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.
- If you are a Provider or Facility, skip to this step [Provider/Facility](#).
- Of you are a MCO, skip to this step, [MCO](#).
- If you are a member of the public, continue to the next step.

## Incident Management

### Member of the public

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

<input checked="" type="radio"/> <b>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)</b>	<input type="radio"/> 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)	<input type="radio"/> 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)
	<input type="radio"/> 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)	<input type="radio"/> 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.

# Incident Management

## Reporter Information

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

Unanswered

Friend/Caregiver

Relative

Agency

Medical staff

Self

Facility

Ombudsmen

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 information for your records.  
Enter response...

**Would you like to remain anonymous?**

Yes  No

# Incident Management

## 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.

**Time of Occurrence**

**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?**  
 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.

**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.

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

## Incident Management

- 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

- 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

## Incident Management

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



Enter response...

Email 

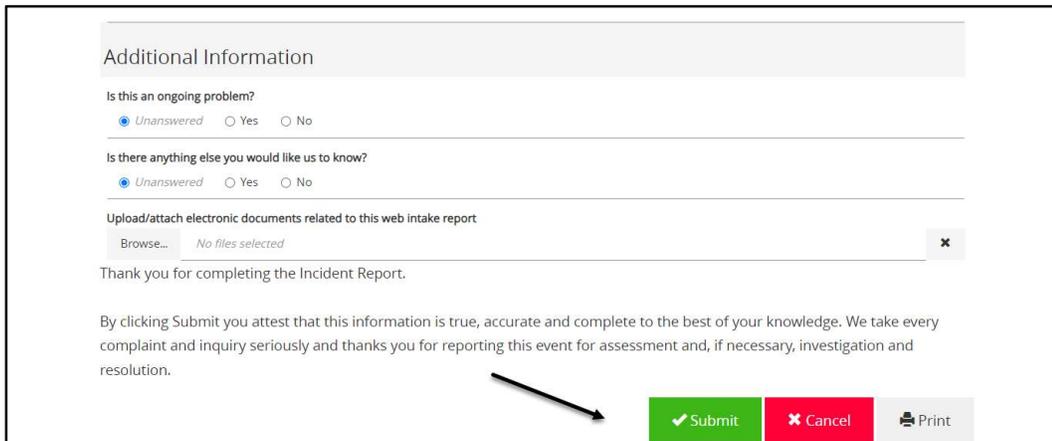
Enter response...

Is Perpetrator a State Worker?

Unanswered  Yes  No  Unknown

Cancel OK

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

[Return to DHSS website](#)

# Incident Management

## Provider/Facility

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

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 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 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

# Incident Management

## 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.

**Time of Occurrence** required

**Incident Discovered Date** required  
When the Reporter became aware of the Incident

**Police Contacted?** required  
 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

**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.

**Incident Type** required

**Incident Site Type (DHCQ Acute)** required  
Indicate where the incident took place.

**Provider ID** required

**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.

## Incident Management

- 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.

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

<a href="#">+ New</a>	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.

<a href="#">+ New</a>	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)**

<a href="#">+ New</a>	Last Name	First Name	Relationship	Phone

Additional Information

- 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 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

## Incident Management

Enter response...

Email   
Enter response...

Is Perpetrator a State Worker?  
 Unanswered  Yes  No  Unknown

Cancel OK

20. 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

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 number for your records: 10008

Return to DHSS website Print

## MCO

22. Select “MCO” & “Division of Health Care Quality Acute”

# Incident Management

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

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 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**  
*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

# Incident Management

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 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

**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 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.

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

## Incident Management

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.

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

<a href="#">+ New</a>	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.

<a href="#">+ New</a>	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)**

<a href="#">+ New</a>	Last Name	First Name	Relationship	Phone

Additional Information

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 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

## Incident Management

Enter response...

Email 

Enter response...

Is Perpetrator a State Worker?

Unanswered  Yes  No  Unknown

Cancel OK

A black arrow points down from the top right of the form towards the 'OK' button.

27. 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.

A black arrow points to the 'Submit' button.

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

**Success!**

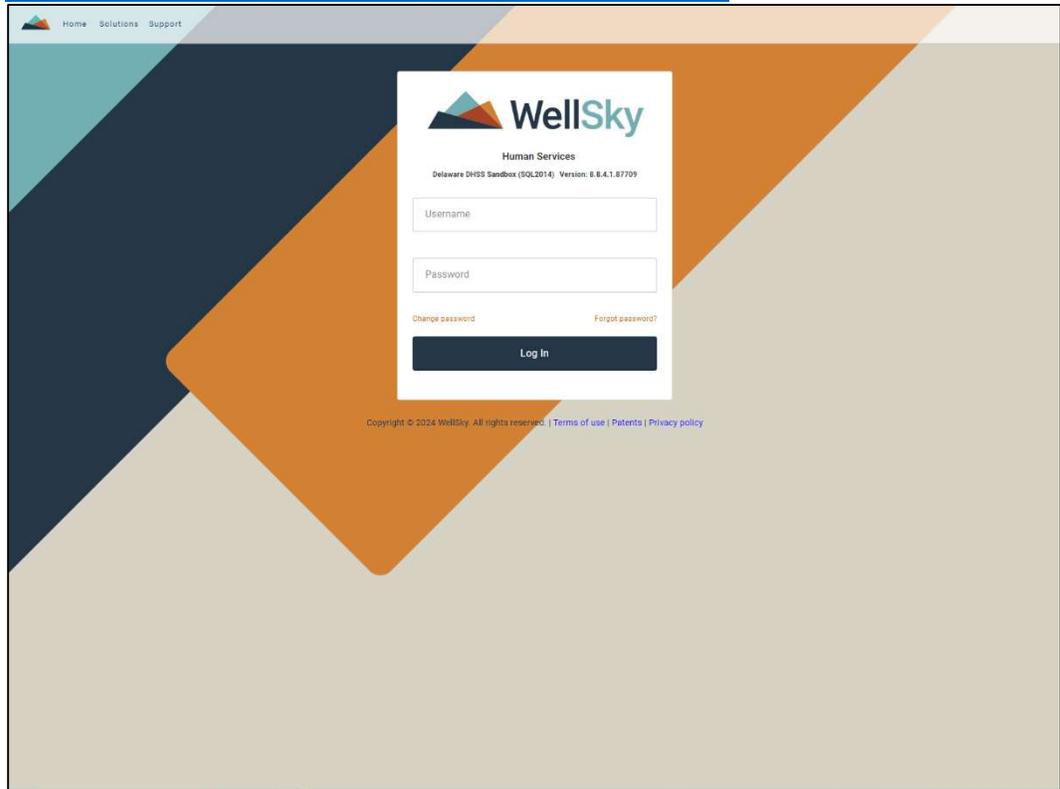
Success! The incident was submitted successfully.

Please keep this reference number for your records: **10008**

[Return to DHSS website](#) 

## 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/>



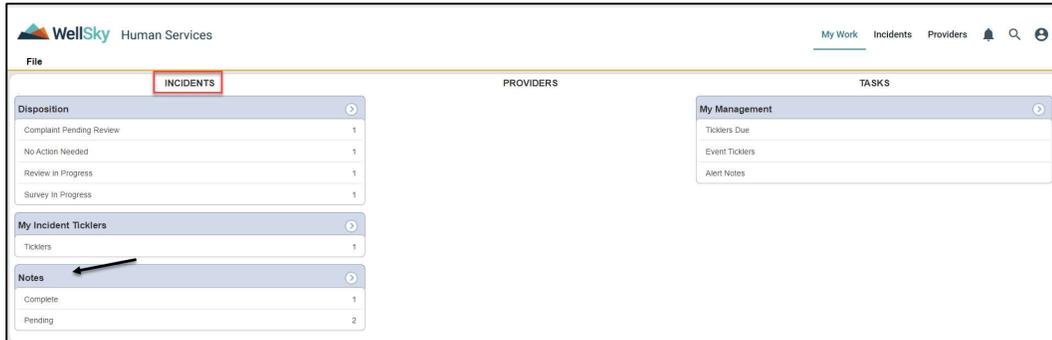
a. System will default to the My Work screen



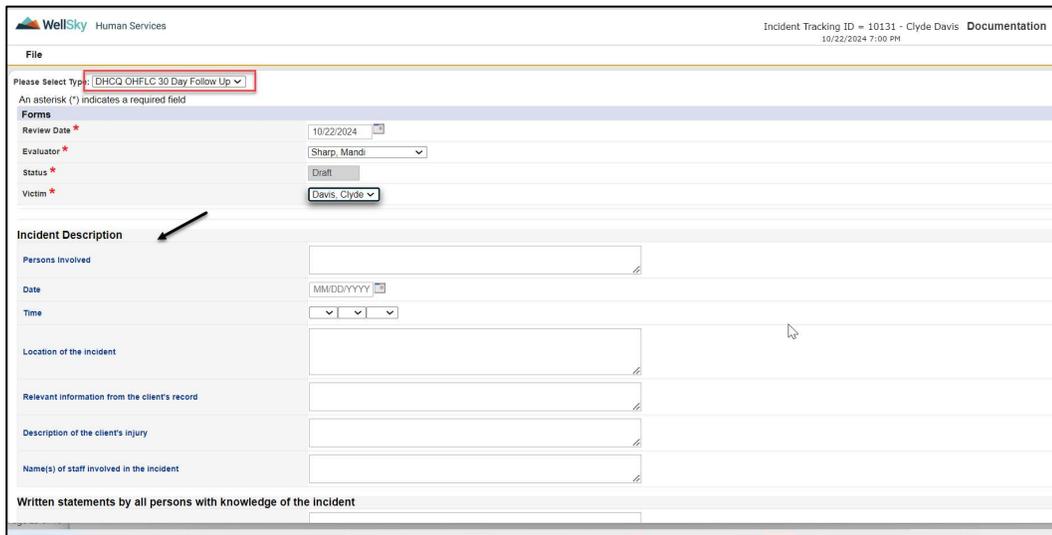
## Chapter 3 Provider 30 Day Follow Up

### Role: DHCQ Acute Provider

1. Monitor **My Work** dashboard for incoming Pending notes.



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.



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

## Incident Management

The screenshot shows a form titled "DHCQ OHFLC 30 Day Follow Up" in the WellSky Human Services system. The form includes a "File" menu at the top. Below the title, a note states "An asterisk (\*) indicates a required field". The "Forms" section contains several fields: "Review Date" with a date picker set to 10/22/2024; "Documentation" with a dropdown menu set to "DHCQ OHFLC 30 Day Follow Up"; "Evaluator" with a dropdown menu set to "Tarzwell, Dawn"; "Status" with a dropdown menu set to "Submitted", which is highlighted with a red rectangular box; and "Victim" with a dropdown menu set to "Davis, Clyde".

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**.

The screenshot shows the WellSky Human Services interface. In the top right corner, it displays "Incident Tracking ID = 10131 - Clyde Davis" and "Notes" with a timestamp of "10/22/2024 7:42 PM". On the left side, there is a "File" menu with options: "Add Note", "Print", "Close Notes", "Documentation", and "Notes". The "Add Note" option is highlighted in yellow, and a mouse cursor is pointing at it. To the right of the menu, there is a search bar with "Search" and "Reset" buttons, and a status indicator that says "0 record(s) returned".

- 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

# Incident Management

Note Date \* 10/22/2024

Note By \* Sharp, Mandi

Note Type \* Notifications

Note Sub-Type Provider

Note Details

Status \* Pending

Attachments

Add Attachment

Attachments Grid

Document	Description	Category
There are no attachments to display		

Notes Recipients

Add Note Recipient:

Lookup Clear

Note Recipients Grid

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		

Notes Recipients

Add Note Recipient:

Lookup Clear

Note Recipients Grid

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