Critical Incident Report

C O N F I D E N T I A L – For Internal Use Only

INSTRUCTIONS: Reports must be written in a specific, objective, and factual manner. Events should be listed in chronological order and include follow-up actions. This report is classified as ***confidential***. Pages 1, 2 & 3 of the incident report must be documented completely within 24 hours of when the incident was observed or reported and submitted per policy. Please write N/A if a section does not apply.

A. SPECIFICS OF INCIDENT			
1. Name of Individual Involved:	2. ☐ Individual (Client) ☐ Staff ☐ Other (specify) _____	3. Gender ☐ Male ☐ Female	
4. Date of Birth / /	5. Contact Phone Number ( ) - -	6. Street Address	
7. City/State/Zip:	8. Program Name:	9. Program Type:	
10. Location of Incident (Street Address):	11. City/State/Zip:	12. ☐ Program ☐ Residence ☐ Community ☐ Other: _____	
13. Date of incident	14. Date Observed	15. Date of Report	
16. Time of Incident _____ : _____ ☐ a.m. ☐ p.m. ☐ Unknown	17. Time Observed _____ : _____ ☐ a.m. ☐ p.m.	18. Time of Report _____ : _____ ☐ a.m. ☐ p.m.	
19. Name of Other Involved/Witness (not including staff-see below) ☐ Client ☐ Other: _____	23. Name of Other Involved/Witness (not including staff-see below) ☐ Client ☐ Other: _____		
20. Street Address:	24. Street Address:		
21. City/State/Zip:	25. City/State/Zip:		
22. Contact Phone Number ( ) - -	26. Contact Phone Number ( ) - -		
27. Other Staff Involved, if applicable: Name: _____ Contact #: _____ Name: _____ Contact #: _____ Name: _____ Contact #: _____ Name: _____ Contact #: _____ Name: _____ Contact #: _____ Name: _____ Contact #: _____			
28. Name of Person Completing Report:	**29. Signature:**	**30. Date:** / /	**31. Phone Number:**

B. DESCRIPTION OF INCIDENT (BASED ON RELEVANT FACTS ONLY) Please **PRINT** clearly.

2. Name of Person Completing Report:	**3. Signature:**	**4. Date:** / /	**5. Phone Number**

C. TYPE OF INCIDENT (Contact appropriate external agencies and complete forms as listed on page 5)

Staff members shall report all incidents/ critical events observed, discovered or reported by another person. If the incident resulted in events that can be classified under multiple categories of incidents, **please check off ALL that apply.**

☐ **Reportable Disease**

☐ **Bomb Threat**

☐ **Emergency Closure/Relocation**

☐ **Potential Negative Community Involvement**

☐ **Falls** ☐ **Seizures that do not require EMS**

☐ **Allegations of Rights Violation/Privacy Violation/Identity Theft**

☐ **Property /Equipment Damage**

Alleged Criminal Act / Theft / Misuse of Funds / Exploitation
☐ Individual to Individual ☐ Staff to Individual ☐ Other: _____

☐ **Threats with Intent to Cause Injury (Staff, Client, or Other Parties)**

Law Enforcement Activity (complete Police form):
☐ Violation of Parole
☐ Crisis intervention
☐ Employee / Caregiver
☐ Individual charged with a crime/under police investigation
☐ Individual victim of crime
☐ Moving violation
☐ Site crimes (vandalism, break-in, etc.)
☐ Other: _____

Fire:
☐ Carbon Monoxide/Gas/etc. alarm
☐ Fire personnel response to false alarm(cooking, fire drill, malfunction)
☐ Fire requiring relocation/closure
☐ Fire with property damage
☐ Fire without property damage
☐ Other: _____

☐ **Suicide Threat**

Suicide Attempt: ☐ ER Treatment ☐ Hospital ☐ Other: _____

☐ **Missing Person**

☐ **Allegations of Unsafe Environmental Conditions (Physical Plant)**

☐ **Bed Bugs**

Injury (Complete / Attach Injury Form):
☐ No Medical Tx ☐ First Aid Only

☐ **Medical - Non-Hospitalization (specify, i.e.: boil, infection, swelling, bump)** _____

☐ **Vehicle Accident (Complete Accident Form)**

Hospitalization – Psychiatric:
☐ Admitted Involuntary changed to Voluntary
☐ Admitted Voluntary changed to Involuntary
☐ Involuntary
☐ Voluntary

Hospitalization – Medical (Non-Psychiatric):
☐ Elective medical procedure
☐ Elective surgery
☐ Illness (specify below)
_____
☐ Illness-chronic/recurring
☐ Illness-new
☐ Injury individual to individual
☐ Injury accidental
☐ Injury resulting from restraint
☐ Injury self inflicted
☐ Injury staff to individual
☐ Injury unexplained

Injury requiring treatment beyond first aid (Complete/attach Injury Form) (If employee hospitalization, death, loss of eye or amputation, contact on-call Admin)
☐ Injury accidental
☐ Injury individual to individual
☐ Injury from restraint
☐ Injury self inflicted
☐ Injury staff to individual
☐ Injury individual to staff
☐ Injury unexplained
☐ Injury other
☐ Toxic Reaction
☐ CPR
☐ Abdominal Thrusts
☐ Injury did not occur at NHS

Emergency Room Visit / Medical / Emergency Problem beyond first aid:
☐ Illness-chronic/recurring
☐ Illness-new
☐ Injury accidental
☐ Injury unexplained
☐ Injury resulting from restraint
☐ Injury did not occur at NHS
☐ Injury self inflicted
☐ Injury individual to individual
☐ Injury staff to individual
☐ Injury other
☐ Psychiatric
☐ Seizures that require EMS

Allegations of Abuse – Individual (Consumer) to Individual (Consumer): *
☐ Physical ☐ Psychological ☐ Sexual
☐ Verbal

Allegations of Abuse–Staff to Individual (Consumer):*
☐ Physical ☐ Sexual
☐ Psychological ☐ Verbal
☐ Improper or unauthorized use of restraint

Allegations of Assault – Individual (Consumer) to Individual (Consumer)*
☐ Physical ☐ Verbal

Allegations of Neglect: * ☐ Failure to provide needed care
☐ Failure to provide other needed supervision
☐ Failure to provide protection from hazards
☐ Leaving individual(s) unattended
☐ Other: _____

☐ **Death:**
☐ CCID Operated
☐ Location Suicide
☐ Other: _____

***Allegations of Abuse or Neglect:**
☐ **Family/Guardian/Other Person Responsible for Care**
☐ **Non-Family** **Childline contacted** ☐ **Yes** ☐ **No**
If yes, Childline report #: _____

Physical Intervention/Restraint: ☐ **Yes** ☐ **No**
☐ Physical ☐ Mechanical ☐ Chemical
If yes, report #: _____

☐ **Other – Specify:**

FOR EHR REPORT ONLY:
☐ Ingesting Inedible

Medication:
☐ Omission - missed medication not approved by physician
☐ Wrong Dose - Gave too much or too little medication during a scheduled administration
☐ Wrong Form - Gave the wrong form of the medication
☐ Wrong Medication - Gave an extra dose of medication that should not have been given
☐ Wrong Medication - Gave medication that was supposed to be given for another reason
☐ Wrong Person - Gave person someone else's medication
☐ Wrong Position - Person was positioned improperly to receive medication
☐ Wrong Route - Gave medication by the wrong route
☐ Wrong Technique/Method - Medication was prepared improperly
☐ Wrong Time - Gave medication too early or too late
☐ Documentation Error ☐ Missing Medication

D. SUPERVISOR'S PRELIMINARY FINDINGS

1.

2. Follow-up /corrective action (including responsible parties and target dates):

Corrective Action	Responsible Party	Target Date for Completion

E. SIGNATURES

1. Name of Supervisor:	2. Signature:	3. Date of Signature: / /
4. Name of Director / Executive / Administrator:	5. Signature:	6. Date of Signature: / /
7. Division Location Cost Center _____ _____ _____	8. **Investigation Required**: ☐ Yes ☐ No	

F. ADMINISTRATIVE COMMENTS / SUMMARY / CONCLUSION

G. NOTIFICATION/FOLLOW-UP CHECKLIST

***** **L** = Letter; **F** = Fax; **E** = E-mail; **V** = Verbal

INTERNAL	Notified Y/N/NA	Date	Time	How * L/F/E/V	Name of Person Notified	Title	Notified by (Initials)
Supervisor							
Manager							
Director							
Case Manager / PS							
Vice President							
Office of Corp Account							
Human Resources							
Nursing							
Psychiatric/Medical							
Insurance/RM							
Workers Comp.							
PQI							
Safety							
Facilities							
Other:							

EXTERNAL	Notified Y/N/NA	Date	Time	How * L/F/E/V	Name of Person Notified	Title	Notified by (Initials)
**** Attach a Copy of Any External Reports ****							
Family/Guardian							
Payor / Funding (CBH, MBH, CCBH)							
County MH/IDD (CSB)							
Regional MH/IDD(Adult Protective Services)							
State MH/DD							
County Children & Youth (CPS)							
County Juvenile Justice							
Office on Aging							
Childline (Attach CY47) *							
DRN (Human Rights)							
HCSIS Report #:							
Licensing (If Applicable)							
Other:							

Childline Report #: _____ **Childline Follow-Up (within 30 days)** ☐ Founded ☐ Unfounded ☐ Indicated

H. INVESTIGATION INFORMATION (As Required)

1. Name of Investigator:	2. Title of Investigator:	3. Telephone Number: ( ) - -
4. Date Assigned: / /		

Additional Space for Reporting