PerformCARE

Critical Incident Report

Date of Report: ___________________________

Name of Member (Last, First, MI):	Provider Name:
MA Identifier Number:	Level of Care: Date of Admission:
Member Home Address, including County:	Provider Address:
Member Telephone:	Provider Contact Name and Telephone Number:
Date of Birth:	Date of Incident: Time of Incident:
Location of Incident:	Date Provider notified of Incident:
Provider Staff involved:	Is this an addendum to a previously submitted report? ❑ Yes ❑ No If yes, date of initial report:_______________

Check type of Incident ***(Please refer to PerformCare Policy QI_-CIR-001Critical Incident Reporting)***

- ❑ Unanticipated death occurring in a behavioral health treatment setting, completed suicide, overdose, apparent serious physical accident and/or suspicious death
- ❑ A potentially lethal suicide attempt that requires medical treatment greater than first aid and/or the individual suffers or could have suffered significant injury. Report all suicide attempts on Provider site or Provider is present
- ❑ Overdose requiring treatment greater than first aid or that occur on Provider site or Provider present
- ❑ Medication error resulting in the need for urgent or emergent medical intervention
- ❑ Any Member event requiring fire department or law enforcement agency engagement while Member is on Provider site or Provider is present
- ❑ Allegations of sexual or physical abuse/neglect/exploitation by a Provider ***(*Complete Mandatory Notification Section below)***
- ❑ Allegations of physical or sexual abuse between peers while on Provider site or Provider is present ***(*Complete Mandatory Notification Section below)***
- ❑ Consensual sexual contact between peers both under the age of 18 while on Provider site or while Provider present
- ❑ Serious injury to Member requiring treatment greater than first aid while Member is on Provider site or Provider is present
- ❑ Life threatening illness requiring hospitalization of a Member while on Provider site or Provider is present
- ❑ A Member receiving treatment in a behavioral health residential setting providing around-the-clock treatment care who is out of contact with staff
- ❑ Any condition that results in a temporary closure of a behavioral health residential facility providing around-the-clock care
- ❑ Member injury requiring treatment greater than first aid due to restraint or seclusion or improper use of restraint or seclusion
- ❑ Provider Preventable Conditions (PPC)
- ❑ Severe physical aggression resulting in damage to property or injury to staff or peers that requires treatment greater than first aid that occurs on Provider site or Provider is present
- ❑ Other occurrence representing actual or potentially serious harm to a Member:____

Describe what happened and any circumstances that may have precipitated the incident. ***Use additional sheets if necessary***.

Outcome/Resolution of event: (Please include any medical or crisis assessments that may have occurred)

What action has been taken to prevent reoccurrence? (Please include if safety/crisis plan implemented or updated)

*Mandatory Notification Completed:	Submitted by: Name Title Contact Number
❑ Child Line ❑ Adult Protective Services ❑ Older Adult/ Office of Aging Date Completed: _______________ Reference No:_______________________________ **OR** Name of person reported to:_____________________________ ❑ Other:_______________________________________ ❑ County if applicable:______________________________	Signature and Date