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)***

- ☐ All unanticipated death of a Member who is receiving behavioral health treatment in any level of care including death by suicide, overdose, serious physical accident, and all other suspicious deaths
- ☐ 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
- ☐ Provider Preventable Conditions (PPC)
- ☐ Allegations of sexual/physical/psychological abuse; neglect; or exploitation by a Provider*
- ☐ 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 mental health residential setting providing around-the-clock 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 has access to an item on provider site that has the potential to cause harm or causes harm to self or others. Item is not typically found at the provider site. (Contraband)
- ☐ Member injury requiring treatment greater than first aid due to restraint or seclusion or improper use of restraint or seclusion
- ☐ 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:

☐ Child Line ☐ Adult Protective Services ☐ Older Adult/ Office of Aging

Date Completed: _____

Reference No:_____ **OR**

☐ Name of person reported to:_____

☐ Other:_____

☐ County if applicable: _____

Submitted by: Name Title Contact Number

Signature and Date