COLORADO
Department of Health Care Policy & Financing

# Critical Incident Form

Definition: A Critical Incident is an actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a client that could have, or has had, a negative impact on the mental and/or physical well-being of a client in the short or long term. A critical incident includes accidents, suspicion of abuse, neglect, or exploitation, and criminal activity.

| **Member Information** | | |
|---|---|---|
| Last Name: | First Name: | M.I.: |
| Medicaid ID#: | Date of Birth: | |
| Mailing Address: | | |
| HCBS Waiver Program: | | |

| **Critical Incident Reporting** | |
|---|---|
| Date of Incident: | Time of Incident: |
| Case Manager Notification Date: | Case Manager Incident Notification Time: |
| Entry Date: | Entry Time: |
| Case Manager Name: | |
| Case Manager Agency Name: | |
| Case Manager Phone Number: | |
| Case Manager Email Address: | |
| Entered By: | |
| Phone Number of Contact Person: | |
| Email Address of Contact Person: | |

| **Reporter Information** |
|---|
| Name of Person Reporting Incident to CMA: |
| Did the member report this incident? ☐Yes ☐No |
| Name of Provider Agency or PASA who Reported incident to Case Manager: |
| Is the Provider Agency reporting the incident an Alternative Care Facility (ACF)? ☐Yes ☐No |
| Was a Provider involved in the Critical Incident? ☐Yes ☐No |
| Provider Type: |
| Name of Provider: |

| Reporter Information |
|---|
| Was anyone other than the client involved in the incident? ☐Yes ☐No |
| Has this critical incident been substantiated? ☐Yes ☐No |
| Was a Referral Made to APS/CPS? ☐Yes ☐No |
| Was Law Enforcement involved in this CIR? ☐Yes ☐No |

| Incident Info |
|---|
| Incident Type: Medication Management |
| Location of Incident: |
| Location Address: |
| If applicable Facility Name: |
| Did this incident involve Restrictive Interventions? ☐Yes ☐No |
| Type of Intervention: |
| Explanation of Intervention: |
| Was this incident referred to the Human Rights Committee (HRC) for review? ☐Yes ☐No |
| Was the use of Restrictive Intervention used Appropriately? ☐Yes ☐No |
| Did the incident result in an admission and/or treatment in the Emergency Room? ☐Yes ☐No |
| Did the Incident Result in Hospitalization? ☐Yes ☐No |
| If applicable – Type of Hospital: |
| If applicable – Name of Hospital: |
| Did this incident result in a Skilled Nursing Facility Rehab Stay? ☐Yes ☐No |
| Did this incident result in Nursing Facility placement? ☐Yes ☐No |
| Did this incident result in a change and/or additional waiver services? ☐Yes ☐No |
| Explanation of additional waiver services: |

| Incident Info |
| --- |
| Did this incident result in Reverse Deinstitutionalization (RDI)? ☐Yes ☐No |
| Did the incident require an occurrence report to CDPHE? ☐Yes ☐No |
| Could this critical incident have been prevented? ☐Yes ☐No |
| What could be done to prevent this type of incident in the future? |
| What was the client's health status prior to this Critical Incident? |

**Medication Management:**
Problems with medication dosage, scheduling, timing, set-up, compliance, administration or monitoring that result in documented harm or an adverse effect which necessitates medical care. Incidents involving Medication Management must be reported to HCPF by the next business day following discovery of the incident or allegations.

Reporting incidents to HCPF does not relieve the facility from reporting requirements of other regulatory agencies.

| Incident Type |
| --- |
| What is the Root Cause of the Critical Incident? |
| Incident Type: Medication Management |
| Description of Incident: |
| Medication Event Type: |
| Medication Event Type Other: |
| Medication Event Reason: |
| Medication Event Reason Other: |
| Medication Administered/Set-up by: |

| Incident Type |
| --- |
| Medication Administered by Role: |
| Name of Medication: |