Keystone First
Community HealthChoices

Keystone First Community HealthChoices (CHC) Critical Incident Report

Instructions: Submit all pages of this form with as much information as possible within the required reporting time frames.

Provider/facility information

National Provider Identifier (NPI):		Phone number:
Provider or agency name:		
Provider address:		
City:	State:	ZIP code:

Reporting party

Reporter's first name:	Last name:	
Title:		
Email:		Phone number:
Point of contact to discuss incident if different from reporter:		
First name:	Last name:	Phone number:

Keystone First CHC Participant

Medicaid number:	First name:	Last name:
Address:		
City:	State:	ZIP code:
Date of birth:	Age:	Participant's gender: ☐ Male ☐ Female

Service Coordinator (SC)

First name:	Last name:	
Address:		
City:	State:	ZIP code:
Email:		Phone number:
SC contacted Participant within 24 hours of discovering incident? ☐ Yes ☐ No		
Date SC contacted Participant:	Time SC contacted Participant:	

Incident

Date incident occurred **(required)**:	Time of incident:	☐ a.m. ☐ p.m. ☐ Unknown
Was the incident witnessed? ☐ Yes ☐ No	Date incident discovered **(required)**:	
Person to learn of incident:		
First name:	Last name:	Title:

Location of incident

Select location type (If other, specify.)

☐ **Participant's home.**	☐ **Community.**	☐ **Other location.**
☐ Living alone.	☐ Work.	☐ State facility.
☐ Living with relatives.	☐ School.	☐ Correctional facility or jail.
☐ Living with unrelated person.	☐ Vehicle.	☐ Nursing facility.
☐ Residential care facility (RCF).	☐ Day program.	☐ Hospital or clinic.
☐ Assisted living.	☐ Other:	☐ Other:
☐ Other:		

Name of location or facility:		
Location or facility address:		
City:	State:	ZIP code:

Witnesses

People present during incident (Provide name of person, initials if a Participant, and the person's relationship to the Participant. If other, specify.)

1.

☐ Another Participant ☐ Staff ☐ Family ☐ Roommate ☐ Other:

2.

☐ Another Participant ☐ Staff ☐ Family ☐ Roommate ☐ Other:

3.

☐ Another Participant ☐ Staff ☐ Family ☐ Roommate ☐ Other:

4.

☐ Another Participant ☐ Staff ☐ Family ☐ Roommate ☐ Other:

5.

☐ Another Participant ☐ Staff ☐ Family ☐ Roommate ☐ Other:

Services

Were services being provided? ☐ Yes ☐ No

Service name:

Reporting

Service Coordinator informed? ☐ Yes ☐ No ☐ N/A	Date informed:
Guardian informed? ☐ Yes ☐ No ☐ N/A	Date informed:
APS/OAPS report made? ☐ Yes ☐ No ☐ N/A	Date of report:
Report number:	APS/OAPS report accepted? ☐ Yes ☐ No

Other entities contacted (specify):

Incident description

Description (Include who, what, when, where, and how in a clear concise manner noting the circumstances of the incident.)

Immediate resolution (Include action taken to secure the Participant's safety and proposed prevention plan to address.)

Incident type (continued)

The following are critical incidents. Select all that apply.

- ☐ Death (other than by natural causes).
- ☐ Serious injury resulting in emergency room visits, hospitalizations, or death.
- ☐ Hospitalization (other than hospital stay planned in advance).
- ☐ Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities.
- ☐ Abuse, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a Participant, including:
  - Physical abuse.
  - Psychological abuse.
  - Sexual abuse.
  - Verbal abuse.
  - Neglect, which includes the failure to provide a participant the reasonable care that he/she requires, including, but not limited to, food, clothing, shelter, medical care, personal hygiene, and protection from harm.
- ☐ Exploitation, which includes the act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust or cruel manner, against one's will, or without one's consent or knowledge for the benefit of self or others.
- ☐ Restraint, which includes any physical, chemical, or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body.
- ☐ Service interruption, which includes any event that results in the Participant's inability to receive services that places his or her health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the Participant's back-up plan.
- ☐ Medication errors resulting in hospitalization, an emergency room visit, or other medical intervention.

☐ **Physical injury** (Injury requiring physician's treatment or admission to a hospital.)

☐ Burn.	☐ Laceration.	☐ Poisoning or toxin ingestion.
☐ Dislocation.	☐ Puncture wound.	☐ Other:
☐ Concussion.	☐ Fracture or break.	
☐ Human or animal bite.	☐ Loss of consciousness.	

Injury is due to (check all that apply):

☐ Mechanical restraint.	☐ Aggressive behavior.	☐ Vehicular accident.
☐ Removal of mobility aids.	☐ Accidental fall.	☐ Assault.
☐ Personal harm.	☐ Aspiration or choking.	☐ Other:

Were restraints or restrictive interventions used during occurrences? ☐ Yes ☐ No

If restraints or restrictive interventions were used, please explain:

☐ **Medication error** (Medical intervention sought or pattern of medication errors identified. Check all that apply.)

☐ By staff.	☐ Wrong dosage.	☐ Unauthorized administration.
☐ By Participant.	☐ Wrong medication.	☐ Overdose.
	☐ Missed dose.	☐ Other:
	☐ Wrong time.	

Medication error led to (check all that apply):

☐ Physical injury.	☐ Emergency mental health.	☐ Abuse report.
☐ Death.	☐ Law enforcement.	

☐ **Death** (other than by natural causes). Apparent cause:

☐ Accident.	☐ Unknown.	
☐ Homicide.	☐ Suicide.	
Preventable? ☐ Yes ☐ No	Autopsy requested? ☐ Yes ☐ No	Hospice involved? ☐ Yes ☐ No
Autopsy performed? ☐ Yes ☐ No	Was there a DNR order? ☐ Yes ☐ No	

Location death occurred:

Location address:

City:	State:	ZIP code:

Incident type

☐ **Emergency mental health** (Check all that apply.)

Suicidal? ☐ Yes ☐ No

Self-injurious? ☐ Yes ☐ No

Aggressive to others? ☐ Yes ☐ No

Participant needed to be admitted for treatment? ☐ Yes ☐ No

☐ **Law enforcement** Reason involved:

☐ Criminal.
☐ Medical.
☐ Location unknown/elopement.
☐ Mental health.
☐ Welfare check.
☐ Other:
☐ Behavioral.

☐ Victim.
Arrested? ☐ Yes ☐ No
☐ Perpetrator.
Charged? ☐ Yes ☐ No

☐ **Abuse report or restriction**

☐ Victim.
☐ Physical injury.
☐ Sexual abuse.
☐ Perpetrator.
☐ Exploitation.
☐ Denial of critical care.
☐ Self-denial of critical care.
☐ Mental injury.

☐ **Location unknown/elopement** (Location unknown by provider responsible for protective oversight.)

Approximate length of time location unknown:

Resolution

Incident-specific resolutions
This section includes multiple types of resolutions possible for reported incidents. Check all that apply. Describe the agency course of action, proposed plans, self-corrective actions, measures needed to prevent or diminish the probability for future occurrences, or other information needed for each checked resolution.

☐ **Staff review and updates**
(Complete this section if staff issues will be addressed by the agency or facility. Describe any changes in staffing patterns.)

☐ Initiated ☐ Completed

Describe:

☐ **Participant review**
(Complete this section if the Participant's plan, health, or care needs will be reviewed or revised.)

☐ Initiated ☐ Completed

Participant care and treatment plan revised? ☐ Yes ☐ No

Describe:

☐ **Equipment and supplies review and updates**
(Complete this section if necessary equipment or supplies need to be purchased, repaired, or assessed.)

☐ Initiated ☐ Completed

Describe:

☐ **Environment review and updates**
(Complete this section if the Participant's environment will be evaluated, accommodated, or modified for safety or accessibility needs.)

☐ Initiated ☐ Completed

Describe:

☐ **Policy and procedure review and updates**
(A review or adjustment of formal written policies, procedures, and guidelines implemented by the agency or facility.)

☐ Initiated ☐ Completed

Describe:

Resolution (continued)

☐ **Agency-wide planning**
(Systemic resolution to include, but not limited to, training or retraining, self-CAP, communication and awareness regarding updates, employee screening, etc.)

☐ Initiated ☐ Completed

Self-corrective action initiated? ☐ Yes ☐ No

Describe:

☐ **No resolution required**
(Indicate how incident was isolated.)

Describe:

Additional follow-up and notes (Place additional detail regarding incident or resolution as discovered.)

Date received:	Incident ID:	Staff reviewer:

Keystone First Community HealthChoices must investigate all critical events or incidents reported by network providers and subcontractors and report the outcomes of these investigations.

Please submit as much information as possible within 24 hours of the occurrence to Keystone First Community HealthChoices: **kfchccriticalincident@keystonefirstchc.com.**

Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.