COLORADO
Department of Health Care Policy & Financing

Residential Childcare Provider Critical Incident Information Form

Today's Date: _____

Time of Incident: _____

Case Manager Name: _____

Case Management Agency Name: _____

Member Name: _____

Member Health First Colorado ID: _____

Provider Type: (check one)

- ☐ Residential Child Care Center (RCCF) (52)
- ☐ Qualified Residential Treatment Program (QRTP)(68)
- ☐ Psychiatric Residential Treatment Facility (PRTF) (30)

Who reported the incident to the Case Manager?
Name: _____

Agency and Role: _____

Primary Incident Type: (check one)

- ☐ Death
- ☐ Damage to Member's Property/Theft
- ☐ Abuse/Neglect/Exploitation
- ☐ Medication Management
- ☐ Criminal Activity
- ☐ Missing Person
- ☐ Serious Injury or Illness of Member
- ☐ Other High-Risk Issues

Date of Incident: _____

Time of Incident: _____

Location of Incident: (check one)

- ☐ Alternative Care Facility (ACF)
- ☐ Day Program
- ☐ School
- ☐ Hospital
- ☐ Group Home
- ☐ Host Home
- ☐ Personal Residence In Community
- ☐ Place of Employment
- ☐ Transportation
- ☐ Other _____

Persons Involved in Incident:
Was anyone other than the member involved in the incident?

- ☐ Yes
- ☐ No

(*If yes is selected, complete the section below)*

Persons Involved and Role:

- ☐ Family Member
  - ❒ Alleged Participant ❒ Alleged Perpetrator ❒ Witness ❒ Other
- ☐ Personal Care Provider
  - ❒ Alleged Participant ❒ Alleged Perpetrator ❒ Witness ❒ Other
- ☐ Provider Staff
  - ❒ Alleged Participant ❒ Alleged Perpetrator ❒ Witness ❒ Other
- ☐ Co-habitant
  - ❒ Alleged Participant ❒ Alleged Perpetrator ❒ Witness ❒ Other
- ☐ Other
  - ❒ Alleged Participant ❒ Alleged Perpetrator ❒ Witness ❒ Other

Description of Incident:
Please complete the items specific to the incident type below.

DEATH
Death Type:

- ☐ Suicide
- ☐ Homicide
- ☐ Unexpected/Unexplained Death
- ☐ Accidental Death
- ☐ Anticipated Death/Natural Causes
- ☐ Other _____

ABUSE/NEGLECT/EXPLOITATION

Type of Abuse/Neglect/Exploitation: [check one]

- ☐ Self-Neglect
- ☐ Sexual Abuse
- ☐ Caregiver Neglect
- ☐ Physical Abuse
- ☐ Exploitation
- ☐ Emotional Abuse
- ☐ Inability to Give Informed Consent
- ☐ Other _____

Source of Abuse/Neglect/Exploitation: [check one]

- ☐ Self
- ☐ Family Member
- ☐ Provider
- ☐ Staff
- ☐ Co-Habitant
- ☐ Peer
- ☐ Other _____

Did Abuse/Neglect/Exploitation Result in Hospitalization?

- ☐ Yes
- ☐ No

If Yes is selected, Where was the member hospitalized? _____

SERIOUS INJURY TO OR ILLNESS OF MEMBER

Serious Injury/Illness Type: [check one]

- ☐ Laceration requiring sutures/staples
- ☐ Serious Burn
- ☐ Fracture
- ☐ Skin Wound due to poor care
- ☐ Dislocation
- ☐ Suicide Attempt
- ☐ Loss of Limb
- ☐ Brain Injury
- ☐ Other _____

Cause of Injury/Illness: [check one]

- ☐ Fall Accident
- ☐ Medical Condition Treatment Error
- ☐ Poor Care Undetermined
- ☐ Seizure
- ☐ Other _____

Did Serious Injury/Illness Result in Hospitalization?

- ☐ Yes
- ☐ No

If Yes is selected, where was the member Hospitalized? _____

DAMAGE TO MEMBER'S PROPERTY/THEFT:

Type of Loss: (check one)

- ☐ Damage to Property
- ☐ Theft of Property
- ☐ Deliberate Diversion of Medication
- ☐ Other

MEDICATION MANAGEMENT

Name of Medication: _____

Medication-Related Event Type: (check one)

- ☐ Medication Omission
- ☐ Wrong Dose
- ☐ Wrong Medication Wrong Time (>1hr. variance)
- ☐ Wrong Route of Administration Medication Refused
- ☐ Non-Compliance
- ☐ Other _____

Reason for Event: (check one)

- ☐ Administration Error
- ☐ Supply Exhausted
- ☐ Forgotten Refusal
- ☐ Prescription Unfilled
- ☐ Incorrect Chart Entry
- ☐ Other _____

Administered by/Set-up by: (check one)

- ☐ Consumer
- ☐ Provider
- ☐ Provider Set-up Only
- ☐ Provider Administration Only
- ☐ Family Member
- ☐ Other _____

Did the Medication Error Result in Hospitalization?

- ☐ Yes
- ☐ No

If Yes is selected, where was the member Hospitalized? _____

OTHER HIGH-RISK ISSUES

Risk Issue Type:

- ☐ Lost/Missing Person
- ☐ Suicidal Ideation/Attempt
- ☐ Loss of Home/Eviction
- ☐ Substance Abuse
- ☐ Member Fraud Provider Fraud
- ☐ Criminal Justice Involvement
- ☐ Critical Service Interruption
- ☐ Victim of Crime Abusive/Violent Behavior by Member
- ☐ Other _____

Why is this issue of particular risk to this person? _____

_____

CRIMINAL ACTIVITY

Has the member been arrested/incarcerated?

- ☐ Yes
- ☐ No

If Yes, what are the charges? _____

Criminal Activity: [check one]

- ☐ Assault and Battery
- ☐ Domestic Violence
- ☐ Drug Possession
- ☐ DUI/DWI
- ☐ Probation/Parole Violation
- ☐ Theft/Larceny
- ☐ Other _____

MISSING PERSON

Has a missing person report been made to law enforcement?

- ☐ Yes
- ☐ No

If No is selected, why has a missing report not been made? _____

_____

Action Steps Taken: *Mark All That Apply*

Mandatory Reports Made:

- ☐ Mandatory Report to Adult Protective Services
  Worker taking report: _____
- ☐ Mandatory Report to Child Protective Services
  Worker taking report: _____
- ☐ Mandatory Report to Colorado Dept. of Public Health and Environment
  Worker taking report: _____

Additional Follow-up:

- ☐ Additional Follow-up with Member
- ☐ Additional Follow-up with Provider(s)
  Contact Name/phone: _____
- ☐ Additional Follow-up with Family Member
  Contact Name/phone: _____
- ☐ Additional Follow-up with Contractor
  Contact Name/phone: _____

Referrals Made:

- ☐ Referred to Law Enforcement
  Contact Name/phone: _____
- ☐ Referred to Emergency Department
  Contact Name/phone: _____
- ☐ Referred to Ambulance/Paramedics
  Contact Name/phone: _____
- ☐ Referred to Fire Department
  Contact Name/phone: _____
- ☐ Referred to Mental Health Provider
  Contact Name/phone: _____
- ☐ Referred to Primary Care Provider
  Contact Name/phone: _____

Notifications Made:

- ☐ Notification to Provider Agency
  Contact Name/phone: _____
- ☐ Notification to Advocate/Ombudsman
  Contact Name/phone: _____
- ☐ Notification to Member Representative/Guardian
  Contact Name/phone: _____
- ☐ Notification to Other: specify
  Contact Name/phone: _____

Additional Information: