

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

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:
AmeriHealth Caritas PA CHC Participant		
Medicaid number:	First name:	Last name:
Address:		
City:	State:	ZIP code:
Date of birth:	Age:	Participant's gender: <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date SC contacted Participant:	Time SC contacted Participant:	
Incident		
Date incident occurred (required) :	Time of incident:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Unknown
Was the incident witnessed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date incident discovered (required) :	
Person to learn of incident:		
First name:	Last name:	Title:
Location of incident		
Select location type (If other, specify.)		
<input type="checkbox"/> Participant's home. <input type="checkbox"/> Living alone. <input type="checkbox"/> Living with relatives. <input type="checkbox"/> Living with unrelated person. <input type="checkbox"/> Residential care facility (RCF). <input type="checkbox"/> Assisted living. <input type="checkbox"/> Other:	<input type="checkbox"/> Community. <input type="checkbox"/> Work. <input type="checkbox"/> School. <input type="checkbox"/> Vehicle. <input type="checkbox"/> Day program. <input type="checkbox"/> Other:	<input type="checkbox"/> Other location. <input type="checkbox"/> State facility. <input type="checkbox"/> Correctional facility or jail. <input type="checkbox"/> Nursing facility. <input type="checkbox"/> Hospital or clinic. <input type="checkbox"/> Other:
Name of location or facility:		
Location or facility address:		
City:	State:	ZIP code:

AmeriHealth Caritas Pennsylvania (PA) Community HealthChoices (CHC) Critical Incident Report

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.)

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

Injury is due to (check all that apply):

- Mechanical restraint.
- Removal of mobility aids.
- Personal harm.
- Aggressive behavior.
- Accidental fall.
- Aspiration or choking.
- Vehicular accident.
- Assault.
- 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.
- By Participant.
- Wrong dosage.
- Wrong medication.
- Missed dose.
- Wrong time.
- Unauthorized administration.
- Overdose.
- Other:

Medication error led to (check all that apply):

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

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

- Accident.
- Homicide.
- Unknown.
- 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: _____

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Incident type		
<input type="checkbox"/> Emergency mental health (Check all that apply.)		
Suicidal? <input type="checkbox"/> Yes <input type="checkbox"/> No	Aggressive to others? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Self-injurious? <input type="checkbox"/> Yes <input type="checkbox"/> No	Participant needed to be admitted for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Law enforcement Reason involved:		
<input type="checkbox"/> Criminal.	<input type="checkbox"/> Medical.	<input type="checkbox"/> Location unknown/elopement.
<input type="checkbox"/> Mental health.	<input type="checkbox"/> Welfare check.	<input type="checkbox"/> Other:
<input type="checkbox"/> Behavioral.		
<input type="checkbox"/> Victim.	Arrested? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Perpetrator.	Charged? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Abuse report or restriction		
<input type="checkbox"/> Victim.	<input type="checkbox"/> Physical injury.	<input type="checkbox"/> Sexual abuse.
<input type="checkbox"/> Perpetrator.	<input type="checkbox"/> Exploitation.	<input type="checkbox"/> Denial of critical care.
	<input type="checkbox"/> Self-denial of critical care.	<input type="checkbox"/> Mental injury.
<input type="checkbox"/> 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.
<input type="checkbox"/> Staff review and updates (Complete this section if staff issues will be addressed by the agency or facility. Describe any changes in staffing patterns.) <input type="checkbox"/> Initiated <input type="checkbox"/> Completed Describe:
<input type="checkbox"/> Participant review (Complete this section if the Participant's plan, health, or care needs will be reviewed or revised.) <input type="checkbox"/> Initiated <input type="checkbox"/> Completed Participant care and treatment plan revised? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
<input type="checkbox"/> Equipment and supplies review and updates (Complete this section if necessary equipment or supplies need to be purchased, repaired, or assessed.) <input type="checkbox"/> Initiated <input type="checkbox"/> Completed Describe:
<input type="checkbox"/> Environment review and updates (Complete this section if the Participant's environment will be evaluated, accommodated, or modified for safety or accessibility needs.) <input type="checkbox"/> Initiated <input type="checkbox"/> Completed Describe:
<input type="checkbox"/> Policy and procedure review and updates (A review or adjustment of formal written policies, procedures, and guidelines implemented by the agency or facility.) <input type="checkbox"/> Initiated <input type="checkbox"/> Completed Describe:

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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:

AmeriHealth Caritas Pennsylvania 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 AmeriHealth Caritas Pennsylvania Community HealthChoices to: **CHCCriticalIncident@amerihealthcaritas.com**