

**Department of Health and Human Services/ Behavioral and Developmental Services
Critical Incident Reporting Form**

The reporting, evaluation, and analysis of critical incidents is a DHHS/BDS quality improvement activity as required by statute (Title 34B MRSA Section 1207). Informing clients of this activity is the responsibility of the licensed contracting provider.

<p>The following types of incidents must be reported by phone to the DHHS/BDS Regional Director or Facilities Operations Director immediately (within 4 hours) after incident becomes known to staff and followed by a faxed incident report:</p> <p><u>Level I incidents</u></p> <ul style="list-style-type: none"> A. Suicides B. Homicides/other unexplained deaths C. Major physical plant disasters D. Other events that significantly jeopardize client and/or public safety [e.g., serious crimes (assault or hostage taking), serious injury to consumer or staff requiring emergency medical intervention, arson, lost or missing client with adverse results, etc.; or with children events which present extreme risk of harm] D1. Serious suicide attempt 	<p>The following incidents must be reported by phone to the DHHS/BDS Regional Director or Facilities Operations Director within 24 hours after an incident becomes known to staff and followed by a faxed incident report:</p> <p><u>Level II incidents</u></p> <ul style="list-style-type: none"> A. Major medication errors or other adverse clinical events resulting in the need for immediate/emergency medical attention B. Alleged physical and/or sexual abuse of a client by a staff member or by another client; or with children a report of physical or sexual abuse filed with DHHS child protective services.
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INCIDENT DESCRIPTION (please print or type)

Client Name: _____ (DHHS/BDS operated programs/facilities only)

Parents/Guardian Name (if applicable): _____

Client Identification Number: _____ (agency/provider client i.d. number for client involved in incident)

Descriptive Data: (1) Male _____ (2) Female _____ Age: _____ Date of Birth: _____ -- --

Current Residence: County: _____ ; Town/City: _____

Class Member Status (Check one): _____ (1) AMHI Class _____ (3) Community MR Class
 _____ (2) Member of both _____ (4) Not a Class Member

Level of Incident I _____ II _____ **Type of Incident (A, B, C, D, D1):** _____

Date of Incident: _____ **Time of Incident:** _____

Location of Incident: _____

Date/Time Received by DHHS/BDS: _____

(COMPLETE INCIDENT DESCRIPTION AND CONTACT INFORMATION QUESTIONS ON NEXT PAGE)

Incident Summary Description (brief): (attach additional sheet if necessary)

Staff Response: (Use categories below; include specific actions taken by agency/facility & person(s) involved in response)

1. Client safety secured:

2. Medical attention required:

3. Administrative response (both for this child and for agency)

4. Treatment Response (what was learned and how will future episodes be prevented?)

Person(s) Notified: (List all individuals who were notified of the event):

___ Guardian

___ Client's family

___ Psychiatrist

Name: _____

___ Police

___ DHHS Protective Services

___ Agency administrator

Name: _____

___ Medical provider/doctor

___ Case manager

___ Therapist

Name: _____

___ Other (describe): _____

Staff Member Submitting Report: (PRINT) _____ **Telephone:** _____

Agency Name and Unit: _____

Program Area Affiliation (Check one)

Program Type (Check one)

_____ (1) MR/DD (Adult)

___ (1) Residential

___ (2) Hospital Inpatient

_____ (2) Mental Health (Adult)

___ (3) Case management

___ (4) Outpatient

_____ (3) Children

___ (5) Crisis

_____ (4) Substance Abuse Services

___ (6) Other _____

Signature of Person Completing Report: _____ **Supervisor Signature:** _____