Nebraska Medicaid Critical Incident Report

Critical Incidents that occurred while in the care of a behavioral health inpatient setting.
Instructions: Submit all pages of this form with as much information as possible within the required reporting timeframes.

Incident Levels 1 and 2 (Adverse and Substantial) must be reported to UHC and DHHS immediately.

Allegations of abuse, neglect, or sexual contact between peers, or between peers and staff must be reported immediately to the Nebraska Hotline at 1-800-652-1999**, then to UHC and will be considered substantial or significant deviations from quality care.**

- **Submitthisformby:**
  - Email — **critical_incidents@uhc.com**
  - Fax — **855-371-7638**

Incident Status: ☐ Initial (Pending Further Investigation) ☐ Completed (Investigation Completed)

Reporting Party:
National Provider Identifier: _____ Provider/Agency Name: _____
Provider Address: _____ City: _____ State: _____
Zip:_____
Phone #:_____
Reporter Name: _____ Title: _____ Email:
_____

Medicaid Member:
Medicaid State No.:_____ Last Name: _____ First Name: _____
Address: _____ City: _____ State: _____ Zip:
_____

Date of Birth: _____ Member's Gender: ☐ Male ☐ Female

Case Manager:
First Name: _____ Last Name:
_____
Mailing Address: _____
Email: _____ Phone #:_____
Case Manager was informed: ☐ Yes ☐ No Date Informed: _____

Incident Information:
Date of Incident: _____ Time of Incident: _____☐ a.m. ☐ p.m. ☐ unknown
☐ Discovered ☐ Witnessed Date of Discovery: _____
First person to learn of the incident: Name_____ Title_____

Location of Incident:
Location: _____

People Present During Incident: (Provide name of person, initials if a member, and their relationship to the member):

1. _____ ☐ Other member ☐ Staff ☐ Family ☐ Roommate ☐ Other_____

2. _____ ☐ Other member ☐ Staff ☐ Family ☐ Roommate ☐ Other_____

Services (select one):

Services were being provided at time of incident: ☐ Yes ☐ No

Service Name: _____

Notifications:

Guardian Informed: ☐ Yes ☐ No ☐ N/A Date Informed:

_____

DHHS Report Made: ☐ Yes ☐ No Date of Report: _____ Report #:_____

DHHS report accepted: ☐ Yes ☐ No

Law Enforcement: ☐ Yes ☐ No Date Contacted: _____ Officer Name:_____

Incident Description (Include Who, What, When, Where, and How in a clear concise manner noting the circumstances of the incident, immediate resolution/action taken to secure the member's safety, and proposed prevention plan. Attach additional information if necessary)**:**

Incident Type:

☐ Suicide attempt
☐ Suicide death
☐ Non-suicide death
☐ Unexpected death
☐ Homicide
☐ Homicide attempt
☐ Accidental injury with significant medical intervention
☐ Allegation of abuse/neglect (physical)
☐ Allegation of abuse (psychological)
☐ Medication error resulting in requiring medical intervention
☐ Adverse drug reaction
☐ Unusual, unexpected illness or disease
☐ Unauthorized leave
☐ Fire setting or property damage
☐ Unusual, unexpected illness or disease
☐ Emergency medical treatment resulting from injury, medication error, or adverse medication reaction
☐ Other serious occurrence, including sexual contact between peers or peers and staff which member is under treatment _____
☐ Use of restraints or seclusion requiring significant medical intervention
- If a PRTF or ThGH facility then complete the Restraints and Seclusion Reporting Form

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CRITICAL INCIDENT LEVELS

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1. ☐ **ADVERSE INCIDENT**

Death of a patient or the health of a patient is seriously jeopardized

- ☐ Homicide
- ☐ Suicide Death
- ☐ Unexpected Death
- ☐ Homicide Attempt
- ☐ Natural Death

2. ☐ **SUBSTANTIAL INCIDENT**

Incident resulting in moderate client and/or staff injury

- ☐ Any injury as a result of restraint or seclusion
- ☐ Medication reaction or medication error
- ☐ Significant self-harm injury
- ☐ Significant accidental injury

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3. ☐ **PROBLEMATIC INCIDENT**

Incident resulting in low client and/or staff injury

Examples: Significant property damage; injury treated by nurse; Attack on peer or staff with resulting minor injuries; Minor self-harm or accidental injury

4. ☐ **MINOR INCIDENT**

Incident resulting in no client or staff injury

Examples: Physical health issue not related to MH/SA treatment; Elopement, "running" for more than 24 hours; Police or sheriff contacted due to criminal behavior; Attack on peers or staff without injuries; Client taken to Mental Health inpatient unit or detention

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Incident-Specific Resolutions (Indicate agency course of action, proposed plans, self-corrective actions, measures to prevent ore diminish probability for future occurrences, etc.)

☐ Staff Review/Updates ☐ Initiated ☐ Completed

Describe:

_____

☐ Member Review/Updates ☐ Initiated ☐ Completed

Treatment Plan Revised: ☐ Yes ☐ No

Describe: _____

_____

☐ Policy and Procedure Review/Updates ☐ Initiated ☐ Completed

Describe: _____

☐ Agency Wide Planning (Training/retraining, self-CAP, communication/awareness on updates, etc.)

☐ Initiated ☐ Completed

Describe: _____

☐ No Resolution Required (Indicate how incident was isolated)

Describe: _____

_____

Additional Follow-up/Notes: