

Critical Incident Form

Colorado Department of Human Services (CDHS), Office of Behavioral Health (OBH) is committed to maintaining the life, safety, and well being of all consumers, families, and providers/agencies/facilities. In so doing, OBH requires that all critical incidents, involving programs/agencies/facilities it contracts with, licenses, or otherwise approves, shall be reported to OBH.

CRITICAL INCIDENTS (DEFINITIONS USED TO DISTINGUISH REPORTABLE INCIDENTS)

- **Death**
 - Death of an active/current client, staff person, volunteer, or visitor on program/agency/facility premises.
 - Death of an active/current client, off premises, *that is unexpected.*
- **Physical and/or Sexual Assault**
 - Physical and/or sexual assault (*on or off premises*) by or upon an active/current client.
- **Hospitalization**
 - Suicide attempt or self-inflicted injury, by an active/current client, requiring medical attention/hospitalization.
- **Eloped from Court-Ordered Treatment**
 - Active/current client who leaves or elopes from court-ordered treatment (e.g., involuntary commitment, certified inpatient hospitalization, 72 hour mental health hold and treat order).
 - Active/current Forensic Community Based Services (FCBS) client currently on community placement or conditional release status.
 - Does NOT include active/current clients involved in DUI treatment.
 - Does NOT include active/current clients who are on probation or parole.
- **Breach of Confidentiality**
 - As defined by 42 Code of Federal Regulations, Part 2 and 45 Code of Federal Regulations, Parts 142, 160, 162, 164, and the Health Insurance Portability and Accountability Act (HIPAA).
 - Theft or loss of client data and/or records containing client-identifying information.
- **Incident deemed critical by the Program/Agency/Facility Executive Director**

Only programs that administer, dispense, monitor or store medications on site.

- **Medication Diversion**
 - Diversion of medication.
 - Theft or loss of medication.
 - Injury sustained by clients, or their significant others, as a direct result of diversion, use, or misuse of controlled substances, during or within 90 days following most recent treatment episode.

Forensic Community Based Services (FCBS): Community Placement/Conditional Release (ONLY)

- Any arrest
- Any felony level charge

OBH Contact Information (all Critical Incidents will be faxed to this number)

OBH Critical Incident Desk Fax# (303) 866-7481

Critical Incident Reporting Form

Program/Agency/Facility Information



Agency:	License Number:
Address:	City:
County:	Zip:
	Phone:

Critical Incident Type (check all that apply)

<u>OBH</u>		
<input type="checkbox"/> Death (<i>Excluding natural causes</i>)	<input type="checkbox"/> Physical and/or Sexual Assault	<input type="checkbox"/> Hospitalization
<input type="checkbox"/> Eloped from Court Ordered Treatment	<input type="checkbox"/> Breach of Confidentiality	<input type="checkbox"/> Other
<input type="checkbox"/> Medication Diversion		
<u>FCBS Only</u>		
<input type="checkbox"/> Any arrest	<input type="checkbox"/> Any Felony Level Charge	

Date Critical Incident Occurred (required for all incidents): _____ Time: Actual Estimate

If estimated time, please explain:

Date Critical Incident Discovered (required for all incidents): _____ Time: _____

Date Critical Incident Reported (required for all incidents): _____

<u>Detailed Description of Critical Incident and Investigation Findings</u> <p>(please include:</p> <p><u>client demographic information</u></p> <p><u>level of care (outpatient, inpatient, meds only, Community Crisis Services),</u></p> <p><u>last time seen by clinician,</u></p> <p><u>how agency was notified,</u></p> <p><u>Other pertinent information related to the incident</u></p>
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<u>Identified Plan(s) of Correction/Action/Improvement:</u> <input type="checkbox"/> Staff training <input type="checkbox"/> Personnel action <input type="checkbox"/> Rewrite of policies and procedures <input type="checkbox"/> Facility Deficiencies/Improvements <input type="checkbox"/> Other (Explain):
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Report Prepared By:	Title:	Date:
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