____ Patient Safety Event

Critical Incident and Injury Report

Client/Person: ________________________________ **Gender**: ____**Male** ____**Female** **D.O.B.**: _______ **Ethnicity/Race**___________

___**Client** ___**Visitor** ___**Staff** **Date of Incident**: ________________ **Time**: ______ **to** _______ **Facility Name:** ____________________

Location/Facility License Number: _________________ **Program**: ________________ **Reporting Staff**: ___________________________

Sexual Orientation: ________________________ **Gender Identity:** ______________________ **Gender Expression:** _________________

Summary of Incident (include the names of **all staff & clients** involved, indicate case/report number if police are contacted)
(**For RT staff**: check box if you are writing a separate summary on another page ☐ See Attached)

Precipitating Event(s) and/or Type of Incident. Check all that apply.

If asterisked, complete all of the pages:

___ *Physical Holds
___ *Runaway/AWOL
___ Injury Requiring Medical Tx
___ Injury
___ Epidemic Outbreak
___ Medication Issue
___ Property Damage
___ Security/Theft
___ Self-Harming Behavior
___ Sexualized Behavior
___ Medical Illness/Emergency
___ Alleged Client's Rights Violation
___ Suicidal Ideation/Gesture/Behavior
___ Violence/Aggressive Behavior or Language
___ Recreation Related Injury
___ Drug/Alcohol Use/Possession
___ Alleged Child Abuse/Elder/Dependent Adult Abuse
___ Other (specify):

Actions Taken: Check all that apply:

___ Provided First Aid
___ Suicide Risk Assessment
___ Observation/Monitoring
___ Contact Doctor/RN/Psychiatrist
___ Treatment Team Notified
___ School
___ Transport to Urgent Care/Hospital
___ Supervisor/Administrator Notified
___ Parent /Legal Guardian Notified
___ Structuring the Environment
___ Police/911 Called/Police Report
___ County Social Worker
___ Community Care Licensing Notified
___ Notified & Completed CPS/APS Report
___ Transported to Nearest ER for Psychiatric Eval.
___ Room Arranged to Reduce Risk
___ Charges filed by Police
___ Other (specify):

Person Contacted: ____ Date: ___________________ By: ___ Phone ___ Written
Person Contacted: ____ Date: ___________________ By: ___ Phone ___ Written
Person Contacted: ____ Date: ___________________ By: ___ Phone ___ Written

Were there Adverse Results:

___ No Adverse Results
___ Client Injury/Illness
___ Staff Injury/Illness
___ Visitor Injury/Illness
___ Property Damage
___ Client Expelled
___ Other (specify):

If Injury Occurred Include Name of the Medical Facility, Physician, Treatment, and Follow-Up Appointment, if Available:

Supervisor's Review, Recommendations, Comments, Outcome, and Follow-Up:

___ None Required
___ Staff Education
___ Counseling
___ Debriefing
___ Policy Revision
___ Remove Equipment/Item
___ Review Documentation
___ Further Investigation
___ Notify:
___ Tx. Plan Revision

____ **Signature of Reporting Person & Date Report Completed**

____ **Signature of Supervisor & Date Review Completed**

SEND COMPLETED FORM TO QUALITY ASSURANCE AND NOTIFY ADMINISTRATION 527-6839 (QA fax)