MFP Critical Incident Report – Form M

Instructions: This form is to be completed after a critical event which causes, or is likely to cause, changes in the plan of care. This is an important step in the process of preventing new critical incidents, improving the care, treatment, and services for participant, and changing systems and processes to improve outcomes.

Date of Report (MM/DD/YYYY): RIN:

Participant Name:

Current address:

Program: ☐ DD ☐ DMH ☐ IDOA ☐ DRS Class Member:

Name of person completing this report:

Agency Name:

Transition Coordinators and Other Workers

Name: Agency Name: Email:

Name: Agency Name: Email:

Name: Agency Name: Email:

Incident Information

Date of Incident (MM/DD/YYYY): Time of Incident: a.m. or p.m.

Date incident discovered by TC (MM/DD/YYYY):

How did TC learn of the incident:

Did reporter directly observe incident? ☐ Yes ☐ No ☐ Self-report ☐ N/A

Did the incident occur when a provider was present or was scheduled to be present? ☐ Yes ☐ No

Were other individuals involved in the incident? ☐ Yes ☐ No

Information about Other Person(s) Involved in Incident, if any

a. First Name	Last Name	c. Phone	f. Relationship to participant
		( )	☐ Family ☐ Caregiver ☐ Paid care worker ☐ Other
		( )	☐ Family ☐ Caregiver ☐ Paid care worker ☐ Other
		( )	☐ Family ☐ Caregiver ☐ Paid care worker

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☐ ☐Other

Incident Type Check all that apply (If participant reinstitutionalized, select Nursing Facility Placement)

☐ **Death**

- ☐ Accidental
- ☐ Suicide
- ☐ Unusual Circumstances
- ☐ Other Unexpected or Sudden Death
- ☐ Other:

☐ **Alleged Fraud/Misuse of Funds**

- ☐ By participant
- ☐ By provider
- ☐ By both
- ☐ Other:

☐ **Suicide Attempt**

- ☐ First Known Attempt
- ☐ Repeated Attempt

☐ **Nursing Facility Placement**

- ☐ If yes, Reason:

☐ **Unplanned Hospital Visit**

- ☐ ER visit – illness
- ☐ ER visit – injury
- ☐ Medical Hospitalization
- ☐ Psychiatric Hospitalization

☐ **Property Damage**

- ☐ Damage of provider property
- ☐ Damage of participant property

☐ **Behavioral Incident Involving Participant**

- o If yes, explain:

☐ **Criminal Activity**

- ☐ Alleged victim
- ☐ Alleged perpetrator

☐ **Assault**

- ☐ Sexual Assault – alleged victim
- ☐ Sexual assault – alleged perpetrator
- ☐ Physical assault – alleged victim
- ☐ Physical assault – alleged perpetrator

☐ **Missing Person/Elopement**

- ☐ Elopement - Law enforcement contacted
- ☐ Elopement - Law enforcement not contacted
- ☐ Other: Law enforcement contacted
- ☐ Other: Law enforcement not contacted

☐ **Fire**

- ☐ Intentional – started by individual
- ☐ Intentional – not started by individual
- ☐ Accidental – started by individual
- ☐ Accidental – not started by individual

☐ **Vehicle Accident**

- ☐ Participant vehicle
- ☐ Public transportation
- ☐ Other vehicle
- ☐ Pedestrian
- ☐ Other:

☐ **Suspected Mistreatment (abuse, neglect, exploitation)**

- ☐ Alleged victim of physical abuse
- ☐ Alleged victim of verbal abuse
- ☐ Alleged victim of neglect by caregiver
- ☐ Self-Neglect
- ☐ Alleged victim of exploitation

☐ **Physical Altercation**

- ☐ Individual to individual – alleged victim
- ☐ Individual to individual – alleged perpetrator

☐ **Other serious Injury to Participant**

- ☐ Fall
- ☐ Medication related
- ☐ Bruising
- ☐ Bleeding
- ☐ Cut or puncture wound
- ☐ Burn
- ☐ Worsening pressure ulcer/non-healing, existing wound
- ☐ Sprain/strain
- ☐ Other:

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How did the serious injury or illness occur? check all that apply

- ☐ Inflicted by self
- ☐ Inflicted by caregiver
- ☐ Inflicted by peer
- ☐ Inflicted by other
- ☐ Fall
- ☐ Transfer/Handling
- ☐ Equipment
- ☐ Insect/animal bite
- ☐ PICA/eating non-food items
- ☐ Seizure
- ☐ Substance Use/Abuse
- ☐ Environmental
- ☐ Unknown
- ☐ Other:

Please describe the critical incident and/or serious injury (if any) in more detail:

Response to Incident:

- ☐ First aid rendered
- ☐ Emergency room visit
- ☐ Physician notified
- ☐ Reported to DHS-OIG
- ☐ Law enforcement notified
- ☐ Refused treatment
- ☐ Participant/family interviewed
- ☐ Reported to Elder Abuse
- ☐ Other, describe: _____

If applicable, did reporter discuss with the individual activities to prevent a similar incident from occurring in the future

- ❑ No
- ❑ Yes, describe: _____

Date of report: Time of report:

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Critical Event Internal Review (To Be Completed by MFP Agency Supervisor)

Date of Review (MM/DD/YYYY): MFP Agency:

Lead Reviewer Name: Title:

Names and Titles of Other Individuals Present for Critical Incident Review (if any):

Name Title

Documents for critical event review:

- ☐ Participant record
- ☐ Assessment of risk and mitigation plan
- ☐ Hospital/ED record if available
- ☐ Other:

Staff recommendations/summary based on critical event:

- ☐ Additional staff training needed
- ☐ Changes in MFP policy or procedure
- ☐ Other:

Recommendation summary:

Other comments by agency staff members participating in critical event internal review:

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Critical Event External Review (To Be Completed by UIC College of Nursing Staff)

Date of External Review (MM/DD/YYYY):

Reviewer 1: Reviewer 2:

Summary of staff recommendations based on critical event:

One Month Post-Incident Follow Up Summary and Recommendations (completed by UIC staff):