Critical Incident Report Form — Independent Nurse Provider

EOHHS
Commonwealth of Massachusetts
www.mass.gov/masshealth

This form is for MassHealth Independent Nurses (IN) to report critical incidents involving MassHealth members. Independent Nurses are not required to use this form to submit a critical incident report, as long as their report meets the requirements established under 130 CMR 414.417(H). Submission of the form does not alter any provider liability for the incident, nor does it supersede or negate any independent responsibility a provider may have to report the incident to other authorities (i.e., Department of Children and Families, Disabled Persons Protection Commission, Executive Office of Aging & Independence, and the Disabled Persons Protection Commission).

Examples of Reportable Critical Incident

A reportable critical incident is any sudden or progressive development (event) that requires immediate attention and decisive action to prevent or minimize any negative impact on the health and welfare of one or more MassHealth members. Examples of incidents which might require a Critical Incident Report include the following:

- serious physical injury, including a self-inflicted injury and injuries where the cause or origin is unknown and where the member requires medical treatment beyond basic first aid;
- exposure to hazardous material (including blood-borne pathogens) that results in serious injury;
- medication error (requiring medical intervention) that results in serious injury;
- mistreatment or allegation of mistreatment of a member including abuse, neglect, emotional harm, sexual or financial exploitation, or any other mistreatment, whether perpetrated by the IN provider or another provider supporting the member concurrently (if known);
- person missing from scheduled care caused by abuse or neglect; and
- death of a member from non-natural cause, including suicide, homicide, or any other unexpected cause for death.

Recordkeeping

INs must comply with the MassHealth provider regulations and policies for the maintenance of records. This includes maintaining documentation of reportable critical incidents, along with any ongoing notes, observations, and follow-up action in any affected member's record, or in a separate accessible file.

Instructions for Reporting a Critical Incident

When identifying a reportable critical incident, the IN must follow the instructions below:

1. Provide any necessary immediate action to ensure member safety.
2. Complete and submit the MassHealth Independent Nurse (IN) Provider Critical Incident Report Form or submit a separate report that meets the requirements at 130 CMR 414.417(H) by secure email to CommCase@umassmed.edu or faxing to (508) 421-5905 within five business days of the incident.

   INs are reminded that they are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) and that, pursuant to HIPAA requirements, protected health information (PHI) must be secure. INs must ensure that the email transmission is secure.
3. If the member's condition changes significantly in relation to the critical incident, the IN must report the change to the Community Case Management Program (CCM) by the end of the same business day.
4. If additional updates are requested by MassHealth, the IN must respond to MassHealth or the MassHealth designee for additional information.

Complete one report form for each critical incident. If multiple members are affected, fill out each section and then list all affected members in Section 5.

SECTION 1. General Information

Member

Member name | MassHealth ID

Address

Phone number

Incident

Date and time

Location of incident

Provider

Provider Name

Address | Phone number

SECTION 2. Witness of Incident

Name and contact information of person reporting or witnessing incident:

Name and contact information of person filing report (if different from witness):

Names and contact information of all individuals involved in the incident:

SECTION 3. General Nature of Incident *(Check all that apply. Attach additional pages if needed.)*

- ☐ Incident/accident during IN visit resulting in a member's serious injury
- ☐ Incident/accident resulting in a member's unexpected death (even if the IN was not involved in the incident/accident).
- ☐ Incident of abuse/neglect involving the IN and the member
- ☐ Incident of abuse/neglect committed by another provider supporting the member concurrently as the IN (if known).

SECTION 4. Describe Incident and Cause

(Include location and events preceding incident. Attach additional pages if necessary. For multiple members, please list all affected members in this section.)

SECTION 5. Interventions and Outcomes *(Attach additional pages if needed.)*

Action taken by IN provider and outcome:

SECTION 6. Other Parties or Agencies Contacted/Involved *(e.g., family, police, HCP, hospitals, etc.)*

- ☐ Agencies (e.g., VNA, HHA, case manager, residential program, etc.)
- ☐ Division of Children and Families (under age 18)
- ☐ Disabled Persons Protection Commission (DPPC) (ages 19-59)
- ☐ Elder Affairs Protective Service (ages 60+)
- ☐ Family/caregiver
- ☐ Guardian
- ☐ Hospital
- ☐ Police
- ☐ Primary care physician or other health care practitioner
- ☐ Media
- ☐ Other (specify): _____

Describe action taken/involvement by other parties (including medical intervention if needed), provide contact information, and attach any reports from listed authorities.

SECTION 7. Member's Current Status *(Include health and other status.)*

- ☐ Emergent primary care physician or another medical visit
- ☐ Emergency room visit
- ☐ Hospitalized
- ☐ Nonroutine PCP or another medical visit
- ☐ Remains at home under care of _____ .
- ☐ Stable
- ☐ Unstable
- ☐ Further follow-up required after incident (explain):

SECTION 8. Describe Corrective Action Taken to Prevent Future Incidents

SECTION 9. IN Provider Signature and Submission

I certify that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge.

Printed Name: _____ Signature: _____

Title: _____ Date: _____

Date of Submission to CCM: _____