Initial Update

CONFIDENTIAL REPORT OF CONCERNS REGARDING CRITICAL AND SENTINEL INCIDENTS (NOT PART OF MEDICAL RECORD)

*All sections must be completed – **Handwritten versions <u>will not be accepted</u>***

Complete this form **<u>in full</u>** and give to your Manager/Director for review & signature, then fax a copy to the appropriate number below. All sections required to be completed prior to submission, including contacts and signature. ATTN: County of Santa Clara Behavioral Health Services Department

☐ Submit Form with use of Secure Email to QualityofCareConcern@hhs.sccgov.org

1. Client Information

a. Division:

b. ☐ County Clinic ☐ County Contracted Provider

c. Agency & Program Name:

d. Date of Report:

e. Date of Incident:

f. Avatar MRN:

g. Name of beneficiary/or person involved (Last, First MI)

h. Gender Identity: Choose an item.

i. DOB:

j. Primary Provider:

k. Assigned MD:

2. Account of Incident

a. Where (check all that apply): ☐ Clinic ☐Community/Home ☐ County Owned Property ☐ Residential Facility ☐ Other

b. Address of Incident:

c. Incident Type: *Please check the categories below that best describe the event. **Sentinel Events requiring a** **report within 24 hours are in bold/italic type.*** *All other reports are required within* **2 business days.** *Incident Type (check all that apply):* Violent Behavior

☐ **Physical assault by a client on staff requiring emergency medical intervention**
☐ **Physical assault between clients requiring emergency medical intervention**
☐ **Homicide**
☐ Verbally or physically threatening behavior by a client (includes mandatory reports of threatened violence)
☐ Physical assault by a client on staff NOT requiring emergency medical intervention
☐ Physical assault between clients NOT requiring emergency medical intervention
☐ Damage to program property by client
☐ Violent behavior or thoughts resulting in a psychiatric hold
☐ Other violent behavior (e.g., visitors, witness community violence)

Sexual Assault/Misconduct (all considered sentinel)
☐ **Sexual assault/misconduct involving client by staff**
☐ **Sexual assault/misconduct involving client by another client**

Client Suicide Attempt
☐ **Requiring emergency medical intervention**
☐ NOT requiring emergency medical intervention, and serious

Medication Issue
☐ **Client required emergency care, hospitalization, or transfer to medical unit as a result of medication issue.**
☐ Client was administered the wrong medication
☐ Client was administered the wrong dose, causing problems but not requiring medical intervention
☐ Issue with the timeliness of obtaining or the administration of a client's medication

Other medication-related issue

☐ **Acts constituting a violation of professional code of ethics or of any County of Santa Clara policy governing professional conduct**

Client Death (all considered sentinel)
☐ **Expected medical problem** ☐ **Unexpected medical problem** ☐ **Accidental/fatal injury** ☐ **Homicide**
☐ **Suicide** ☐ **Alcohol/drug overdose** ☐ **Unknown**

Service Disruption Resulting in Temporary or Prolonged Program Closure Due To (all considered sentinel)
☐ **Client behavior** ☐ **Fire** ☐ **Water/flood** ☐ **Terror threat** ☐ **Crime scene** ☐ **Earthquake**
☐ **Unusual odors/vapors** ☐ **Violence** ☐ **Infestation** ☐ **Disease outbreak** ☐ **Other**

Injury, Accident, or Acute Medical Problem
☐ **Staff injury, accident, or acute medical problem requiring emergency medical intervention**
☐ **Client injury, accident, or acute medical problem requiring emergency medical intervention**
☐ **Client or staff needle stick**
☐ Staff injury, accident, or acute medical problem NOT requiring emergency medical intervention (Significant Injury, requiring possible medical attention in the immediate future)
☐ Client injury, accident, or acute medical problem NOT requiring emergency medical intervention (Significant Injury, requiring possible medical attention in the immediate future)
☐ Unauthorized/Unexcused Client Absence from 24-hour Care Settings (AKA AWOL)
☐ Other

3. Provide details of incident as related by beneficiary and/or witness(es) and relevant information leading up to and including the incident (Include condition of person(s) involved, relevant medication, date last seen in clinic, etc., any prior activity to incident, other activity related, or contributing to incident; and how long this consumer has been open to the system)

a. *Details (be sure to attach other agency reports, as appropriate):*

CONFIDENTIAL REPORT OF CONCERNS REGARDING CRITICAL AND SENTINEL INCIDENTS (NOT PART OF MEDICAL RECORD)

*All sections must be completed – **Handwritten versions will not be accepted***

b. *Outcome* (check any that apply):

☐ 5150 ☐ Ambulance ☐ APS/CPS ☐ EPS/CSU Visit ☐ ER/ED Visit ☐ Fire Dept ☐ Police ☐ Other

4. Plan of Correction taken/planned by program (include dates/estimated dates of completion for each step/action). If action plan, or further action information is not yet available, please indicate who will follow-up with these details and when they will plan to get this to the county Quality of Care Coordinator. Please complete in current form and indicate that this is an update (required to be completed within 30 days).

5. Witnesses or Persons Familiar with Incident:

Name & Relationship to Incident	Email	Phone #

6. Staff Person Completing Report:

Name	Title	Phone # and Email	Date

7. Agency Director/Designee (REQUIRED for submission):

Name	Title	Signature	Phone	E-Mail

CONFIDENTIAL REPORT OF CONCERNS REGARDING CRITICAL AND SENTINEL INCIDENTS (NOT PART OF MEDICAL RECORD)

*All sections must be completed – **Handwritten versions <u>will not be accepted</u>***

FOR USE BY BEHAVIORAL HEALTH SERVICES DEPARTMENT ONLY

Behavioral Health Services Department Follow Up:

Reviewer ______________________ ______________________ ______________________ ______________

Name (Print Clearly) | Title | Signature | Date

BHSD ADMINISTRATIVE SIGNATURES:

Title (UM Manager)	**Name (Print clearly)**	**Signature**	**Date**
(If Sentinel Event or Deemed appropriate by 2ndary review) BHSD Division Director and/or Risk Manager:			

If Death
BHSD Medical Director

Medical Director First and Last Name: ______________________

Medical Director License: ______________________

Medical Director Signature: ______________________

CONFIDENTIAL REPORT OF CONCERNS REGARDING CRITICAL AND SENTINEL INCIDENTS (NOT PART OF MEDICAL RECORD)

*All sections must be completed – **Handwritten versions will not be accepted***

CONFIDENTIAL REPORT OF INCIDENT (NOT PART OF MEDICAL RECORD)

ATTORNEY-CLIENT PRIVILEGED COMMUNICATION

ALL SECTIONS ARE REQUIRED TO BE COMPLETED AND RELEVANT SIGNATURES OBTAINED PRIOR TO SUBMISSION!

This is a new integrated Incident Reporting form to be used by both BHSD and Contractor Staff. No other form will be accepted. Please type all forms – *Handwritten versions will not be accepted*.

1. **Agency & Client information**
   a. **Division**: Please use the drop-down menu here. Please select one. Do not leave blank.
   b. **County Clinic /County Contracted Provider** Please check one of these boxes.
   c. **Agency & Program Name**: Enter in text the name of your clinic and Program (e.g., "Momentum, Nikki's Place").
   d. **Date of Report**: Please use this standard drop down calendar and select the correct date.
   e. **Date of Incident**: Please use this standard drop down calendar and select the correct date.
   f. **Avatar MRN**: Please click here and enter the beneficiary Avatar Medical Record Number.
   g. **Name of beneficiary or person involved**: Please write out the full name of beneficiary: Last, First, Middle.
   h. **Gender Identity**: Please use the drop-down menu and select one.
   i. **DOB:** Please use this standard drop down calendar and select the correct date.
   j. **Primary Provider**: Please write out the full name and credential of the primary clinician/case manager.
   k. **Assigned MD**: Please write out the full name of the primary MD.
2. **Account of Incident**
   a. **Where:** Please check one box here if the incident occurred "onsite" or "offsite".
   b. **Address of the Incident:** Please type out address and city of where incident occurred.
3. **Provide details of incident** as related by beneficiary and/or witness(es) and relevant information leading up to and including the incident (Include condition of person(s) involved, relevant medication, date last seen in clinic, etc., any prior activity to incident, other activity related, or contributing to incident; and how long this consumer has been open to the system)
   a. **Details**: Please provide robust details of the incident as related by the beneficiary and/or witness(es) and relevant information leading up to and including the incident. Please include the condition of the person(s) involved, relevant medication, date last seen in clinic, etc., and any prior activity to the incident, other related activity, or contributing factors related to the incident. Please include how long the beneficiary has been open to the system.
   b. **Outcome**: Please check all boxes that apply. If you check "Other", please include a short description of another type of outcome in section 4a. For example, if client went AWOL, an outcome could be… "Beneficiary returned to group home".
4. **Plan of Correction taken/planned by program (include dates/estimated dates of completion for each step/action**): This is a very important part of the IR. The Plan of Correction (POC) should be robust with definitive action steps taken by the agency during or after the event. If it is something the agency plans to do, please include an estimated date of completion for each action/step.
5. **Witnesses or persons familiar with incident**: This can either be a staff person, another beneficiary, family member, or anyone else associated with the event.
6. **Staff person completing report**: Please write out the complete name and credential of the staff completing the IR.
7. **Agency director/designee**: (MANDATORY) The agency Director/Designee must sign here, to include their clearly printed name, signature, and phone number please

If you have questions regarding completion of this form, please call the Quality Assurance Unit at 1-800-704-0900.