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| **DEPARTMENT OF HEALTH SERVICES** **DIVIS****ION OF BEHAVIORAL HEALTH SERVICES ADVERSE INCIDENT REPORT** |
| **Date of Incident:       Date of Report:** **Client Name:****Age:** **DOB:** **EHR #:** **Agency/Facility/Program:** **Assigned Worker:** **Supervisor:** **Agency Designee:** **Contact Number:**  |
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| **Type of Incident (see Instructions for definitions):**[ ] **1. Death** [ ]  **2. Suicide Attempt** [ ]  **3. Serious Injury** [ ]  **4. Patients’ Rights**[ ]  **5. Sexual Harassment** [ ]  **6. Med. Side Effect** [ ]  **7. Communicable Disease** [ ]  **8. Facility Event**[ ]  **9. Credentialing** [ ]  **10. Catastrophes** [ ]  **11. Emergency Services** [ ]  **12. Litigation**[ ]  **13. Adverse Political/Media Attention** [ ]  **14. Other** |
| **Program Admission Date:** **Last face to face contact date:**  |
| **Identify Other Agencies Involved in treatment:** **Other Agencies Notified (examples: CCL, APS, CPS, Sheriff, PD, etc.):**  |
| 1. **Description of the incident (including date, time, location & people or programs involved). Additional sheet(s) may be added:** Click or tap here to enter text.
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| 1. **What services were provided prior to the incident? (Summary of type and frequency of services)** Click or tap here to enter text.
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| 1. **Action taken since incident:** Click or tap here to enter text.
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| 1. **Follow up plan:** Click or tap here to enter text.
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| **Signatures and Date:** **Agency Designee:** **Date:****County Program Coordinator/Contract Monitor:** **Date:****County Program Manager:** **Date:****County Division Manager:** **Date:** **DBHS Director:** **Date:**  |
| **For Internal County Use Only Follow up actions taken:**Click or tap here to enter text. |

**Instructions:**

Provider emails AIR to Contract Monitor (PC)

After PC and Provider review, AIR is sent to QM qm-air@saccounty.gov

Maintain a copy in the Agency Adverse Incident File

# Definitions:

Agency Designee: The person who reviewed the information and submitted the form to the County. Assigned Worker: The primary staff working with the client.

Supervisor: Direct Supervisor for the Assigned Worker

# Type of Incident:

1. Death – Death of any client for any cause
2. Suicide Attempt – Serious suicide attempt requiring professional medical attention.
3. Serious Injury – A client or employee injury on site that requires hospital care of more than one day.
4. Patients’ Rights – A complaint of serious infraction(s) of patient’s rights, including client abuse.
5. Sexual Harassment – A complaint of sexual harassment or undue familiarity involving staff or clients.
6. Med. Side Effects – Serious medication side effects requiring hospitalization.
7. Communicable Disease - All cases of communicable diseases reported under Section 2502 of Title 17 CCR, shall be reported to the local health officer in addition to DHCS and the County
8. Facility Event – A facility fire or explosion requiring evacuation of clients and/or staff.
9. Credentialing – Falsification of professional credentials required for licensure, practice, or work related duties.
10. Catastrophes - Flooding, tornado, earthquake, or any other natural disaster.
11. Emergency Services – Incidents involving emergency services at treatment facility (Ambulance, Police, Fire, etc.)
12. Litigation – Incident with exposure to liability that would likely lead to litigation.
13. Adverse Political/Media Attention – Incident that may engender media coverage.
14. Other

# Completing the form

This form should be completed with all available information within two (2) days from when agency staff is made aware of the incident. Supplemental Information Report form can be used when more space is needed to include all required information.

# Description of the Incident

This section should include all known information regarding the events leading up to the incident, the incident itself, and any outcome of the incident, including hospitalization, first responder involvement, reports made to other agencies, etc.

# What services were provided prior to the incident?

This section should include information relevant to the incident, regarding length of stay, frequency and type for any and all of the following services and supports:

* 1. Mental Health
	2. Psychiatric or Medication
	3. Alcohol and/or Other Drug
	4. Family Advocate, Peer and/or Youth Peer Mentor
	5. Inpatient
	6. Emergency
	7. Residential
	8. Primary Care
	9. Prevention

# Action taken after the incident

This section should include follow up actions taken by the provider. It may include but is not limited to: safety planning, updating policies and procedure, training for staff, plans of correction or disciplinary actions, notification of treatment team participants, requesting of documents from outside agencies, etc.