

 <p style="text-align: center;"><b>County of Sacramento</b>  <b>Department of Health and Human Services</b>  <b>Division of Behavioral Health Services</b>  <b>Policy and Procedure</b></p>	Policy Issuer (Unit/Program)	<b>QM</b>
	Policy Number	<b>QM-09-01</b>
	Effective Date	<b>04-20-1997</b>
	Revision Date	<b>8/25/2025</b>
Title: <b>Adverse Incident Reports</b>	Functional Area: <b>Quality Improvement Program</b>	
Approved By: (Signature on File) <b>Signed version available upon request</b>  <b>Alexandra Rechs, LMFT</b> Quality Management Program Manager		

**BACKGROUND/CONTEXT:**

On occasion, incidents occur that require review to ensure quality care and to promote quality improvement. Additionally, some incidents that involve current or former clients generate inquiries from the media or the public. In order for the Division of Behavioral Health Services (DBHS) to improve the quality of service and respond to inquiries, management must be informed of such incidents in a timely manner.

**DEFINITIONS:**

- A. An Adverse Incident is a situation when any of the following events have occurred involving a client, who is receiving or has received Mental Health Plan (MHP) or Substance Use Prevention and treatment Services:
  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
  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.) Examples include but are not limited to; respiratory issues, chest pain, open wound, head trauma, severe pain, pregnancy complications/issues, overdose, use of Narcan.
  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 – Any other adverse incident involving a client. Examples include but not limited to; anything that threaten the welfare, safety, or health of clients, personnel, or visitors.

- B. Division of Behavioral Health Services (DBHS) encompasses the Sacramento County Mental Health Plan (MHP), Substance Use Prevention and Treatment Services (SUPT), and Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Services. This includes both County Operated and Contracted Provider programs that are funded through the Behavioral Health Services System.
- C. Agency Designee is the agency representative who is responsible for reporting and filing all Adverse Incident reports with the County.
- D. County Program Coordinators/ Contract Monitors refer to County employees designated to oversee a particular Agency, County Operated Program, County Contract, or Unit.
- E. County Program Managers are County Managers who oversee Program Coordinators in a particular unit.
- F. County Division Managers are County Managers who oversee either the Adult or Child/Family systems of care within DBHS.
- G. The Director oversees all aspects of the Division of Behavioral Health Services for the County of Sacramento.

## **PURPOSE:**

The purpose of this policy is to provide a standardized Adverse Incident reporting method. The goal is to assist service providers and county staff in evaluating and improving the quality of client services through appropriate identification and investigation of adverse incidents. The Adverse Incident report identifies a specific event, relevant practices and/or services expected to prevent such an event, follow-up services provided, areas for improvement in policy and practice and training, and offers an opportunity for corrective action.

## **DETAILS:**

### **REPORTING PROCESS**

- A. PROVIDER RESPONSIBILITY:
  1. Immediately after learning of an adverse incident, the clinician, case manager, or Agency Designee must verbally communicate the incident to the Program Coordinator / Program Contract Monitor. If the Program Contract Monitor/Program Coordinator is unavailable, the report should be given to an available Program Contract Monitor, Program Manager or Division Manager. For SUPT Providers: Information must also be forwarded to the State of California, Department of Health Care Services (DHCS) [DHCSLCBcomp@DHCS.ca.gov](mailto:DHCSLCBcomp@DHCS.ca.gov) .
  2. Within two (2) working days of becoming aware of the incident, the Adverse Incident Report form should be completed in consultation with the County Program Coordinator/Contract Monitor and submitted for review and recommended edits. If returned for correction/clarification by County the AIR will be resubmitted by the provider to County within one (1) working day.
  3. Immediately upon completion of the written final report, send one copy of the Adverse Incident to:
    - BHS Quality Management Program Manager via:
      - Mail (7001 A East Parkway, Suite 300, Sacramento, CA 95823);
      - **Secured/encrypted** email at [QM-AIR@saccounty.gov](mailto:QM-AIR@saccounty.gov) or;
  4. The provider will initiate requests for the relevant law enforcement, autopsy, or licensing reports and attach the reports to the Adverse Incident Report form if available.

5. Any additional clarification, further developments, follow-up, or information (see item 4 above) should be recorded and forwarded through the chain of command. The “Supplemental Information Report” form may be used for this purpose (see attached).
6. Provider Designees are responsible for implementing the changes delineated in the corrective action plan, when applicable.
7. The provider will make available the original chart, as applicable, when requested by the County. Providers within their own EHR have five business days.

**B. COUNTY PROGRAM COORDINATOR/PROGRAM CONTRACT MONITOR RESPONSIBILITY:**

1. After being notified of the adverse incident, the County Program Coordinator/Program Contract Monitor will immediately inform his/her County Program Manager or their designee.
2. The County Program Coordinator/Program Contract Monitor may review the client’s chart and any relevant collateral information upon request.
3. After receiving and approving the written report, the County Program Coordinator/Program Contract Monitor will sign and date the report using a secure electronic routing system (DocuSign) and submit to the County Program Manager with along with any relevant information (i.e. EHR Services List Page for last quarter, known information regarding complaints, citations, and inspections for foster homes, 24-hour residential programs, day care and all CCL facilities, etc.).
4. If an AIR is reviewed by the Quality Improvement Executive Committee (QIEC) and a Corrective Action Plan is required, the Program Coordinator/Contract Monitor will coordinate with the QIEC to monitor the implementation and completion of the corrective action plan.

**C. COUNTY MANAGEMENT RESPONSIBILITY:**

1. Upon receiving the verbal report regarding the adverse incident, the County Program Manager will evaluate whether a Division Manager, DBHS Director or Quality Management Program Manager needs to be contacted immediately or can be notified up on receipt of the written report.
2. After receiving and approving the written report, the County Program Manager will sign and date the report using a secure electronic routing system (DocuSign), and send to the Division Manager for review and signature. The report will then be forwarded to the DBHS Director for review and signature.
3. The DBHS Director forwards the signed original adverse incident report to Quality Management Program Manager using a secure electronic routing system (DocuSign).

**COUNTY QUALITY MANAGEMENT RESPONSIBILITY**

- A. The Quality Management Program Manager will review all adverse incidents and refer them to the QIEC when appropriate.
- B. The QIEC will evaluate all client records relevant to the Adverse Incident Report.
- C. As deemed appropriate, the QIEC will require a corrective action plan be developed by the provider for the identified problems. The Corrective Action Plan will be monitored by the County Program Coordinator/Contract Monitor and reviewed by the QIEC for relevance and implementation of best practice.
- D. The QIEC or the County Quality Improvement Committee (QIC), or its designee, may meet with relevant staff from the reporting Provider to discuss the Adverse Incident report and to obtain any additional details, answer questions and provide clarification if needed.
- E. The QIEC or Quality Management staff may review the client’s chart and any relevant collateral information at any time.
- F. Quality Management staff may interview others who have been involved with the adverse incident.
- G. Quality Management staff will prepare a report of the findings as appropriate, and submit it

to the County Program Manager, Division Manager, DBHS Director and to the Provider designee of the reporting agency/facility.

**CORRECTIVE ACTION PROCESS**

- A. If the Provider disagrees with the accuracy or content of the QIEC report, s/he will prepare a report addendum and submit it to the Quality Management within ten (10) working days.
- B. The Quality Management Program Manager and staff will meet with the Contract Provider and Program Coordinator/Contract Monitor to resolve disagreement(s) regarding thereport.
- C. The Provider and appropriate personnel will develop a corrective action plan with time frames. The corrective action plan should be completed within thirty (30) days of the Quality Management report of findings or resolution of disagreements, and a copy should be sent to the Quality Management Program Manager.
- D. The final report and the corrective action plan will be used when Quality Management conducts any future reviews of the agency/program.

**ADDITIONAL INFORMATION**

Adverse Incident Reports are risk management documents and are ***not to be filed*** in the client’s chart, nor should the completion of an Adverse Incident report be documented in a client’s chart. It must be filed separately from the client chart in a secured location that complies with HIPAA regulations with limited access at the Provider site.

**REFERENCE(S)/ATTACHMENTS:**

- Adverse Incident Reporting Form
- Additional Information Form

**RELATED POLICIES:**

- Not Applicable

**DISTRIBUTION:**

Enter X	DL Name	Enter X	DL Name
X	County Mental Health Staff	X	Substance Use Prevention and Treatment Services
X	Adult Contract Providers	X	MHSA PEI Programs
X	Children’s Contract Providers	X	All other relevant BHS contracted service organizations

**CONTACT INFORMATION:**

- Quality Management  
[QMInformation@saccounty.gov](mailto:QMInformation@saccounty.gov)

**DEPARTMENT OF HEALTH SERVICES  
DIVISION 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: \_\_\_\_\_

**Type of Incident (see Instructions for definitions):**

- |                                                                |                                              |                                                  |                                              |
|----------------------------------------------------------------|----------------------------------------------|--------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> 1. Death                              | <input type="checkbox"/> 2. Suicide Attempt  | <input type="checkbox"/> 3. Serious Injury       | <input type="checkbox"/> 4. Patients' Rights |
| <input type="checkbox"/> 5. Sexual Harassment                  | <input type="checkbox"/> 6. Med. Side Effect | <input type="checkbox"/> 7. Communicable Disease | <input type="checkbox"/> 8. Facility Event   |
| <input type="checkbox"/> 9. Credentialing                      | <input type="checkbox"/> 10. Catastrophes    | <input type="checkbox"/> 11. Emergency Services  | <input type="checkbox"/> 12. Litigation      |
| <input type="checkbox"/> 13. Adverse Political/Media Attention |                                              | <input type="checkbox"/> 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.](#)

2. **What services were provided prior to the incident? (Summary of type and frequency of services)** : Click or tap here to enter text.

3. **Action taken since incident:** Click or tap here to enter text.

4. **Follow up plan:** Click or tap here to enter text.

**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 [gm-air@saccounty.gov](mailto:gm-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:

- a. Mental Health
- b. Psychiatric or Medication
- c. Alcohol and/or Other Drug
- d. Family Advocate, Peer and/or Youth Peer Mentor
- e. Inpatient
- f. Emergency
- g. Residential
- h. Primary Care
- i. Prevention

Route: Email AIR to Quality Management and Contract Monitor/Program Coordinator, add copy to Agency Adverse

**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.

**DEPARTMENT OF HEALTH SERVICES DIVISION  
OF BEHAVIORAL HEALTH SERVICES  
ADVERSE INCIDENT REPORT – SUPPLEMENTAL INFORMATION REPORT**

Date of Incident: \_\_\_\_\_ Date of Initial Report: \_\_\_\_\_

Client Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ EHR#: \_\_\_\_\_

Agency/Facility/Program: \_\_\_\_\_ Assigned Worker: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Agency Designee: \_\_\_\_\_ Contact Number: \_\_\_\_\_

**Additional information reported or discovered since initial report:** Click or tap here to enter text.

**Additional action taken since initial report:** Click or tap here to enter text.

**Client response to initial action taken:** Click or tap here to enter text.

**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**

**Additional follow up actions taken:**