ALAMEDA COUNTY Behavioral Health Care Services	Date Approved: 12/07/2015 By: [signature] Manuel Jimenez, MA, MFT Behavioral Health Director
POLICY TITLE **Unusual Occurrence and Death Reporting**	**Policy No:** 1603-4-1 **Date of Original Approval**: 1/16/2012 **Date(s) of Revision(s):** 12/07/2015

PURPOSE

This policy updates and retitles the "Sentinel Event/Death Reporting Policy and Procedure" originally approved on January 16, 2012. The term "Sentinel Event" is being replaced with "Unusual Occurrence" to be consistent with terminology used by other governmental and certifying bodies. This revision also defines "Unusal Occurrence" for reporting purposes within Alameda County Behavioral Health Care Services (ACBHCS).

ACBHCS tracks and reviews Unusual Occurrences and deaths of ACBHCS beneficiaries. This policy is designed to ensure that explanations of incidents and trends from Unusual Occurrence and Death Reporting Forms (UODRF) are applied to the continuous quality improvement of all services offered by ACBHCS and its contractors.

Reporting will be used to identify and address areas including, but not limited to:

- Utilization patterns that suggest issues with access to services
- Gaps within the service continuum
- Linkage between services
- Coordination of care
- Issues of concern which impact consumers, staff and the public
- Quality Improvement

All Unusual Occurrence and Death Reports and related materials submitted pursuant to this policy are covered by the confidential Quality Assurance (QA) process, subject to QA confidentiality, and are not subject to discovery in legal proceedings per the authorities listed below.

AUTHORITY

Title 9, CCR, Section 1810.440, MHP Quality Management Programs; MHP contract with CA Department of Health Care Services (DHCS). QA Activities are governed by California statutes including, but not limited to, Welfare and Institutuions Code §§ 4030, 4070, and Evidence Code §§1156.1, 1157, 1157.5, 1157.6 and 1157.7; Civil Code 43.7.

SCOPE

All county-operated programs in addition to entities, individuals and programs providing services under a contract, or subcontract with ACBHCS are required to report Unusual Occurrences (see definition on Pages 4 and 5) and deaths of ACBHCS beneficiaries.

POLICY

This policy establishes the requirements for reporting Unusual Occurrences and deaths of ACBHCS beneficiaries.

PROCEDURE

A. Deaths: All Beneficiary deaths shall be reported regardless of cause or circumstances.

B. Unusual Occurences: All Unusual Occurences as defined on Pages 4 and 5 shall be reported. Reportable events should be credible as determined by clinical staff or a staff person in an authority position.

C. How to Report a Death or Unusual Occurrence to ACBHCS:

i. Timeline for Reporting. All county-operated programs in addition to entities, individuals and programs providing services under a contract or subcontract with ACBHCS shall make a report by completing the *Unusual Occurrence/Death Reporting Form (UODRF)* and submitting it to the ACBHCS Quality Assurance Office within 7 days of the knowledge of the death of a Beneficiary or an Unusual Occurrence.

ii. Who should make the report. Staff with the most knowledge of the incident, the treating staff member, the program's Quality Assurance lead staff, or a staff member in an authority position. Multiple programs may file a report as each may have different knowledge.

iii. Location of Form: The *Unusual Occurrence/Death Reporting Form* is available online on the ACBHCS provider website http://www.acbhcs.org/providers/qa/docs/qa_manual/6-4_unusual_occurrence_and_dealth_reporting_form.pdf

iv. How to Submit the Form

The report can be faxed to:	QA Office, 510-639-1346
Or submitted via USPS to:	QA Office, ACBHCS 2000 Embarcadero, Suite 400 Oakland, CA 94609

D. Filing of Mandated Reports

The filing of this report does not exempt providers, entities, individuals and programs from the necessity and/or legal requirement to file other legally mandated reports including those required by their certifying or licensing body; the state or federal government; JCAHO; Alameda County Risk Management pursuant to the terms of their contract; OR to complete their internal QA/QI process, and/or to file an Incident Report with ACBHCS-Human Resources if required. See additional reporting responsibilities listed on the attached *ACBHCS Unusual Occurrence & Death Reporting Comparison Chart*. ***Provider shall include copies of all such mandated reports with the submission of the ACBHCS Unusual Occurrence & Death Reporting Form (UODRF) to the ACBHCS QA Office.***

E. Initial QA Review Process

i. The ACBHCS Quality Assurance Office will do an initial review of the Unusual Occurrence and Death Report and, if deemed necessary, gather any other relevant information to determine the events reported, their precursors, results, and any actions taken subsequent to the event.

ii. The ACBHCS Quality Assurance Office reserves the right to obtain a police report, coroner's report, or other reports and information concerning the Beneficiary and/or the event. ACBHCS-QA also reserves the right to request and examine any charts pertaining to services the Beneficiary has received through ACBHCS affiliated providers.

iii. As a result of the initial review of the event and any related materials, the ACBHCS Quality Assurance Office may give the provider recommendations for quality improvement or require a Plan of Correction to remedy a deficiency in such areas as quality of care or chart documentation.

iv. Subsequent to or concurrent with the initial review, a Formalized Case Review may be convened which includes a further review of the event by a larger panel. Please see ACBHCS's Formalized Case Review Policy and Procedure # 1603-4-2 in the QA Manual.

F. Role of ACBHCS Quality Improvement Committee. On at least an annual basis, statistical reports summarizing Unusual Events/Death Reports will be presented to the ACBHCS Quality Improvement Committee (QIC) for the purpose of identifying any system-wide trends and recommendations for improvement. All information presented to the QIC will be de-identified of beneficiaries' Protected Health Information (PHI).

CONTACT

BHCS Office	Current as of	Email
Quality Assurance Office	December 2015	qaoffice@acbhcs.org

DISTRIBUTION

This policy will be distributed to the following:

- ACBHCS Staff
- ACBHCS County and Contract Providers
- Public

ISSUANCE AND REVISION HISTORY

Original Author: Kyree Klimist, MFT, QA Administrator
Original Date of Approval: 01/16/2012 by Marye Thomas, MD, ACBHCS Director
Date of Revision: 12/07/2015 by Manuel Jimenez, MA, MFT, ACBHCS Director

Revise Author	Reason for Revise	Date of Approval by (Name)
Donna Fone, MFT, LPCC Anthony Sanders, PhD	Policy update and title change. Previously titled "Sentinel Event/Death Reporting Policy and Procedure"	12/07/2015 by Manuel Jimenez

DEFINITIONS

Term	Definition
Beneficiary	Anyone currently receiving ACBHCS care or services, or who has received ACBHCS care or services in the last 12 months. The term 'beneficiary' is also synonymous with 'consumer,' 'patient,' or 'client'.
Unusual Occurrence	An Unusual Occurrence is an unexpected event that has occurred that may have caused physical and/or psychological harm, or has potiential to do so, to a Beneficiary OR to another person that involves a Beneficiary. The term

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<td>Unusual Occurrence (cont'd)</td>
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“Unusual Occurrence” is also synonymous with ‘sentinel event.’ Reportable events should be credible and may include both physical and psychological factors as well as occurrences which are witnessed by staff or reported by others, regardless of location. Events that trigger a mandated child abuse or elder/dependent adult abuse report are <u>not</u> reportable under this policy with the exception of the item marked with * below. Reportable events include but are not limited to:
Physical Events Involving a Beneficiary:

Death or serious injury to a current consumer or an individual who received services within the previous twelve months
Death or serious injury to any person that involved an individual who received services within the previous twelve months
Suicides or suicide attempts
Problems involving seclusion and/or restraint of a consumer
Any allegations of abuse of consumers (or family members) by a provider or another consumer within the same agency*
Falls by consumer or family member for any reason (with or without injury) within a provider facility
Errors in the prescription or administration of medications
Assault of a consumer or by a consumer
Allegations of property loss

Psychological Events Involving a Beneficiary

Allegations of unethical relationships or other unprofessional conduct between staff and consumer or family member
Observation and/or information regarding questionable or inappropriate staff behavior related to client care.

Other Events

Suspected violation of professional licensure and/or ethics by a staff member serving ACBHCS beneficiaries
Incidents related to physical facility issues that impact the consumer, staff or public.
Events which involve a potential for ACBHCS liability or media attention.

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ATTACHMENTS

A. ACBHCS Unusual Occurrence and Death Reporting Form
B. ACBHCS Unusual Occurrence and Death Reporting Comparison Chart