7.1.16 UNUSUAL OCCURRENCES AND SENTINEL EVENT REPORTING

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References:	California Welfare and Institutions Code §§ 4070 and 5325.1 California Evidence Code §§ 952, 1040, 1156.1, 1157, 1157.6 and 1157.7 Title 9 of the California Code of Regulations §§10531, 10561 and 1810.440 Title 42 of the Code of Federal Regulations 438.608(a)(3) DHS Policy 06.03, Psychotherapist's Duty to Warn – Mandated Reporting Requirements DHS-BHD Policy 7.1.17, Documentation Requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services DHS-BHD Policy 7.4.1, De-Escalation and Containment (Seclusion and Restraint) DHS Policy 08-01, Accident and Incident Reporting Guideline PRISM Addendum B Liability Claims Administration Standards
Policy Owner:	Behavioral Health Division, Quality Assessment and Performance Improvement (QAPI), Quality Improvement Manager
Director Signature:	**Signature on File**

I. Policy Statement

The Department of Health Services – Behavioral Health Division (DHS-BHD) maintains a confidential, internal reporting mechanism available to all Division staff and contracted network providers to report and alert management of Unusual Occurrences, including Sentinel Events. This mechanism supports the Division's Quality Management Program by ensuring evaluation, issuance of recommendations, and follow-through on issues affecting the quality of behavioral health care, in compliance with the requirements of 9 CCR § 1810.440.

II. Scope

This policy applies to all DHS-BHD Covered Persons including employees (full-time, part-time, extra-help), unpaid interns, paid interns, temporary agency workers, registered volunteers, and all individual providers contractually designated as Covered Persons. Covered Persons do not include Community Based Organizations (CBOs) staff.

III. Definitions

A. **Quality Improvement Committee (QIC):** A multidisciplinary committee responsible for monitoring, evaluating, and improving the quality of care and member safety across Division programs.

B. **Sentinel Event:** A clinical event that results in, or has the potential to result in, death; serious physical and/or psychological injury; including permanent loss of function or severe temporary harm. Sentinel events require timely review and response to reduce the likelihood of recurrence.

C. **Sentinel Event Subcommittee:** A multidisciplinary subcommittee of the QIC, responsible for monitoring, evaluating, and improving quality of care in response to Sentinel Events and Unusual Occurrences.

D. **Unusual Occurrence:** Is an event that: (a) causes a member direct or indirect harm, or has the potential to do so, and is outside of the member's established baseline and/or functioning; or (b) involves a member causing direct or indirect harm, or the potential to do so, to individuals and/or staff. An Unusual Occurrence may include a Sentinel Event.

IV. Policy

A. All covered persons who witness, experience, or become aware of an “Unusual Occurrence” are required to comply with applicable County policies and procedures.

B. The County’s DHS-BHD shall ensure timely review and response to reported events, and shall maintain quality assurance mechanisms to investigate and address events with the intention of improving quality for our members and staff, and reducing the probability of such an event in the future.

C. This policy does not replace or supersede mandated reporting requirements. All mandated reporters are required to comply with applicable reporting laws in addition to County policies.

D. Unusual Occurrences may need to be reported to the Department of Health Services (DHS), as directed in DHS Policy 08-01 Accident and Incident

Reporting Guideline. Where applicable, alternative incident forms may be submitted in lieu of Sentinel Event form MHS 107. Eligible form substitutions include, but are not limited to, the Community Care Licensing Division (CCL) form LIC 624 – Unusual Incident/Injury Report or DHCS 5079 form.

E. Sentinel Event Reports are reviewed by the Sentinel Event Subcommittee of the QIC. The Subcommittee provides recommendations for corrective action and follow-up, as appropriate, and monitors to ensure member and staff safety and ensure quality of care.

F. All QIC meetings and communications related to Sentinel Events are confidential and protected from disclosure under Evidence Codes, Sections 1157.6 and 952.

V. Procedures

A. Reportable Unusual Occurrences

1. Reportable Unusual Occurrences, including Sentinel Events, include the following:

   a. Assault committed by or to a member, including assaults that are sexual or physical in nature.

   b. Physical or sexual abuse of a member.

   c. Death of a member (other than suicide or homicide) who is:

      i. Currently open to a DHS-BHD program, or

      ii. Within 90 days of contact or discharge from a DHS-BHD program.

   d. Member Elopements

      i. From a 24-hour facility, and are on 5150 legal status, conservatorship, or other legal hold status; and/or

      ii. When the member otherwise presents a risk of danger to self or others.

   e. Homicides or attempted homicide.

   f. Seclusion or restraint resulting in member injury or death.

   g. Serious threats of harm to others, including Tarasoff-reportable events. See DHS Policy 06.03, Psychotherapist's Duty to Warn – Mandated Reporting Requirements for additional guidance.

   h. Suicides or suicide attempts.

i. Prescription or administration of medication resulting in adverse or potential adverse events (e.g. missed dose, incorrect dose, medication reactions excluding common side effects).

j. Errors in the administration of medications (e.g., prescribing error, administration error) if the error reaches the member and/or adverse medication event occurs.

k. Significant delays in treatment resulting in adverse or potential adverse outcomes.

B. Immediate Notification

1. Upon witnessing, experiencing, or becoming aware of an Unusual Occurrence, Covered Persons shall verbally notify the supervising Program Manager.

C. Reporting Documentation

1. The notifying staff shall complete the required fields of Section I of the Sentinel Event Report Form (MHS 107) and immediately sends to the assigned Quality Improvement (QI) Coordinator.

2. Within one business day of initiating the report, the notifying staff shall complete any remaining fields of Section I of MHS 107 form and forward it to the Program Manager.

a. Alternative reporting forms may be utilized in lieu of the MHS 107 as long as all of the essential information is provided. Programs may use their own internal incident reporting forms for this purpose. For programs licensed through CCL, a copy of form LIC 624 is sufficient written notification of a Unusual Occurrence.

D. Program Manager Responsibilities

1. The Program Manager shall:

a. Complete Section II of the Sentinel Event Report Form (MHS 107).

b. Forward the completed form to the appropriate Section Manager as soon as possible, and no later than three working days from the date the report is completed, as noted in Section I of MHS 107.

c. The Program Manager must verbally notify the Section Manager promptly for all serious incidents, e.g. Sentinel Event, including suicides, serious suicide attempts, homicides, serious homicide attempts, deaths other than suicides/homicides, assaults or serious threats of harm by a member, and elopements as described in Section 1.d.

E. Section Manager Responsibilities

1. The Section Manager shall:

    a. After review, completion, and approval of Section II, the Section Manager will forward the Sentinel Event Report as soon as possible and no later than seven working days (of the "date report completed" as noted in Section I of the form) to the QI Coordinator.

    b. Promptly notify the Behavioral Health Director and the Medical Director of Sentinel Events, including suicides, serious suicide attempts, homicides, serious homicide attempts, deaths other than suicides/homicides, assaults or serious threats of harm by a member, and elopements as described above.

F. Timeliness Responsibilities

1. The Program Manager and Section Manager are jointly responsible for ensuring that Unusual Occurrence and Sentinel Event reporting is completed in a timely manner.

G. Confidentiality

1. Unusual Occurrences are to be treated as confidential.

    a. Form MHS 107, or another form used in its place, must not be copied or entered into member's medical record.

    b. Staff must **not** reference the completion of form MHS 107 in the progress notes.

        a. Staff should document only the clinically relevant aspects of the event in the client’s progress notes, and only when it is appropriate and necessary for the client’s treatment record, in accordance with documentation standards outlined in DHS-BHD Policy 7.1.17, Documentation Requirements for all Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services, and Policy 7.4.1, De-Escalation and Containment (Seclusion and Restraint), when applicable.

H. Quality Improvement Review and Oversight

1. The QAPI Section shall be responsible for oversight and review of all reported events.

    a. Report Review

All reports shall be promptly reviewed and screened for completeness.

b. Incident Assessment

Upon receipt, the QI Coordinator shall assess the event details provided and assign a Quality of Care Severity Rating that will be used to prioritize case review and inform trend monitoring:

i. Level 0 = No quality of care concerns

ii. Level 1 = Minimal quality of care concerns

iii. Level 2 = Minimal to moderate quality of care concerns

iv. Level 3 = Moderate quality of care concerns

v. Level 4 = Severe quality of care concerns

c. Risk Notification

i. Events shall be referred by the QI Coordinator to Sonoma County Risk Management through a risk memorandum, as appropriate. These events include incidents on the Public Risk Innovation, Solutions, and Management (PRISM) mandatory reporting list:

(1) Death

(2) Paralysis, paraplegia, quadriplegia

(3) Loss of eye(s), or limbs

(4) Spinal cord or brain injury

(5) Dismemberment or amputation

(6) Sensory organ or nerve injury or neurological deficit

(7) Serious burns

(8) Severe scarring

(9) Sexual assault or battery, including but not limited to rape, molestation or sexual abuse

(10) Substantial disability or disfigurement

(11) Any other serious type of bodily injury

(12) Any event with a potential for a claim against the county

I. Committee Review

1. Events shall be reviewed by the QIC's Sentinel Event Subcommittee:

    b. Unusual Occurrences with a rating of 0-2 shall be tracked for trend reporting and may be reviewed on an ad hoc basis at the discretion of the committee, or QI Coordinator.

    c. Unusual Occurrences with a rating of 3-4 shall be presented to the Subcommittee for case review.

a. The Subcommittee shall provide guidance on the triage process and issue additional recommendations as needed.

b. When indicated, the Subcommittee may:

    i. Provide guidance on the Quality of Care Severity Rating determination;

    ii. Refer the event to the Medical Staff Committee for peer review (Morbidity and Mortality Conference); and/or

    iii. Refer the event for a root cause analysis with appropriate staff to evaluate quality of care concerns. Root cause analysis shall be led by QI staff and/or Sentinel Event Subcommittee members, as appropriate.

c. The Subcommittee shall report significant quality of care issues or trends to the QIC for review and policy recommendations.

J. Reporting and Analysis

1. All events shall be tracked for trends and systemic issues.

2. The QI Coordinator shall prepare a report, no less than quarterly, for the Sentinel Event Subcommittee including:

    a. Numbers of Unusual Occurrences;

    b. Types of events; and

    c. Other information as requested (e.g. trend reports).

3. Reports shall be presented to the Sentinel Event Subcommittee; and may be reported to the QIC at the discretion of the Subcommittee.

K. Record Retention

1. Unusual Occurrence and Sentinel Event reports, along with related documentation, shall be retained in a locked, confidential file, and maintained in compliance with the DHS Records Retention Schedule.

VI. Forms

A. Sentinel Event Report Form, MHS 107

VII. Attachments

None