San Mateo County Behavioral Health & Recovery Services

(DO NOT PLACE IN CHART)

CRITICAL INCIDENT REPORT

Confidential Risk Management/Quality Assurance Document – Protected by Evidence Code 1157 Et. Seq.

BHRS programs - Email report with Unit Chief/Med Chief/Supervisor Comments to QM:

Contracted programs Fax to 650-**525-1762 County Staff -email to HS_BHRS_QM@smcgov.org**

Must SEND TO BHRS QM WITHIN 24 HOURS

The person most closely involved or the person discovering the incident should complete this form on both sides as soon as practical after an incident has occurred.

Reported by (print): ______________________________

Phone:___________________________

Reporting Program: Access □ ADS □ ARM □ BAART-AOD □ BHRS AOD □ Caminar □ Central □ Child Welfare □ Coastside □ Cordilleras □ EPA □ Edgewood □ Fred Finch □ Interface □ Mateo Lodge/Wally's □ MHA □ North □ Oasis □ OCG □ Palm Ave □ Pathways □ PES □ Pre to 3 □ Program Office □ Puente □ PV-SBMH □ Service Connect □ Shasta □ South □ StarVista □ TDS □ Telecare □ Total Wellness □ VRS □ YSC □ YTAC □ Other □:______________________________

Who was involved? (Check all that apply)

☐ **Client Name** ______________________________ **MH#** ____________________ **age** _______

(Circle one) ☐**Male** ☐**Female** ☐**Other** **Conserved** ☐yes ☐no **Dependent adult** ☐yes ☐no

☐ **Client Name** ______________________________ **MH#** ____________________ **age** _______

(Circle one) ☐**Male** ☐**Female** ☐**Other** **Conserved** ☐yes ☐no **Dependent adult** ☐yes ☐no

☐ **Staff Member(s)** ____

Date occurred?_____/_____/_____ **Time** _______**AM or PM** **Incident Resulted in Arrest:** At clinic □ Offsite □

Where occurred? ☐ **Clinic/Agency** ☐ **Home/Apartment** ☐ **School** ☐**Shelter** ☐**Community** ☐ **Other** _____________

☐ **Supported Residence: Name**__________________________ ☐ **Residential Facility: Name**__________________________

Was Incident: Observed □ Reported/Alleged □ **Substance Use Involved:** ☐ **No** ☐ **Yes** ☐ **Suspected** ☐ **Unknown**

BEHAVIOR RELATED

□**AWOL/Wandering- Returned:** □**Yes** □**No** □ **Symptom Related Issue** □ **High Risk Behavior (Drugs, sex, etc.)** □ **Rule Compliance**

HOSPITAL/PES/POLICE RELATED

□ **5150 Problem/IP Care Related/Ambulance (not routine):** Name of Hospital/Ambulance__________________

□ **Police Related: Police/Sherif Department**_______________

ASSAULT/ABUSE

□ **Allegation of abuse by staff/provider/facility** □ **Assault to staff** (Check one) Physical □ Verbal □ Sexual □ Property □

□ **Assault/Abuse to client** (Select all that apply) **Type:** Physical □ Verbal □ Sexual □ Property □

□ **Assault/Abuse by client** (Select all that apply) **Type:** Physical □ Verbal □ Sexual □ Property □ Child □ Elder □ Dep. Adult □

□ **Threat –** Did you… (Select all that apply) Give warning? □ Break Confidentiality? □ Notify Police? □

□ **Homicide by client**

MEDICAL

□ **Fall/Injury** □ **Medical Problem:** ________________________________

□ **Medication Error:** Med name(s):____ (check one) by: Staff □ Client □

□ **Serious Medical/Medication Error (requiring immediate medical attention)**

□ **Poisoning** □ **Fire/Explosion** □ **Communicable disease:**__________________________

□ **Self Harm** □ **Survived Suicide Attempt** □ **Suicide:** (Select one) Overdose □ Train □ Gun □ Hanging □ Other □:_______

□ **Death:** (Select one) Medical Illness □ Natural Causes/age □ Accident □ Overdose □ Determined to be accident- suspected suicide □ Suicide □ Homicide □ Unknown Cause/No Report of Cause □

PHARMACY

□ **Pharmacy Error:** Med Name(s):_________________________________ Missing Meds □ Wrong Dose □ Wrong Meds

Pharmacy Name/Location:___________________

BREACH/SECURITY

□ **Breach of Confidentiality** □ **Car Accident** □ **Theft/Loss** □ **Legal Issue** □ **Facility Safety/Vandalism** □ **Other Security Issue**

OTHER ____________________________

Describe the incident and important facts of the event. Include names, dates, times and witnesses. Add pages if necessary. **Report(s) made to:** ☐ **APS** ☐ **CPS** ☐ **Police/Sheriff** ☐ **PES** ☐ **Other:________________**

List any predisposing factors relevant to this incident:

____________________/________________________ ______________ _______________________________

Print/Signature of person completing report **Date** **Clinic/Team**

For Unit Chief/Med Chief/Supervisor to Complete (Must be completed before submitting)

Briefly describe follow-up/future prevention and findings from review:

____________________/___________________________ __________________ ____________________________

Print Name/ Signature of Supervisor/Unit Chief/Med Chief **Date** **Phone Number**

For Manager to Complete- Required for High Risk Incidents

Briefly describe follow-up/future prevention and findings from review:

____________________/___________________________ __________________ ____________________________

Print Name/ Signature of Manager **Date** **Phone Number**