SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility	**Effective:**	4/6/2011
Sub-section	Administration and Management		
Policy	Unusual Occurrence Reporting	**Last Revised:**	1/4/2017
Policy #			
Director's Approval	Alice Gleghorn, PhD	**Date**	1/10/17
PHF Medical Director's Approval	Leslie Lundt, MD	**Date**	1/18/17
Supersedes:	NG and L – Incident Reports	**Audit Date:**	1/4/2020

1. PURPOSE/SCOPE

1.1. To define unusual occurrences and establish a reporting and review process to ensure continuous focus on patient safety through effective performance improvement and quality assessment practices.

2. POLICY

2.1. Santa Barbara County Psychiatric Health Facility (PHF) shall report unusual occurrences pursuant to Title 22, California Code of Regulations §77036 and §77137, Welfare and Institutions Code §15610.63, §15658 and §15630, and the Code of Federal Regulations, Title 42, §482.13(g)(1)(i-iii).

2.2. It shall be the policy of the PHF to investigate the source of any unusual occurrence, initiate any safety measures deemed necessary and comply with the requirements of any participating regulatory agency involved. Such actions may require an intense analysis to be conducted in a timely and thorough manner, relative to any identified qualifying unusual occurrence, with the intent to develop, implement, and monitor the effectiveness of a correction action initiated to prevent the risk of reoccurrence.

3. DEFINITION OF UNUSUAL OCCURRENCE

3.1. **Unusual Occurrence Defined**: An unusual occurrence is any condition or event which has jeopardized or could jeopardize the health, safety, security or well-being of any patient, employee or any other person while in the facility and shall include, but not be limited to:

a) An epidemic outbreak of any disease, prevalence of communicable disease, whether or not such communicable disease is required to be reported by Title 17, California Administrative Code, Section 2500, or epidemic infestation by parasites or vectors;

b) Poisonings;

c) Fires;

d) Physical injury to any person which, consistent with good medical and professional practice, would require treatment by a physician;

e) Death of a patient, employee or visitor from unnatural causes;

f) Sexual acts involving patients who are nonconsenting[1];

g) Physical assaults on patients, employees or visitors;

h) All instances of patient abuse;

i) Actual or threatened staff walkout, or other curtailment of services or interruption of essential services provided by the facility;

j) Patient escape from the facility with serious consequences (e.g., serious injuries or death);

k) Patient transfer to a hospital for serious and emergent medical situation as a result of the services, treatment, (or a lack thereof), and/or lack of supervision provided by the psychiatric facility;

l) Attempted patient suicide with serious consequences / outcomes, (e.g., fractured or broken bones, sutures, loss of major body function, surgery);

m) Seclusion/Restraint resulting in or related to death or serious injury to a patient, (e.g., fractured or broken bones, sutures, surgery).

n) Significant patient and staff exposure to human blood/body fluids. A significant exposure is defined as a contact with blood, saliva, tissue, or other body fluids that are potentially infectious to an area with percutaneous injury (e.g., needlestick or cut with a sharp object) or contact of mucous membrane or nonintact skin (e.g., exposed skin that is chapped, abraded, or with dermatitis).

4. PROCEDURE

4.1. Upon discovery by PHF staff of an unusual occurrence, that individual will immediately contact the PHF Nursing Supervisor or designee, who will in turn follow the chain of command for reporting or immediately contacting the PHF Chief Executive Officer (CEO) and/or PHF Medical Director.

4.2. It will be the responsibility of the PHF Nursing Supervisor to develop and submit the initial report to the California Department of Health Care Services (DHCS), as well as serve to as the liaison with that agency during the subsequent investigation process. In the event that the PHF Nursing Supervisor is not available, a designee will report the event to the DHCS. Disclosure of individually identifiable patient information is permitted consistent with applicable law.

[1] Patients identified as engaging in sexual contact, a psychiatric evaluation will be conducted to determine both patient's capacity to consent to sex acts and engage in consensual sex during the course of their stay at the PHF. Patients who have been deemed competent to consent to and engage in consensual sex are excluded from reporting.

4.3. Unusual occurrences shall be reported by the PHF within 24 hours, by telephone with written confirmation via email or fax, to the PHF CEO, PHF Medical Director and DHCS. An unusual occurrence report shall be retained on file by the PHF for three years. The PHF shall furnish other pertinent information related to the occurrences as the PHF CEO or the DHCS may require.

4.4. Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, as defined in Welfare Institutions Code, Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone or through a confidential Internet reporting tool, as authorized by Section 15658, immediately or as soon as practicably possible. If reported by telephone, a written report shall be sent, or an Internet report shall be made through the confidential Internet reporting tool established in Section 15658, within two working days.

4.5. Every fire or explosion which occurs in or on the premises shall be reported immediately to the local fire authority.

5. PATIENT DEATH FOLLOWING SECLUSION AND RESTRAINT

5.1. The PHF must report the following information by fax to DHCS and the California Department of Public Health (CDPH) no later than the close of business on the next business day following knowledge of the patient's death:

1. Each death that occurs while a patient is in restraint or seclusion.
2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
3. Each death known to the hospital that occurs within one (1) week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. “Reasonable to assume” in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.

5.2. The PHF Nursing Supervisor, PHF Program Manager and QCM Manager will coordinate reporting with the PHF CEO and PHF Medical Director to ensure that all required reports are completed and forwarded to DHCS and the California Department of Public Health (CDPH). CDPH will be contacted by phone within 24 hours of the patient’s death at (805) 604-2926 or (800) 547-8267.

5.3. Clinical staff will outreach to impacted family members and offer support through the resources of the department, potentially including meetings, referrals, and other supportive actions. Staff will respect the confidentiality rights of the injured or deceased individual(s) involved during this process.

ASSISTANCE

Charlotte Balzer-Gott, RN, PHF Nursing Supervisor

REFERENCES

California Code of Regulations
Title 22, Sections 77036 and 77137

Welfare and Institutions Code
Sections 15610.63, 15658 and 15630

Code of Federal Regulations – Conditions of Participation: Patient's Rights
Title 42, Section 482.13(g)(1)(i-iii)

ATTACHMENTS

A. Unusual Occurrence Incident Report
B. 24 Hour Unusual Ocurrence Incident Report

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION
12/15/16	1.2	• Clarified reporting requirements for patient death following seclusion and restraint

Culturally and Linguistically Competent Policies
The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).