

Behavioral Health and Recovery Services (BHRS) Serious Incident Report (SIR)

**Confidential – BHRS Quality Management Program Form
Not Part of the Client Record**

Instructions:

This form is to be used for reporting Serious Incidents as defined in the BHRS-06 Policy & Procedure. This form is intended for internal BHRS use only. Its purpose is to provide a full accounting of the Serious Incident and to obtain names of witnesses that can be interviewed, should follow-up review/investigation be required.

A Level 1 incident is to be emailed to BHRSMQ@marincounty.gov or faxed to 415-329-3312 immediately upon knowledge of the incident. A level 2 incident is to be emailed or faxed within 3 calendar days of the knowledge of the incident.

Level 1

1. Any event that has been reported in the media (including social media), current or recent past regardless of the type of incident.
2. The event has resulted in a death or serious physical injury on the **program's premises**.
3. The event is associated with a significant adverse deviation from the usual process for providing behavioral health care.

Level 2

All other Serious Incidents are reported as Level 2.

Routing for this Form:

Employee (directly involved in or who witnesses unusual occurrence):

1. Complete this form and submit it to your supervisor for signature and further handling. **Form must be typed.** If your supervisor is unavailable, submit your completed form to another available manager or supervisor.
2. DO NOT make any additional copies of the completed form.
3. At no time should a copy of this form be included in a client record.

Supervisor or Program Manager:

1. Assist employees, who are either directly involved in or who witness the Serious Incident, to complete this form.
2. Review and complete sections H & I (supervisory review) on the form.
3. Sign the form.
4. Email or Fax the form directly to BHRS Quality Management Program at BHRSMQ@marincounty.gov or Fax: **415 329-3312**
5. DO NOT make any additional copies of the completed form.
6. Route the form – original to QM Program.

To route place original form in a sealed envelope marked confidential.

Original ➔ Address envelope to the QM Program at 20 N. San Pedro, then hand deliver or send via inter-office mail

SECTION A: STAFF MAKING THE REPORT

Name of employee who was directly involved or who witnessed the occurrence:	Employee's Phone Number:
Employee's Supervisor's Name:	Employee's Supervisor's Phone Number:
Program:	DATE & TIME OF THIS REPORT:

SECTION B: PERSON (CLIENT, PARENT/GUARDIAN OR MEMBER OF THE PUBLIC) INVOLVED IN INCIDENT

Last Name:	First Name:	
If person is a minor, Name of Parent or Guardian:		
Address:	City/State:	Zip Code:
Telephone Number:	Medical Record Number (MRN) or WITS number	

**Privileged and Confidential Attorney – Client Work Product
Not Part of the Client Record**

SECTION C: DESCRIPTION OF THE SERIOUS INCIDENT

Please choose type of incident Choose type of incident	Level 1 or Level 2 Level 1
Date:	Time:
Location:	Was a police report filed: Report #

Please provide a detailed description of the Serious Incident. Please include: *who, what, when, where, how* it happened, any events leading up to the serious incident, and any additional information that may have contributed to the incident (i.e., were drugs and/or alcohol involved?) You may attach additional pages if you need more space to complete your description. *For any racism/discrimination by client toward a staff member, please include client and staff demographic information, which protected classes were violated, type of harassment, etc.*

SECTION D: DESCRIPTION OF ANY BODILY INJURY

Please provide a detailed description of any injuries that occurred.

Was medical treatment required? Yes No

If yes, explain:

SECTION E: DESCRIPTION OF ANY ACTION TAKEN BY STAFF

Please provide a detailed description of any action taken by staff including any medical care rendered, including name(s) of physician(s) present or consulted, if any.

Were paramedics called?
Yes No

SECTION F: WITNESS(ES)

Did anyone else witness the event? If yes, please provide the name, address and telephone number for each witness.
Attach additional pages if you need more space to list witnesses.
Yes No

Witness 1. Name:

Address:

Contact Telephone Number:

Witness 2. Name:

Address:

Contact Telephone Number:

SECTION G: SUD RESIDENTIAL PROGRAMS ONLY

Per Title 9, CCR, Chapter, 5, subchapter 3, Article 1, Has the incident been reported by telephone to DHCS and to the County Alcohol and Drug Administrator within one working day of event ?
Yes No

Has copy of written report been submitted to DHCS and the County Alcohol and Drug Administrator within seven days of event?
Yes No

SECTION H: EMPLOYEE SIGNATURE

Employee (*directly involved in or who witnessed the Serious Incident*):

Date:

SECTION I: SUPERVISORY REVIEW

Additional comments and review of incident (i.e. What factors lead up to the incident, what mitigation was conducted, etc.)

SECTION J: SUPERVISORY REVIEW

Were appropriate standards of care and/or specific policies and procedures observed and/or followed?

SECTION K: SUPERVISOR SIGNATURE

Supervisor (*who received the completed form and sent it to BHRSMQ*):

Date: