



YOLO COUNTY

# Health & Human Services Agency

Resource · Partner · Support System

137 N. Cottonwood Street, Woodland, CA 95695

[www.yolocounty.org](http://www.yolocounty.org) (530) 661-2750

## UNUSUAL OCCURRENCE/EVENT (UOE) REPORT FORM

Date of Report:		Person Making Report:	
Date of Incident:		Time of Incident: <input type="checkbox"/> AM <input type="checkbox"/> PM	
Location (Address) of Incident:			
PERSONS INVOLVED			
NAME	MEMBER MR# or STAFF TITLE	CONTACT/PHONE #:	
Supervisor Notified? <input type="checkbox"/> Y <input type="checkbox"/> N	Date:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	
Police Report Filed? <input type="checkbox"/> N/A	Agency:	Time:	<input type="checkbox"/> AM <input type="checkbox"/> PM
TYPE OF INCIDENT			
<input type="checkbox"/> Epidemic/disease outbreak (any kind)	<input type="checkbox"/> Medication Error	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Overdose
<input type="checkbox"/> Physical assault on/by member or member discharged within 30 days or less, employees, or visitors	<input type="checkbox"/> Privacy & Confidentiality	<input type="checkbox"/> Suicide of a member or member discharged within 30 days or less	<input type="checkbox"/> Allegations of sexual harassment or abuse
<input type="checkbox"/> Member or member discharged 30 days or less at the date of the incident, staff, or visitor injury requiring medical treatment, facility related	<input type="checkbox"/> Community Violence <input type="checkbox"/> Weapon <input type="checkbox"/> Member apparent victim <input type="checkbox"/> Family apparent victim <input type="checkbox"/> Member alleged perpetrator	<input type="checkbox"/> Any injury on/in County property (requiring medical treatment)	<input type="checkbox"/> Accidents resulting in unintentional injury/death of anyone if County property involved
<input type="checkbox"/> Sexual acts between non-consenting members, including between members/ members discharged 30 days or less/staff/visitors	<input type="checkbox"/> Death of a member or member discharged within 30 days or less (for SUD programs, any member death, even if death did not occur at facility)	<input type="checkbox"/> Executed Tarasoff Statute Warnings	<input type="checkbox"/> Catastrophic event (i.e., fire, flooding, explosion, other major incident)
<input type="checkbox"/> Other:			

**DESCRIPTION OF INCIDENT**

(Include the name of the individual(s) involved, persons who observed the incident, and how members were affected, including any injuries. If incident involved a medication error, list of medications / doses / frequencies / compliance)

Empty space for description of incident.

**AGENCIES NOTIFIED**

<input type="checkbox"/> Yolo County Sheriff's Dept	<input type="checkbox"/> Woodland PD	<input type="checkbox"/> Davis PD	<input type="checkbox"/> W. Sac PD	<input type="checkbox"/> Winters PD
<input type="checkbox"/> UC Davis PD	<input type="checkbox"/> HHSA	<input type="checkbox"/> CHP	<input type="checkbox"/> CPS	<input type="checkbox"/> Parole
<input type="checkbox"/> Probation	<input type="checkbox"/> Woodland Fire	<input type="checkbox"/> ADP	<input type="checkbox"/> Other	

**EXPLAIN IMMEDIATE ACTION(S) TAKEN**

(include names of people contacted, relevant agencies involved, medical treatment administered, if any)

Empty space for explaining immediate actions taken.

**FOLLOW-UP INCIDATED AFTER IMMEDIATE ACTION(S) TAKEN**

(by whom, with whom, anticipated results, etc.)

Empty space for follow-up information.

SIGNATURE OF PERSON MAKING REPORT DATE

**FOR BH-QM USE ONLY**

Date BH-QM Notified: Time:  AM  PM Staff Initials:

Date HHSA Director Notified: Time:  AM  PM Staff Initials:

Date State DHCS Notified: Time:  AM  PM Staff Initials:

**DO NOT FILE IN MEMBER'S CHART OR RETAIN A COPY.  
ALL DOCUMENTS TO REMAIN IN BEHAVIORAL HEALTH QUALITY MANAGEMENT**

Please submit UOE Report Form within 7 days of incident to [HSAQualityManagement@yolocounty.org](mailto:HSAQualityManagement@yolocounty.org). Be sure to encrypt the email submission

## POST UNUSUAL OCCURRENCE / EVENT REVIEW

**To be completed only after review of Sentinel Events as defined in P&P 5-9-014**

*A sentinel event is a member safety event that results in death, permanent harm, or severe temporary harm. They are a type of serious UOE that may be debilitating to both members and providers involved in the event.*

Member name & Avatar #

Date/Location of Incident

Date UOE Report form submitted to BH-QM

**Management review of Serious Incidents** (i.e., imminent safety concerns. List review participants and titles.)

- Review the incident from the perspective of seeking system improvements, not assigning blame.
- Interview relevant participants in the event and conduct chart review.
- With this information, review systems and/or processes for potential precipitating events or root causes.
- Once review completed address the following:

1. Which systems and/or processes were reviewed (Check all that apply)

<input type="checkbox"/> Behavioral Health Assessment Processes	<input type="checkbox"/> Physical Health Assessment Processes	<input type="checkbox"/> Medication Protocols
<input type="checkbox"/> Staffing Resources	<input type="checkbox"/> Security	<input type="checkbox"/> Facility processes (i.e., set up, procedures, etc.)
<input type="checkbox"/> Care Coordination	<input type="checkbox"/> Availability of Information	<input type="checkbox"/> Risk Assessment Processes
<input type="checkbox"/> Reception Protocols	<input type="checkbox"/> Control of Medications (storage/access)	<input type="checkbox"/> Staff Training
<input type="checkbox"/> Policies and Procedures	<input type="checkbox"/> Communications with member/family	<input type="checkbox"/> Communications among staff

Other

2. Were potential contributing factors to the serious incident identified from the participant interviews, chart review and review of systems/processes?

3. If "Yes" to #2, what actions, if any, are indicated for quality improvement?

4. If actions are indicated for quality improvement, detail the action steps/risk reduction strategies to be implemented:

5. How will implementation of action steps/risk reduction strategies be monitored?

UOE REVIEW FORM SUBMITTED BY:

Date:

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