Sentinel Event Reporting

Sentinel events must be reported by the facility or provider within one (1) business day from learning of the occurrence. A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury. Serious injury may include loss of limb or function.
The following are considered sentinel events:

a. **Homicide or Serious Homicide Attempt** – Any act of a member, who has received care from the facility or provider within three (3) calendar days prior to the incident, which results in the death of another individual, or which was a serious attempt to kill another individual.

b. **Serious Suicide Attempt** – Any act of self-harm by a member that results in stabilization in an intensive care unit. Consideration will be given to lethality of the attempt, intent of member and potential pattern of behavior.

c. **Sexual Assault** – Nonconsensual sexual contact involving a member, including oral, vaginal, or anal penetration or fondling of the member or another patient's sex organ(s).

d. **Unexpected Death/Completed Suicide** – Any unexpected death that occurs during treatment by the facility or provider; or a death that occurs within three (3) calendar days of the member receiving care from the facility or provider.

Incident Reporting

For incidents not meeting the definition of a sentinel event, but that could present a quality of care concern, the facility or provider must notify New Directions within two (2) business days from learning of the occurrence. Examples include but are not limited to:

a. **Alleged or suspected abuse: verbal, physical, sexual, neglect**

b. **Altercation with injury or without injury**

c. **Elopement/unauthorized absence**

d. **Falls with or without injury**

e. **Medication error**

f. **Self-harming behavior or suicide attempt with or without injury**

If you need to report a sentinel event or other adverse incident, please fill out and submit the Adverse Event Reporting Form. **Fax completed forms to 816-237-2374.**

Please report the incident as soon as possible, even if all information is not yet available. Final submission of all information is required within five business days of the event. Though New Directions recommends using our reporting form, we will accept the information in any form or format. Should you wish to submit the information without using our recommended form, please ensure to include all the information requested in the form.

Note: when there is secondary coverage or denied care, reporting is still required.

If you have questions, please contact: QMComplaints@ndbh.com

CONFIDENTIAL INFORMATION CONFIDENTIAL INFORMATION CONFIDENTIAL INFORMATION

Adverse Event Reporting Form

Facility Name

Patient Name

Reporter Name

Patient DOB

Reporter Title

Patient Policy Number

Reporter Phone Number

Patient Phone Number

Reporter Email:

Coverage (if also secondary coverage):

Incident Date

Date of Report

Persons Involved

- ☐ Patient
- ☐ Staff
- ☐ Persons not associated with facility
- ☐ Other ________________________

Location

- ☐ In facility
- ☐ On grounds
- ☐ Off grounds
- ☐ Home
- ☐ Other ________________________

Incident Type

- ☐ Unexpected death:
  - ☐ Suicide
  - ☐ Homicide
  - ☐ Accidental
  - ☐ Cause unknown
- ☐ Expected death:
  - ☐ Non-suicide
  - ☐ Natural causes
- ☐ Altercation (if checked, please complete injury section):
  - ☐ With injury
  - ☐ Without injury
- ☐ Self-harming behavior or suicide attempt (if checked, please complete injury section):
  - ☐ With injury
  - ☐ Without injury
- ☐ Fall
  - ☐ With injury
  - ☐ Without injury
- ☐ Alleged or suspected abuse (If any checked, please complete Abuse/Assault section):
  - ☐ Verbal
  - ☐ Physical
  - ☐ Sexual
  - ☐ Neglect
- ☐ Elopement/unauthorized absence
- ☐ Medication error (if checked, please complete Medication Error section)
- ☐ Other____

---

1. ABUSE/ASSAULT SECTION

Alleged or suspected sexual abuse/assault:

- ☐ Nonconsensual contact (peer to peer)
- ☐ Nonconsensual contact with staff
- ☐ Nonconsensual contact with other perpetrator
- ☐ Consensual contact (peer to peer)
- ☐ Consensual contact with staff
- ☐ Consensual contact with other perpetrator

If nonconsensual:

- ☐ Staff witnessed
- ☐ Admission by the perpetrator
- ☐ Sufficient evidence obtained to support allegations

CONFIDENTIAL INFORMATION CONFIDENTIAL INFORMATION

2. MEDICATION ERROR SECTION

Medication error severity:

- ☐ None (no harm)
- ☐ Mild (monitoring)
- ☐ Moderate (treatment and monitoring)
- ☐ Serious (life threatening &/or permanent adverse consequences)

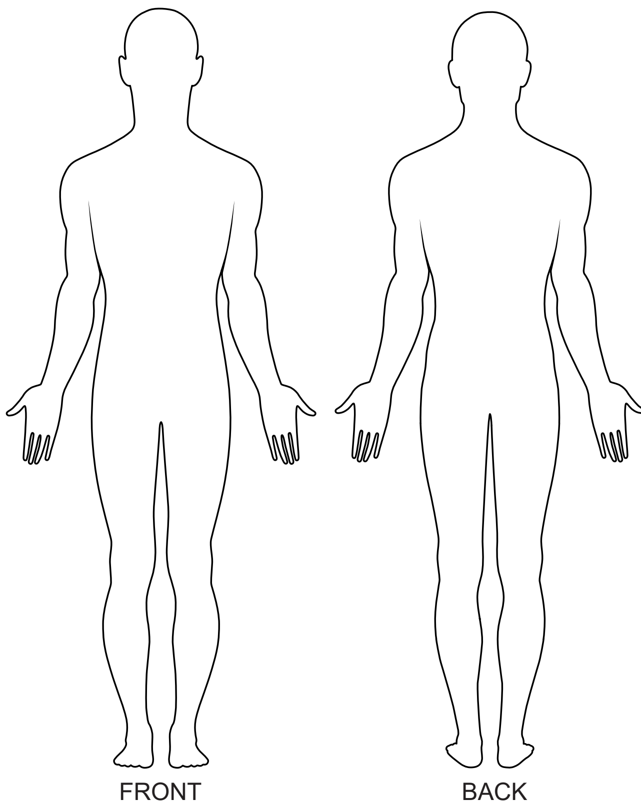
Medication error category:

- ☐ Failure to administer
- ☐ Wrong medication
- ☐ Wrong dose
- ☐ Wrong route
- ☐ Wrong time
- ☐ No MD order
- ☐ Administered w/o parental consent
- ☐ Adverse reaction
- ☐ Other____________________________

3. INJURY SECTION

Injury description:

- ☐ Abrasion
- ☐ Bite
- ☐ Burn
- ☐ Complaint of pain
- ☐ Contusion/bruise
- ☐ Dislocation
- ☐ Fracture/break
- ☐ Laceration/cut
- ☐ Puncture
- ☐ Scratches
- ☐ Strain/sprain
- ☐ Swelling
- ☐ Other: ____________________________



Injured body parts:

- ☐ Head
- ☐ Face
- ☐ Eye – ☐ left ☐ right
- ☐ Ear – ☐ left ☐ right
- ☐ Nose
- ☐ Mouth
- ☐ Teeth
- ☐ Neck
- ☐ Back
- ☐ Chest
- ☐ Shoulder – ☐ left ☐ right
- ☐ Arm – ☐ left ☐ right
- ☐ Elbow – ☐ left ☐ right
- ☐ Wrist – ☐ left ☐ right
- ☐ Hand – ☐ left ☐ right
- ☐ Waist
- ☐ Belly
- ☐ Hip
- ☐ Genitals
- ☐ Buttock – ☐ left ☐ right
- ☐ Thigh – ☐ left ☐ right
- ☐ Calf – ☐ left ☐ right
- ☐ Knee – ☐ left ☐ right
- ☐ Shin – ☐ left ☐ right
- ☐ Ankle – ☐ left ☐ right
- ☐ Foot – ☐ left ☐ right
- ☐ Other: ______________________________

CONFIDENTIAL INFORMATION CONFIDENTIAL INFORMATION CONFIDENTIAL INFORMATION

Family/Guardian Name
Date/Time Contacted

Physician Name
Date/Time Contacted

Law Enforcement
Date/Time Contacted

Department of Child Services
Date/Time Contacted

911
Date/Time Contacted

Other
Date/Time Contacted

Other
Date/Time Contacted

Summary of Incident

Immediate Action Taken

Exam Information

Date
Time
Provider Type

Medication
Date/Time Contacted

CONFIDENTIAL INFORMATION CONFIDENTIAL INFORMATION

Medically Cleared ☐ Yes ☐ No

Date Cleared

Medical Treatment

Location/Facility Name

Medical Admission ☐ Yes ☐ No

Date and Facility Name

Medication Changes: new, change, or discontinued (name of medication, dosage, route, frequency)

Precaution or Restriction Modification

Action steps taking to prevent recurrence

☐ I ____, the reporter, attest the information in this report to be accurate.