

	<b>County of Sacramento Department of Health Services Division of Primary Health Policy and Procedure</b>	Policy Issuer (Unit/Program)	<b>JCH</b>
		Policy Number	<b>B04-1321b</b>
		Effective Date	<b>07-19</b>
		Revision Date	
<b>Title:</b> Safety Concern Reporting		<b>Functional Area:</b> Safety	
Approved By: Pamela Gandy-Rosemond, MSN RN CCHP Health Administrator Approved By: Scarlett Ong, BSN RN Clinic Manager			

**Policy:**

All Juvenile Correctional Health (JCH) staff are responsible for being aware of any safety issues. All concerns are to be brought to the attention of the on-duty Supervising Registered Nurse (SRN). If there is no SRN on duty the report should be made to the On-Call Administrator (if emergent) or by email to the SRN, if minor or resolved issue.

**Procedures:**

- A. Report all incidents of Safety Issues to the SRN, Clinic Manager or Program Manager immediately. If you wish to remain anonymous you may put report in the black box without identifying yourself.
- B. Complete the JCH Safety Incident/Concern form and place in the Black Box, in the break room.
- C. SRN will collect concerns from the box at least every 48-72 hours and complete an Incident Report form.
- D. The SRN will initiate immediate action to rectify the issue to prevent any possible injury to others.
- E. All safety incident/concerns, whether resolved or not, will be brought up at the Workplace Violence and Safety Committee meeting (WVSC).
- F. The WVSC will bring all information to the Quarterly QA Committee to discuss concerns, actions and resolutions.

**References:**

NCCHC, Y-B-04  
Title 15, Article 3, 1321

**Attachments:**

Safety Incident/Concerns form  
JCH Incident Report form

**Contact:**

Scarlett Ong, BSN RN, Clinic Manager  
Pamela Gandy-Rosemond, RN MSN, CCHP, Health Administrator

## SAFETY INCIDENT/CONCERNS

\_\_\_\_\_  
Today's Date and Time:

\_\_\_\_\_  
Name of Person Reporting (Optional)

\_\_\_\_\_  
Date and Time of Incident/Concern:

\_\_\_\_\_  
Date and Time of Location:

---

---

---

---

---

---

---

---

## SAFETY INCIDENT/CONCERNS

\_\_\_\_\_  
Today's Date and Time:

\_\_\_\_\_  
Name of Person Reporting (Optional)

\_\_\_\_\_  
Date and Time of Incident/Concern:

\_\_\_\_\_  
Date and Time of Location:

---

---

---

---

---

---

---

---

# JUVENILE CORRECTIONAL HEALTH INCIDENT REPORT FORM

## Section A

Incident Date: [Click here to enter a date.](#)

Incident Time/Shift:

Staff Initiating the Report: [Click here to enter text.](#)

Discovery Date: [Click here to enter a date.](#)

Time Discovered: [Click here to enter text.](#)

Was there any patient involved?  YES  NO X-REF:

Management Notified?  YES  NO Choose an item.

Date of Notification:

Time of Notification:

---

## Section B - TYPES OF INCIDENT

### 1) Medical Quality of Care YES NO

If yes, please choose the appropriate incident:

**Subsection B-1** - Please complete if the incident involves serious drug reactions or medication errors. Check or choose if not applicable

a) Severity level: Not applicable

b) Patient received the drug: Not applicable

c) If yes, please choose the type of incident. Not applicable

d) Contributing factors: Not applicable

Patient was on pain.

e) Physician notification:

Date notified:

Time notified:

f) Pharmacist notification: Not applicable

Date notified:

Time notified:

g) Poison control notification: Choose an item. [Click here to enter text.](#) Date notified: [Click here to enter a date.](#) Time notified: [Click here to enter text.](#)

**Subsection B-2** – Please complete if the incident there is a discrepancy in the narcotic/controlled substance count. Check or choose if not applicable

a) Name of medication: [Click here to enter text.](#)

b) Current count: [Click here to enter text.](#)

c) Quantity missing: [Click here to enter text.](#)

d) Pharmacist notification: Choose an item. [Click here to enter text.](#)

Date notified: [Click here to enter a date.](#)

Time notified: [Click here to enter text.](#)

**2) Accidents  YES  NO**

If yes, please choose the appropriate incident:

Choose an item.

*Subsection B-2 – if the incident involves staff injury in the workplace, please follow the link and complete the form:*

<http://inside.personnelservices.saccounty.net/Documents/Workers%20Comp%20Claim%20Form.pdf>

**3) Security  YES  NO**

If yes, please choose the appropriate incident:

Choose an item.

Supervising Probation Officer notified: Choose an item.

Name of Supervising Probation Officer: Click here to enter text.

Date notified: Click here to enter a date. Time notified: Click here to enter text. Click here to enter text.

**4) Facility Maintenance  YES  NO**

Choose an item.

Supervising Probation Office notified: Choose an item.

Name of Supervising Probation Officer: Click here to enter text.

Date notified: Click here to enter a date. Time notified: Click here to enter text.

**5) Unusual Occurrence (isolated, noteworthy events deemed reportable to the Supervising Registered Nurse)  YES  NO**

---

**SECTION C – INCIDENT DESCRIPTION**

---

**SECTION D – Electronic Signature**

**Date and Time**

## **SECTION E – FACT FINDING – *For investigating personnel only***

Please include the names of the staff and the interview dates and times.

[Click here to enter text.](#)

**Problem Identification:** Other, please specify

[Click here to enter text.](#)

**Completed by:**

[Click or tap here to enter text.](#)

---

## **SECTION F- MANAGEMENT ACTIONS/RECOMMENDATIONS**

**Action:** Choose an item.