SHIAWASSEE COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

POLICIES AND PROCEDURES MANUAL

Section: Recipient Rights	Effective Date: 4/24/00
Policy Number: 29	Last Revision Date: 5/21/08
Subject: **Sentinel Events**	Page: 1 of 8

Policy

It is the policy of Shiawassee County Community Mental Health Authority (SCCMHA) that the organization will recognize and respond competently and in a timely manner to the occurrence of sentinel events and will act to effectively reduce the potential for recurrence of similar sentinel events in the future.

Purpose

To provide a systematic and comprehensive mechanism for identifying, reporting, and analyzing any unexpected event of significance but particularly those resulting in death or serious injury; to provide a process for improving performance by preventing a future similar occurrence; and to enhance the risk management capacity of the organization.

Applicability

CMHSP's

Definitions

1. An unusual and critical incident is an unexpected circumstance not previously identified within the consumer's person centered plan that involves harm or injury or the risk of harm or injury. Such incidents include but are not limited to:

    a. Serious physical aggression not addressed in a behavioral treatment plan;

    b. Physical aggression that results in the injury of a peer;

    c. Non-suicidal attempts at self-inflicted harm not addressed in a behavior plan;

    d. Any suicidal or homicidal attempt or gesture;

    e. Emergency use of physical intervention that is not identified or anticipated in the plan of service;

    f. Significant property damage (in excess of $100) caused by a consumer;

g. Unauthorized leave of absence by a consumer receiving supervised care;

h. Criminal offenses involving consumers including suspected offenses, arrests and/or convictions;

i. Injury, whether accidental or intentional, that requires a visit to an emergency room, medi-center, urgent care clinic, or admission to a hospital;

j. Physical illness that requires a visit to an emergency room, medi-center, urgent care clinic, or admission to a hospital. It does not include planned surgery, or other elective procedures or treatment whether inpatient or outpatient;

k. All deaths of persons, whether anticipated or unanticipated that occur while the consumer is an active consumer of service or within 60 days of case closure;

l. Unanticipated death or major permanent loss of function associated with a healthcare acquired infection;

m. Adverse medication reaction or side-effects;

n. Medication errors by service staff involving wrong medication, wrong dosage, double dosage, missed dosage, wrong person or wrong time;

o. Traffic accidents involving consumers;

p. Fire occurring in the treatment or service facility, with or without damage;

q. Safety issues which include physical plant and environmental hazards in supervised care settings or CMHSP sites;

r. Suspected abuse or neglect;

s. Non-consensual sexual contact; and

   t. Other events which seriously disrupt or adversely affect the course of treatment or care of a consumer and require further clinical or administrative attention.

2. A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

3. The occurrence(s) referenced in the definition of a sentinel event are the following; these are also considered reportable sentinel events:

   a. An unexpected death that did not occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age.

   b. An unexpected injury occurring as a result of an accident or abuse which required visits to emergency rooms, medi-centers and urgent care clinics/centers and/or admissions to hospitals. The injury also involved death or serious physical or psychological injury (such as assault or rape), or the risk thereof. Serious injury includes debilitating or permanent loss of limb or function (such as paralysis, brain trauma, etc.).

   c. An unexpected physical illness resulting in admission to a hospital. This does not include planned surgeries whether inpatient or outpatient. It also does not include admissions directly related to the natural course of the person’s chronic illness or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.

   d. Serious challenging behaviors not already addressed in a treatment plan which included significant (in excess of $100) property damage, attempts at self-inflicted serious physical harm or serious physical harm to others or unauthorized leaves of absence. Serious physical harm is defined by the administrative rules for mental health (330.7001) as “physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.”

   e. Medication errors, specifically a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage resulting in death, serious injury or the (established identified clinical) risk thereof. It does not include instances in which consumers have refused medication.

      Note: See section 2a for specific criteria for medication error sentinel events.

4. Other reportable events are all arrests and/or convictions that occur with an individual who is in a reportable population at the time the arrest or conviction takes place.

5. 24-hour specialized setting means a specialized residential home certified by Michigan Department of Human Services to serve persons with mental illness or developmental disabilities.

6. Own home for purposes of sentinel event reporting means supported independence program for persons with mental illness or developmental disabilities regardless of who holds the deed, lease, or rental agreement; as well as own home or apartment for which the consumer has a deed, lease, or rental agreement in his/her own name. Own home does not mean a family's home in which the child or adult is living.

7. Persons with substance use disorder or persons receiving substance abuse services are those Medicaid beneficiaries who receive substance abuse services managed by the PIHP, including any that are sub-contracted through the Coordinating Agencies.

8. A root cause analysis (RCA) or investigation is a process for identifying the basic or causal factors underlying variation in performance including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance. A root cause analysis involves:

    a. Determination of the factors (human, systems, etc.) most directly associated with the sentinel event and the associated processes;

    b. Review of the underlying systems and processes to determine where redesign might reduce risk;

    c. Identification of risk points and their potential contributions to this type of event;

    d. Determination of potential improvement in processes or systems that would tend to decrease the likelihood of such event in the future or a determination after analysis that no such improvement opportunities exits;

    e. To ensure credibility attention to internal consistency in the questions asked/unasked and consideration of the organization as a whole entity; and

    f. Review of available relevant literature.

Procedure

1. Monitoring: All SCCMHA employees and contracted service providers will report unusual and critical incidents promptly. Unusual and critical incidents may also be identified through reports from consumers or external agencies.

    a. Reporting mechanism: Sentinel events are reported through the regional sentinel event reporting database on a monthly basis.

2. Identification: All unusual and critical incidents will be reviewed and those that are sentinel events identified. At a minimum consumer deaths, injuries requiring emergency room treatment and/or hospital admission, physical illnesses requiring hospital admission, serious challenging behaviors, and medication errors that occur for individuals in reportable populations will be reviewed to determine whether the incident meets the criteria for a sentinel event as described in this policy and procedure.

    a. Process for determination of sentinel events: A sentinel event is determined by the responsible clinical director through review of trigger events that are entered into the Trigger Event database by the providers. Medication error reports filled out by staff and indicated by the nurse as a potential sentinel event will use the criteria for "serious injury or the at risk thereof" be interpreted to include only bona fide situations, where there is a CLEAR indication, based on competent objective evidence. Such a conclusion should integrate empirical evidence and clinical facts versus being based on mere speculation of possible harm. All medication errors indicated to be sentinel events by the nurse will be routed to the clinical directors for their review and comment.

3. Analysis: With the exception of arrests/convictions and serious challenging behaviors, all sentinel events should be reviewed to determine if the event is related to the practice of care and whether or not the performance of a root cause analysis is warranted. The decision to perform a RCA is determined by the medical director, clinical director, chief operating officer or designee.

    If determined to be appropriate, a RCA will be conducted in a timely and thorough manner. An individual or committee will be assigned lead responsibility for ensuring the completion of each root cause analysis and any resultant action plan. The root cause analysis will be completed within 45 days of knowledge about the event. Persons involved in the review of sentinel events must have appropriate credentials to review the scope of care. For example, sentinel events that involve consumer death or other serious medical conditions must involve a physician or nurse.

    a. Root Cause Analysis: A root cause analysis is conducted when a trigger event is determined by the responsible clinical director to require analysis.

4. Action planning and follow-up: The goal of reviewing sentinel events is to focus the attention of the organization on potential underlying causes of the event so that changes can be made in systems or processes in order to reduce the probability of such an event in the future. Following completion of a root cause analysis or investigation the SCCMHA will develop and implement either a plan of action or intervention to prevent further occurrence of the sentinel event or document the rationale for not pursuing an intervention. The plan will address responsibility for implementation and oversight, pilot testing as appropriate, timelines and strategies for measuring the effectiveness of the actions.

   a. Plan development process: Action plans are developed at the monthly clinical director's performance improvement review meeting. The details are documented in the regional plan of correction form and submitted to the regional performance improvement committee.

5. Record keeping and reporting: The SCCMHA will maintain a system for recording the occurrence of sentinel events and the organizations resultant analysis, action planning, and follow-up. Periodically formal reporting will occur to appraise the organization's leadership and governance concerning the management of the event and all efforts to improve and correct underlying causes. Sentinel events will be reported to the accrediting organization as required.

   The SCCMHA will enter information about Reportable Sentinel Events and Other Reportable Events in the regional database. Deaths that occur as a result of a sentinel event, regardless of the nature of the event, will be reported in the sentinel event death category. Only those events relating to service delivery will be reported. The database information will be used for monitoring by the AAM Performance Improvement Committee and reporting to the Michigan Department of Community Health (MDCH) in accordance with regional policies and procedures and state reporting requirements.

   Reportable Sentinel Events and Other Reportable Events will only be entered in the regional database if the consumer involved was a medicaid beneficiary <u>who, at the time of the event,</u> was the responsibility of the PIHP and:

   - Lived in a 24-hour specialized residential setting (per the Administrative Rule R330.1801-09) or in a child-caring institution;

   - Lived in their own home receiving Community Living Supports;

   - Received Targeted Case Management, ACT, Home-Based, Wraparound or Habilitation Supports Waiver Services;

   - Was enrolled in the Children's Waiver; or

- Resided in a substance abuse residential treatment program.

a. Regional Reporting Process: The Performance Improvement Coordinator reports sentinel events monthly to the affiliation via the regional data reporting database.

b. Accrediting Body Reporting Process: Direct reporting of sentinel events to the accrediting organization is an optional requirement. SCCMHA reports sentinel events only to the affiliation.

Related Materials

1. Sample Guide to Completion of the Framework for Root Cause Analysis in Response to a Sentinel Event

2. Sample Framework for Root Cause Analysis in Response to a Sentinel Event

References/Legal Authority

1. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Master Contract Attachment P 6.7.1.1., Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Health Plans.

2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Master Contract PIHP Reporting Requirements for Medicaid Specialty Supports and Services Beneficiaries.

3. MDCH Guidance on Sentinel Event Reporting

Approved by: Jerry Walden 5/21/09
Board Chairperson Date

Approved By: Scott Gilman 5/21/09
Chief Executive Officer Date