Policy Section	Clinical Administration	Policy Number	IV-001-018
Subject	Sentinel Event	Issue Date	09/29/2008
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POLICY

It is the policy of Tuscola Behavioral Health Systems (TBHS) that the agency 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

The policy and procedure is established to provide a systematic and comprehensive mechanism for identifying, reporting, and analyzing an 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.

APPLICATION

This policy shall apply to all clinical programs and staff of Tuscola Behavioral Health Systems.

DEFINITIONS

Critical Incidents and Risk Events: An event relating to a consumer that involves suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, or arrest of consumer. Risk events include harm to self, harm to others, calls to police for assistance with behavioral issues, emergency use of physical management and unscheduled admissions to a medical hospital. Reference Clinical Administration Policy IV-001-007, Critical Incidents for complete details.

Occurrence(s) referenced in the definition of a sentinel event are the following;

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. Any injury or death that occurs from the use of any behavior intervention remains reportable to MDHHS.
d. 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.

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

Other Reportable Events: 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.

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.

Persons with a Substance Use Disorder or Persons Receiving Substance Abuse Services: those Medicaid beneficiaries who receive substance abuse services managed by the Pre-Paid Inpatient Health Plan (PIHP).

Root Cause Analysis (RCA): or investigation, is a process for identifying the basic or causal factors underlying variations 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 an event in the future, or a determination, after analysis, that no such improvement opportunities exists;
e. 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.

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.

Unexpected Death: Include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

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 recipient;
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 recipient is an active recipient 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 recipients;
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 Community Mental Health Services Program (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.

24-hour Specialized Setting: means a specialized residential home certified by the Michigan Department of Health and Human Services (MDHHS) to serve persons with mental illness or developmental disabilities.

PROCEDURES

1. All TBHS 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.

2. All unusual and critical/risk 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.

3. 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 an RCA is determined through consultation with the Medical Director, Quality Systems/Compliance Supervisor or designee, or Chief Operating Officer/Designee.

4. 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 RCA and any resultant action plan. Persons involved in the review of any adverse event must have appropriate credentials to review the scope of care. Adverse events that involve death or other serious medical issues must involve a physician or nurse.

5. 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 RCA, or investigation, TBHS 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, time lines, and strategies for measuring the effectiveness of the actions.

6. TBHS will maintain a system for recording the occurrence of sentinel events and the organization's resultant analysis, action planning and follow-up. Periodically, formal reporting will occur to apprise 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 CARF as required.

   TBHS will enter information about Reportable Sentinel Events and Critical Incidents and Risk 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 Mid-State Health Network and reporting to the Michigan Department of Health and Human Services (MDHHS) (where applicable, e.g. children and youth serviced by the Michigan Department of Health and Human Services (MDHHS) Home and Community Based Waiver for Children with a Serious Emotional Disturbance (SEDW)) in accordance with regional policies and procedures and state reporting requirements.

7. Reportable Sentinel Events and Critical Incidents and Risk Events will only be entered in the regional database if the consumer involved was a Medicaid (or otherwise specified) beneficiary who, at the time of the event, was the responsibility of the PIHP and:

   a. Lived in a 24-hour Specialized Residential setting (per the Administrative Rule R330.1801-09) or in a Child-Caring Institution;
   b. Lived in their Own Home receiving Community Living Supports;
   c. Received Targeted Case Management, Assertive Community Treatment (ACT), Home-Based, Wraparound or Habilitation Supports Waiver Services; was enrolled in the Children's Waiver (CW), SED Waiver or the MIChild Program and who receive services funded by these programs; or

d. Resided in a substance abuse residential treatment program.

8. All unexpected deaths of Children's Waiver, SED Waiver or MIChild beneficiaries, who at the time of their deaths were receiving specialty supports and services from TBHS, shall be reviewed and shall include:
   a. Screens of individual deaths with standard information (e.g. coroner's report, death certificate).
   b. Involvement of medical personnel in the mortality reviews.
   c. Documentation of the mortality review process, findings and recommendations.
   d. Use of mortality information to address quality of care.
   e. Aggregation of mortality data over time to identify possible trends.

RELATED FORMS & MATERIALS

N/A

REFERENCES/LEGAL AUTHORITY

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

MDHHS/CMHSP Managed Mental Health Supports and Services Contract FY17 Attachment C 6.8.1.1, Quality Improvement Programs for CMHSPs Technical Requirement

MDHHS/CMHSP Managed Mental Health Supports and Services Contract FY17 Attachment C 6.8.3.1, Technical Requirement for Behavior Treatment Plan Review Committees

MDHHS Guidance on Sentinel Event Reporting

TBHS Clinical Policy IV-001-007, Critical Incidents

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