PERSONNEL
(Manual Section)

RECIPIENT RIGHTS:
SENTINEL EVENTS/CRITICAL INCIDENTS
(Subject)

Approval of Policy | Dated:

Original Inception Date: September 14, 2000
Last Revision of Policy Approved:

_____ April 20, 2017

•1 POLICY:

It is the policy of the Agency to report, review, investigate, and act upon sentinel events and critical incidents as required by the Michigan Department of Health and Human Services (MDHHS) and and all appropriate accrediting bodies.

The Risk Review Sub-Committee will conduct a confidential peer review of all sentinel events and critical incidents. All documentation of the peer review is kept secure.

•2 APPLICATION:

All incidents

•3 DEFINITIONS:

Critical Incident: is any of the following events meeting criteria which occurred for individuals actively receiving services.

- Suicide
- Non-suicide death
- Emergency medical treatment due to injury or medication error
- Hospitalization due to injury or medical error
- Arrest of consumer

Incident: is any of the following which should be reviewed to determine whether it meets the criteria for sentinel event as defined below.

- Death of a individual served by the Agency
- Serious illness requiring admission to the hospital
- Injury to an individual served as a result of accident or abuse requiring emergency room visit or admission to hospital
- Serious challenging behaviors
- Medication error
- Arrest (MDHHS only)
- Conviction (MDHHS only)

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 risk thereof' includes any process variation for which a reoccurrence would carry a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response. Any injury or death of an individual servedoccurring from the use of any behavior intervention is considered a sentinel event.

24-Hour Specialized Setting: means specialized residential home certified by Michigan Department of Health and Human Services for persons with mental illness or developmental disabilities.

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.

Ongoing and continuous in-home assistance: means assistance with activities of daily living provided in the person's own home at least once a week, and 6 months or longer.

Death: that which does **not** occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age.

Injuries occurring as a result of accidents or abuse which required visits to emergency rooms, medi-center and urgent care clinics/centers and/or admissions to hospitals should be included in the injury reporting. In many communities where hospitals do not exist, medi-centers and urgent care clinics/centers are used in place of hospital emergency rooms.

Physical illness resulting in admission to a hospital 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. Physical illness which resulted in hospitalization is counted only if it was unexpected and resulted in permanent loss of limb or function or the risk thereof (i.e., if the event had continued, the individual would have died or had major permanent loss of limb or function.)

Serious challenging behaviors are those not already addressed in a treatment plan and include significant (in excess of $100) property damage, attempts at self-inflicted harm or 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 impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient."

Medication Errors mean a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage which resulted in death or serious injury or the risk thereof. It does not include instances in which consumers have refused medication.

Arrests and/or Convictions are any arrests or convictions that occur with individuals who are in the reportable population at the time the arrests or convictions took place. (MDHHS reporting only)

Root Cause Analysis is a process for identifying the basic or casual factors that underlie 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.

•4 CROSS-/REFERENCES:

•5 FORMS AND EXHIBITS:

Administrative Approval of Procedure per:	Dated:
_____	April 20, 2017

•6 PROCEDURE:

Sentinel Events and Critical Incidents As Required by MDHHS/CMHSP Contract

•6•1 APPLICATION:

Individuals served living in 24-hour specialized settings or in child-care institutions; living in their own homes receiving ongoing and continuous in-home assistance; receiving Targeted Case Management, ACT, Home-Based, Wraparound or Habilitation Support Waiver Services

•6•2 OUTLINE / NARRATIVE:

All incidents should be reviewed to determine if the incidents meet the criteria and definitions for sentinel events, and are related to practice of care. The outcome of this review is a classification of incidents as either a) sentinel events, or b) non-sentinel events. Debriefing of staff and individuals served involved in the incident will occur as needed.

Once an incident has been determined to be a sentinel event, the Medical Director must be informed and the Risk Review Sub-Committee will conduct an "appropriate response". An "appropriate response" to a sentinel event requires a thorough investigation be conducted. An investigation is a process for identifying the basic or casual factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

Following completion of an investigation, the Risk Review Sub-Committee must develop and implement either

a) an intervention to prevent further occurrence of the sentinel event. An intervention must identify who will implement and when, and how implementation will be monitored or evaluated. All interventions to prevent further occurrences of the sentinel event must be approved by the Medical Director; or
b) presentation of a rationale for not pursuing an intervention.

The Agency will enter sentinel event information on an on-going basis into the electronic record system. The PIHP will report data as required by MDHHS. The PIHP review team annually reviews the Agency's process for investigation of sentinel events and interventions conducted in response to sentinel events.

CRITICAL INCIDENT REPORTING:

The Agency will report to MDHHS all appropriate critical incidents for all individuals receiving services funded by General Funds.

The Agency will also report the following events to the PIHP for all individuals receiving services funded by Medicaid, except suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services, with individual level data on the individual receiving services ID, event date, and event type:

- Suicide for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the Agency must submit a "best judgment" determination of whether the death was a suicide. In this event, the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
- Non-suicide death for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children's Waiver services. If reporting is delayed because the Agency is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the Agency determined the death was not due to suicide.
- Emergency Medical treatment due to Injury or Medication Error for people who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services or Children's Waiver services.
- Hospitalization due to Injury or Medication Error for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.
- Arrest of individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

Methodology and instructions for reporting are posted on the MDHHS web site at www.michigan.gov/mdhhs. Click on "Keeping Michigan Healthy", then "Behavioral Health & Developmental Disability", then "Reporting Requirements"

CRITICAL EVENT NOTIFICATION

The Agency will notify the PIHP immediately of the following events:

1. Sentinel events and other critical incidents and events putting people at risk of harm.
2. Any death occurring as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing or police investigation. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:

a. Name of beneficiary
b. Beneficiary ID number (Medicaid, MiChild)
c. Consumer ID (CONID) if there is no beneficiary ID number
d. Date, time and place of death (if a licensed foster care facility, include the license #)
e. Preliminary cause of death
f. Contact person's name and E-mail address

SENTINEL EVENT REPORTING:

The Agency has three (3) business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the Agency has two (2) subsequent business days to commence a root cause analysis of the event. Based on the outcome of the analysis or investigation, a plan of action will be developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan and how implementation will be monitored. A rationale for not pursuing a preventative plan may be done instead, if appropriate. A summary of the root cause analysis will be available to the PIHP upon request.

6•3 CLARIFICATIONS:

•6•4 CROSS-REFERENCES:

•6•5 FORMS AND EXHIBITS:

Administrative Approval of Procedure per: **Dated:**

_____ April 20, 2017

•7 PROCEDURE:

Sentinel Events As Required by CARF and Prepaid Inpatient Health Plan (PIHP)

•7•1 APPLICATION:

All individuals served

•7•2 OUTLINE / NARRATIVE:

The Agency is expected to identify and respond appropriately to all sentinel events occurring in the organization or associated with services that the Agency provides, or provides for.

Once an incident has been determined to be a sentinel event, the Medical Director is informed and the Risk Review Sub-Committee will conduct an "appropriate response". An "appropriate response" to a sentinel event includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements. The Medical Director will be available to consult with the Risk Review Sub-Committee and if needed be an active member of the review team. All plans of improvement resulting from a root cause analysis will be approved by the Medical Director.

A written analysis of all sentinel events is conducted at least annually for the purpose of causes, trends, quality improvement, education/training, prevention and internal and external reporting requirements.

REPORTING OF SENTINEL EVENTS:
CARF: Notification and completion of designated reporting form should be made within thirty (30) days of the occurrence.
PIHP: Immediate notification with the completion of the root cause analysis within sixty (60) days, except suicide which requires completion of the root cause analysis within thirty (30) days.

7•3 CLARIFICATIONS:

•7•4 CROSS-REFERENCES:

•7•5 FORMS AND EXHIBITS:

Exhibit A - A Framework for Conducting a Root Cause Analysis in Response to a Sentinel Event
Exhibit B – Sentinel Events Documentation Form

A FRAMEWORK FOR CONDUCTING A ROOT CAUSE ANALYSIS in Response to a Sentinel Event

Figure 1. This two-page grid is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case, and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for the "root cause."

Level of Analysis	Possibilities	Questions	Findings	Risk Reduction Strategies	Measurement Strategies
What happened? ↓	Sentinel event	What are the details of the event?			
		What area/service was impacted?			
Why did it happen? **What was the proximate cause(s)?** (Typically a "special cause" variation) ↓	Human error	Was it the error?			
	Process deficiency	What was the missing or weak step?			
	Equipment breakdown	What broke?			
	Controllable environmental factors	What factors directly affected the outcome			
	Uncontrollable external factors	Are they truly beyond the organization's control?			
	Other	Are there any other factors that have directly influenced this outcome?			
Why did that happen? What processes were involved? ↓	Patient care process(es) ---------- (Specify)	What are the steps in the process?	Flow chart		
		What steps were involved in (contributed to) the event?	Cause-effect; Change analysis; Failure mode & effect analysis		
		What is currently done to prevent failure at this step?	Fault tree analysis	(eg. simplification, redundancy)	
		What is currently done to protect against a bad outcome if there is another failure at this step?	Barrier analysis	(eg. "fail-safe" design, redundancy).	
		What other areas or services are impacted?	Failure mode & effect analysis	(generalize improvements to all applicable areas)	

Framework for Root Cause Analysis, continued

Level of analysis	Possibilities	Questions	Findings	Risk Reduction Strategies	Measurement Strategies
Why did that happen? What systems underlie those processes? (Common cause variation here may lead to special cause variation in dependent processes)	Human resource issues	Are staff properly qualified and currently competent for their responsibilities?			
		Is staffing adequate?			
		Does planning account for contingencies that would tend to reduce effective staffing levels?			
		Can orientation & In-service training be improved?			
	Information management issues	Is all necessary information available when needed? accurate? complete? unambiguous?			
		Is communication among participants adequate?			
	Environmental management issues	Was the physical environment appropriate for the processes being carried out?			
		Are systems in place to identify environmental risks?			
		Are emergency and failure-mode responses adequately planned and tested?			
	Leadership issues: Corporate culture	Is the culture conducive to risk identification and reduction?			
	Encouragement of communication	Are there barriers to communication of potential risk factors?			
	Clear communication of priorities	Is the prevention of adverse outcomes adequately communicated as a high priority?			
	Uncontrollable factors	How can we protect against these?	Barrier analysis		

Sentinel Events Documentation Form

Date: _____Contact Person: _____ Location: _____
Case #: _____ Date of Event: _____

- ☐ Death
- ☐ Injury requiring ER/admission to the hospital
- ☐ Physical illness requiring admission
- ☐ Serious challenging behavior
- ☐ Arrest
- ☐ Conviction
- ☐ Medication error
- ☐ Other: _____

Narrative:

_____

_____

_____

_____

_____

- ☐ Informed Risk Rev Chair/Designee Date: _____
- ☐ Entered into the Electronic Record System Date: _____
- ☐ Medical Director Informed Date: _____
- ☐ Risk Review Committee Convened Date: _____
- ☐ Case deemed Sentinel event
- ☐ Case not a Sentinel event per: _____

Narrative:

_____

_____

_____

- ☐ Informed PIHP, if applicable (5 bus days) Date: _____
- ☐ Informed Accrediting body, if applicable Date: _____
- ☐ Root Cause analysis completed, attached Date: _____
- ☐ Medical Director Approval of Recommend. Date: _____
- ☐ Director's Approval of Recommendations Date: _____
- ☐ Referral of recommendations to appropriate Program Supervisor Date: _____
- ☐ Six Month follow up completed Date: _____
- ☐ Have actions been implemented
- ☐ If actions have not been implemented, explain:

_____

_____

_____

Signature of person completing this form: _____