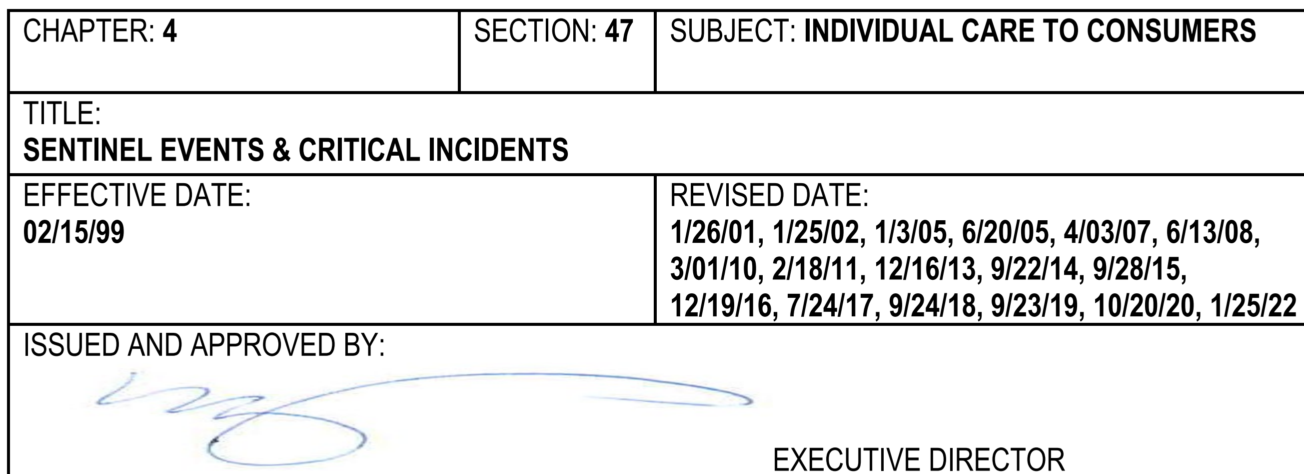

CHAPTER: **4**	SECTION: **47**	SUBJECT: **INDIVIDUAL CARE TO CONSUMERS**
TITLE: **SENTINEL EVENTS & CRITICAL INCIDENTS**		
EFFECTIVE DATE: **02/15/99**		REVISED DATE: **1/26/01, 1/25/02, 1/3/05, 6/20/05, 4/03/07, 6/13/08, 3/01/10, 2/18/11, 12/16/13, 9/22/14, 9/28/15, 12/19/16, 7/24/17, 9/24/18, 9/23/19, 10/20/20, 1/25/22**
ISSUED AND APPROVED BY: EXECUTIVE DIRECTOR		

I. PURPOSE:

To establish and maintain consistent procedures for sentinel event reporting to the Lakeshore Regional Entity (LRE) and/or Michigan Department of Health and Human Services (MDHHS) and to ensure that appropriately credentialed staff are conducting the investigations. CMHOC will analyze the sentinel events and critical incidents at least quarterly to determine what action needs to be taken to remediate the problem or situation and to prevent reoccurrence.

II. APPLICATION:

To all Community Mental Health of Ottawa County (CMHOC) operated and contractual programs (as specified by contract).

III. DEFINITIONS:

Critical Incident (CI): Specific consumer related events, or incidents, that include suicide, non-suicide death, hospitalization due to injury or medication error, emergency medical treatment due to injury or medication error, and arrest of a consumer.

Risk Event (RE): Specific consumer related events, or incidents, that include harm to self or others which requires emergency medical treatment or hospitalization, police calls for emergency assistance when staff are unable to handle a situation, use of physical management, and two or more unplanned hospitalizations within a twelve month period.

***Root Cause Analysis*:** Processes for identifying the most basic or causal factors that underlie variation in performance, including the occurrence of an adverse Sentinel Event. Root cause analyses focus primarily on systems and processes, not individual performance; progresses from special causes in clinical processes to common causes in organizational processes; and identifies potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or determines, after analysis that no such improvement opportunities exist.

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury (or risk thereof) not related to the natural course of the consumers' illness or underlying condition. Such events are called "sentinel" because they signal the need for immediate investigation and response. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Serious Injury: Sensory, motor, physiologic, or intellectual injury requiring continued treatment or life-style change such as the loss of a limb or function.

Risk thereof: Any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

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

SUD Sentinel Event: Pertains to six specific consumer-related events or incidents for persons living in 24-hour specialized residential substance abuse treatment settings at the time the incident occurs: death of a recipient; accidents requiring emergency room visits and/or admissions to hospitals; physical illness requiring admissions to hospitals; arrest or conviction of recipients; serious challenging behaviors.

IV. POLICY:

CMHOC will respond quickly and professionally to any reported sentinel event and/or critical incident. This policy seeks to define agency response and processes following an adverse sentinel event and/or critical incident so that risk of any reoccurrence is reduced by objectively analyzing the information and taking appropriate action. Appropriately credentialed staff will be utilized to collect and analyze information related to the critical incident and/or sentinel event.

V. PROCEDURES:

A. Critical Incidents/Reporting:

1. All Critical Incidents will be verbally reported immediately to the Office of Recipient Rights (ORR) utilizing established procedures by CMHOC staff and all contractual staff. The ORR will notify the Executive Director and the Compliance Manager within 24 hours.

2. All staff with first hand knowledge of the Sentinel Event/Critical Incident/Risk Event will complete an Incident Report as soon as possible after the event and forward to the Office of Recipient Rights within 24 hours of the event.

3. All critical incidents, as defined above, will be reported to the Lakeshore Regional Entity (LRE) monthly as required by the MDHHS/LRE contract:

   a. Critical Incident data will be reported to LRE by the 15th of each month (45 days after the end of the month in which the critical incident occurred).
   b. All required data elements outlined in the MDHHS/PIHP contract will be submitted.
   c. Critical Incident data will be submitted as outlined in LRE Policy 7.3.

4. The LRE will analyze the critical incidents, sentinel events, and risk events quarterly to determine if and/or what action is needed to remediate the problem or situation and to prevent the reoccurrence of additional critical incidents and/or sentinel events.

B. Sentinel Events

1. The CMHOC Compliance Manager has three (3) business days after a critical incident to determine it is a Sentinel Event. After the Compliance Manager has determined the critical incident meets Sentinel Event criteria he/she will then commence a Root Cause Analysis within two (2) business days.

2. The Compliance Officer will report required sentinel events to LRE and/or MDHHS as required per the LRE's policy 7.3.

3. The Compliance Manger will assure the event meets the criteria for a sentinel event and if so, will coordinate a Root Cause Analysis to be completed within 45 days of becoming aware of the Sentinel Event. (If this 45 day time frame cannot be accomplished for whatever reason, the Compliance Manager shall notify the Compliance Committee of the reason for the delay and obtain their authorization to alter the process).

4. The Root Cause Analysis process will involve all persons with first hand knowledge of the events as well as, the Office of Recipient Rights, QI staff, Medical Director, and others as determined appropriate. The completed Root Cause Analysis will be reviewed and approved by Corporate Council and the Compliance Committee prior to being forwarded to the Leadership Group for review.

5. CMHOC Leadership Group will either approve or reject the recommendations contained in the Root Cause Analysis and assign responsibility for implementation of the approved recommendations and a deadline for their completion. The Leadership Group will delegate to the Compliance Committee the task of assuring full implementation of the approved recommendations.

6. The Compliance Manager will forward a copy of the Root Cause Analysis/Sentinel Event Reporting Form to the LRE after approval has been obtained from the CMHOC Leadership Group within 48 hours.

7. The Compliance Committee will report back to the CMHOC Leadership Group the status of the recommendations at the designated deadline.

8. The Executive Director is ultimately responsible for risk management in the organization and, therefore, may take any action he/she deems appropriate at any time in response to a sentinel event. Examples of possible actions include:
• Mandating immediate action on the part of any CMHOC staff to prevent a reoccurrence of the event (even prior to the completion of a Root Cause Analysis) where indicated and warranted.
• Determining that the event is to be reported to CARF immediately.
• Consulting with legal counsel and/or county administrators to prepare for litigation as warranted.

VI. ATTACHMENTS:
Not Applicable

VII. REFERENCES:
CARF Standards
Lakeshore Regional Entity Policy and Procedure 7.3
MDHHS Contract Attachment(s)