CHAPTER: **4**	SECTION: **49**	SUBJECT: **INDIVIDUAL CARE TO CONSUMERS**
TITLE: **SENTINEL EVENTS AND REPORTING CRITICAL INCIDENTS**		
EFFECTIVE DATE: **8/10/2023**		REVISED DATE:
ISSUED AND APPROVED BY:  EXECUTIVE DIRECTOR		

I. PURPOSE:

To establish and maintain consistent policies and procedures for reporting and following up on critical incidents; and sentinel event reporting to the Lakeshore Regional Entity (LRE) and/or Michigan Department of Health and Human Services (MDHHS). 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

1. Critical Incident (CI): An occurrence that disrupts or adversely affects the course of consumer care or agency business. Whether an incident is critical may depend upon individual consumer needs or treatment. When in doubt, staff should consult their supervisor, or a member of the Recipient Rights Office, Health and Safety Officer, and Compliance Manager. Critical incidents may include, but are not limited to:

    1.1. Challenging behaviors, including but not limited to, physical or verbal aggression toward others, use of physical management, medication refusal, or law enforcement involvement, and wandering or elopement.

    1.2. Suicide or non-suicide death.

    1.3 Emergency medical treatment for behavioral health assistance, illness, injury during physical management, injury not during physical management, due to a medication error, or suicide attempt.

    1.4 Health and safety, including, but not limited to, falls (regardless of injury), vehicle accidents, injuries requiring first aid at program/home, unexplained or unknown injury, or other health and safety concerns as appropriate.

    1.5 Hospitalization due to illness, injury during physical management, injury not during physical management, or due to medication error.

    1.6 Law enforcement involvement resulting in the arrest of a consumer.

1.7. Medication Errors involving a recipient not receiving a prescribed medication, the wrong dosage given, or the wrong medication given.
1.8. Other events, including but not limited to, suicide, suspected abuse or neglect, use of seclusion or restraint, communicable disease or infection control, use and unauthorized possession of weapons, biohazardous accidents, unauthorized use and possession of legal or illegal substances, overdose, sexual assault, or other potential Sentinel Events, as defined in III.5.

2. MDHHS Critical Incident Events: MDHHS identified types of critical incidents on five reportable events. The five (5) Reportable Events are:

1. Suicide: by any consumer actively receiving services or who received an emergent service within the last 30 calendar day
2. Non-Suicide Deaths: by consumers who were actively receiving services at the time of their death and met any one of the 2 following conditions:
    a. Living in a Specialized Residential or a Child-Caring Institution or
    b. Receiving any of the following:
        i. Community Living Supports
        ii. Supports Coordination
        iii. Targeted Case management
        iv. ACT
        v. Home-Based
        vi. Wrap-Around
        vii. Habilitation Supports Waiver (HSW)
        viii. Serious Emotional Disturbance (SED) Waiver Services or Child Waiver Program Services (CWPS)
3. Emergency Medical Treatment due to Injury or Medication Error: report consumers who, at the time of the event were actively receiving services and met any one of the following two conditions:
    a. Living in a 24-hour Specialized Residential setting.
    b. Receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Service
4. Hospitalization due to Injury or Medication Error: by consumers who at the time of the event were actively receiving services and met any one of the following two conditions:
    a. Living in a 24-hour Specialized Residential setting.
    b. Receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Service
5. Arrest: of consumers who, at the time of their arrest, were actively receiving services and met either of the following two conditions:
    a. Living in a 24-hour Specialized Residential setting.
    b. Receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Service

3. 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, emergency use of physical management by staff to respond to a behavioral crisis, and two or more unplanned hospitalizations within a twelve month period

4. Physical Management: A technique used by staff to restrict the movement of an individual by direct physical contact in spite of the individual's resistance in order to prevent the individual from physically harming himself, herself, or others. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection or holding his/her hand.

5. Sentinel Event: A sentinel event is 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.

IV. POLICY

It is the policy of Community Mental Health of Ottawa County that all critical incidents that occur while conducting agency business are reported, reviewed, and investigated, if necessary.

V. PROCEDURE

1. The purpose of reporting and reviewing critical incidents is to evaluate the quality and appropriateness of care for consumers, to reduce likelihood of reoccurrence, and to improve the safety of the environment for consumers and staff.

2. All potential critical incidents will be reviewed by appropriate staff to determine if the events meet reporting criteria for Sentinel Events, MDHHS Critical Incidents, and/or Risk Events.

3. All Critical Incidents will be verbally reported 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 Compliance Manager within 24 hours.

4. All staff with primary knowledge of the critical incident must complete the Critical Incident Report. The Critical Incident Report must be completed clearly and concisely and submitted to the Office of Recipient Rights.

5. The CMHOC staff who has the primary responsibility for a consumer during care or who is notified of an incident will complete the Critical Incident Report and document in the clinical record, as appropriate, a summary of the incident. Critical Incident Reports completed by a provider will be routed to the appropriate CMHOC staff for documentation in the clinical record, as appropriate. The Critical Incident Report will not be entered into the clinical record.

6. The Network, Quality Improvement, and Compliance Department will review Critical Incident Reports, record the appropriate data and route the reports to appropriate staff.

a. A Critical Incident Debriefing will be done within forty-five (45) days on critical incidents determined to warrant further investigation and action. This process Reporting Critical Incidents includes distribution via R3 of the CIR to individuals based on the routing matrix so those individuals can follow up on and decide what actions are needed to prevent further CIR's or corrective action, as well as review at the next Clinical Oversight Committee for determination of further actions needed. There is also a quarterly report done to look for trends by the Network, Quality Improvement, and Compliance department submitted to the QI Steering Committee. Critical incident debriefing must be conducted for the following incident types:

.1.1. Suicide or non-suicide death.
5.1.2. Treatment or Hospitalization due to injury during physical management, due to medication error, or suicide attempt.
5.1.3. Law enforcement involvement in response to an individual's challenging behavior, verbal or physical aggression, or use or possession of weapons.
5.1.4. Abuse or Neglect involving Abuse Class I or Neglect Class I.
5.1.5. Use of seclusion or restraint.
5.1.6. Other Sentinel Events.

5.2. Critical incident debrief may be assigned for debriefing, to be determined by Director of Network, Quality Improvement, and Compliance:
5.2.1. Accidents, including falls that result in injury to recipient, medication errors, vehicles, or biohazards.
5.2.2. Unauthorized use and possession of legal or illegal substances.
5.2.3. Emergency use of Physical Management.
5.2.4. Arrest of a consumer not otherwise required in V.I.5.1.3 above.
5.2.5. Wandering or elopement
The goal of reviewing the Critical Incident Debriefing Analysis is to prevent recurrence of critical incidents or sentinel events.
6. The Network, Quality Improvement, and Compliance Department will report quarterly on critical and risk events. Also semi-annually provide an analysis and trending report on incidents reported to the Quality Improvement Steering Committee. They will also trend MDHHS/PIHP Critical Incident Events and Risk Events per PIHP guidelines.
7. The supervisor of the involved department or his/her designee will investigate critical incidents as needed. Results of the investigation, including causal factors and actions to prevent recurrence, will be documented and submitted to the Network, Quality Improvement, and Compliance Department.
8. Critical Incident Reports will be retained for at least 7 years.
9. Critical Incident Reports are peer review documents. Unauthorized release or duplication of CIRs is prohibited.

VI. ATTACHMENT

VII. REFERENCE