

NORTHCARE NETWORK

POLICY TITLE: Sentinel Event

NC REVIEW: March 17, 2005

POLICY EFFECTIVE DATE: June 26, 2002

BOARD ADOPTED: June 26, 2002

BOARD ADOPTED REVISIONS: 10/06/04

PURPOSE

To ensure a process is in place to review and act upon, as appropriate, all sentinel events as defined in the MDCH's contract.

APPLICATION

This policy applies to all incidents (at each affiliate) as outlined in the MDCH Mental Health and Substance Abuse Services Guidance on Sentinel Event Reporting document.

POLICY

All CMHSPs (Community Mental Health Service Providers) and CAs (Substance Abuse Coordinating Agencies) are required to comply with the "Michigan Department of Community Health Mental Health and Substance Abuse Services Guidance on Sentinel Event Reporting" document (Appendix A of contract with MDCH). Appendix A states, "*The Michigan Department of Community Health (MDCH) will require CMHSPs and CAs to report, review, investigate, and act upon sentinel events for persons living in 24-hour specialized settings; those persons living in their own homes receiving ongoing and continued assistance with activities of daily living; and those persons receiving Targeted Case Management or Habilitation Supports Waiver Supports Coordination services. This information will be reported to MDCH semiannually.*" (Health Care Financing Administration approval letter, June 1998)

DEFINITIONS

1. **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 recipient
 - Serious illness requiring admission to hospital
 - Alleged case of abuse or neglect
 - Accident resulting in injury to the recipient requiring emergency room visit or admission to hospital
 - Behavioral episode
 - Arrest and/or conviction
 - Medication error
2. **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 recurrence would carry a significant chance of a serious adverse outcome." (JCAHO 1998; MDCH Guidance on Sentinel Event Reporting)
3. **24-hour Specialized Setting** means specialized residential home certified by Michigan Department of Consumer and Industry Services for persons with mental illness or developmental disabilities. For purposes of sentinel events reporting by Substance Abuse Coordinating Agencies, it means substance abuse residential treatment programs.

4. 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.
5. 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.
6. Death: that which does **not** occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age.
7. Accidents resulting in injuries which required visits to emergency rooms, medi-centers and urgent care clinics/centers and/or admissions to hospitals should be included in reporting. In many communities where hospitals do not exist, medi-centers and urgent care clinics/centers are used in place of hospital emergency rooms.
8. 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.
9. 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 the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.
10. Medication Errors mean 1) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage which result in death or serious injury or the risk thereof. It does not include instances in which consumers have refused medication.

DATA COLLECTION

Each CMHSP and CA will report any sentinel events to NorthCare and MDCH. A report will be submitted semiannually and will aggregate data by event category for number of sentinel events and plans of action or interventions. A "Sentinel Event Reporting by CMHSP/CA" form will be completed and submitted to NorthCare upon completion of a thorough and credible root cause analysis.

Review of sentinel events is a professional/peer review and quality assurance document of NorthCare. It is protected from disclosure pursuant to the provisions of MCL 333.20175, MCL 333.21515, MCL 331.531, MCL 331.533, MCL.21513, MCL 330.1143a, and other State and Federal Laws. Unauthorized disclosure or duplication is absolutely prohibited.

MONITORING OF CMHSP/CAS

NorthCare may review processes used to 1) review critical events; 2) investigate (or root cause analysis) of sentinel events; and 3) the intervention (or action plan) conducted in response to sentinel events or 4) the rationale for not pursuing an intervention. The CMHSP/CA will document the sentinel event process and staff involved in the process, and present actual examples of how the process was implemented. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel event reviews that involve consumer death or other serious medical conditions must involve a physician or nurse. The CMHSP/CAs' Medical Director will review and sign-off on all Sentinel Event investigative reports. If incidents of non-compliance by the

CMHSP/CA in responding to sentinel events per contractual requirement are determined through NorthCare's monitoring processes, a remedial plan of correction will be required.

PROCEDURES

NorthCare has delegated the responsibility to the CMHSP/CAs to review, investigate, and act upon sentinel events occurring within one of its programs for persons living in 24-hour specialized settings and those living in their own homes who are receiving ongoing and continued personal care services.

A. Actions

1. Review to determine if Incidents are Sentinel Events.

All incidents are reviewed by the CMHSP/CA to determine if they meet the criteria and definitions for sentinel events and if they are related to practice of care. The outcome of this review is a classification of incidents as either sentinel event or non-sentinel event. All events classified as a Sentinel Event shall be reported to NorthCare upon classification as such.

2. Root Cause Analysis.

If a determination is made that the incident was a sentinel event, a thorough and credible root cause analysis will be conducted by the individual CMHSP/CA.

3. Plan of Action/Rationale for Not Intervening.

Following root cause analysis, the CMHSP/CA will implement either a plan of action to prevent further occurrence of the sentinel event or presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement the action, when it will occur, and how implementation will be monitored or evaluated.

4. Data Submission to MDCH and NorthCare.

Individual CMHSP/CAs will submit data by event category for the number of sentinel events. NorthCare will receive a copy of the reports when submitted to DCH (Table 13). Plans of action or interventions will be available upon request by MDCH and/or NorthCare. A "Sentinel Event Reporting by CMHSP/CA" form will be completed and submitted for each Sentinel Event to NorthCare upon completion of a thorough and credible root cause analysis.

B. Credentials for Persons Involved in Reviews

Sentinel events are reviewed and acted on as appropriate by individuals possessing the appropriate credentials to review the scope of care. Participation by a physician or nurse will be required in any instance that involves a serious medical condition or death. NorthCare's Medical Director is available for consultation purposes and to review sentinel events as deemed necessary.

CROSS REFERENCE

- Michigan Department of Community Health Mental Health and Substance Abuse Services: *Guidance On Sentinel Event Reporting*, Appendix A of MDCH Contract, as amended.
- Determining a Sentinel Event Flow Chart – MDCH
- Medicaid Subcontracting Agreement (PIHP/CMHSP)
- MDCH Contract Attachment P.6.7.1.1 – Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans
- MI Mental Health Code (Act 258 of the Public Acts of 1974 as amended) Section 330.1748 (9)