

<b>SUBJECT</b> Sentinel Events, Critical Incidents and Risk Events		<b>CHAPTER</b> 07	<b>SECTION</b> 01	<b>SUBJECT</b> 03
<b>CHAPTER</b> Rights of Persons Served		<b>SECTION</b> Individual Rights		
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**I. APPLICATION:**

- PIHP Board                       CMH Providers                       SUD Providers  
 PIHP Staff                       CMH Subcontractors

**II. POLICY STATEMENT:**

It shall be the policy of Region 10 PIHP to identify and review critical incidents, to reduce the occurrence and to improve systems of care.

**III. DEFINITIONS:**

Critical Incident (CI): A CI pertains to five specific consumer-related events, or incidents as follows: suicide, non-suicide death, hospitalization due to injury or medication error, emergency medical treatment due to injury or medication error, and arrest of individual.

Sentinel Event (SE): An “unexpected occurrence” involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “or risk thereof” includes any process for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1988). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

**IV. STANDARDS:**

**A. Critical Incident Reporting System**

The MDHHS critical incident reporting system collects information on *critical events*, as linked to specific service recipients. Within this system, CMH/SUD Providers obtain and report information on the five specific events:

1. Suicide: Any individual actively receiving services at the time of death and any who received emergency services within 30 days prior to death. If 90 calendar days have elapsed without a determination of cause of death, the CMH/SUD Provider must submit a “best judgment” determination of whether the death was a suicide.
2. 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 CMH/SUD provider is

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determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the CMH /SUD provider determined the death was not due to suicide.

3. 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 Specialized Residential facility (per Administration 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.
4. Hospitalization Due to Injury or Medication Error: for individuals 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.
5. Arrest of Consumer: for individuals 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.

#### B. Sentinel Events

The CMH/SUD Provider ensures that the SE review process takes place. This review process determines what action needs to be taken to remediate the problem or situation and / or to prevent the recurrence. SE reviews are monitored and assessed within the Region 10 QAPIP. Refer to Exhibit A - MDHHS Guidelines on Sentinel Event Reporting and Exhibit B – Sentinel Event Review Committee Summary Form.

#### C. Risk Event Management

The CMH/SUD Provider has a process for analyzing *additional critical events* that put individuals (in the same population categories as the critical incidents) at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and the prevent the occurrence of additional events or incidents. MDHHS will request documentation of this process when performing site visits.

#### D. Unexpected Deaths

All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed. Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

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V. PROCEDURES:

A. CRITICAL INCIDENT REPORTING SYSTEM

**CMH/SUD Provider**

1. Reports critical incidents events to the PIHP within fifty (50) days after the end of the month in which the event occurred for individuals actively receiving services. Individual level data on consumer ID, event date, and event type are provided. Reporting is processed through the Region 10 PIHP software system.
2. Reports suicide events within twenty-five (25) days after the end of the month in which the death was determined to be a suicide.

B. SENTINEL EVENTS

**CMH/SUD Provider**

1. Determines whether a critical incident meets SE criteria within three (3) business days after the event has occurred.
2. Once classified as a SE, commences an initial Root Cause Analysis (RCA) within two (2) subsequent business days.
3. Communicates with the PIHP Chief Clinical Officer within fourteen (14) calendar days.
4. Communicates with the PIHP Chief Clinical Officer at a minimum of every thirty (30) days. Communications pertain to RCA status, including discretionary review of applicable documents, updates or necessary plans of correction, along with final disposition, of the SE review process.

**Sentinel Event Review Committee (SERC)**

1. Meets monthly to provide SE monitoring and follow-up as deemed necessary. Analyzes SE information to a) ensure CMH/SUD program compliance in the SE review process, b) assess for regional systems improvement opportunities, and c) report on systems findings and recommendations to the Region 10 PIHP QAPIP.
2. SERC Chair communicates to PIHP Contract Manager / Compliance SE findings and disposition, as such may pertain to issues of contract compliance, systems performance and / or contract amendment.

C. RISK EVENT MANAGEMENT

**CMH/SUD Provider**

1. Maintains a process for analyzing *additional critical events* that put individuals (in the same population categories as the critical incidents) at risk of harm.
2. Submits documentation upon request during MDHHS site reviews.

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D. UNEXPECTED DEATHS

**CMH/SUD Provider**

1. Maintains a process for conducting reviews of unexpected deaths.
2. Ensures that the review process includes: 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, and e) aggregation of mortality data over time to identify possible trends.
3. Submits to the Region 10 SERC mid-year and end-of-year reports summarizing review findings and recommendations.
4. Submits documentation of mortality review process per request during PIHP site reviews.

**Sentinel Event Review Committee (SERC)**

1. Meets as scheduled to provide monitoring and follow-up as deemed necessary. Analyzes semi-annual reports to a) ensure CMH/SUD program compliance in the review process, b) assess for regional systems improvement opportunities, and c) report on systems findings and recommendations to the Region 10 PIHP QIC.
2. SERC Chair communicates to PIHP Contract Manager / Compliance report findings and disposition, as such may pertain to issues of contract compliance, systems performance and / or contract amendment.

VI. REFERENCE:

- A. MDHHS Mental Health and Substance Abuse Services Guidance on Sentinel Event Reporting

VII. EXHIBITS:

- A. MDHHS Mental Health and Substance Abuse Services Guidance on Sentinel Event Reporting
- B. Region 10 Sentinel Event Review Committee Summary Form

**MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES  
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES  
GUIDANCE ON SENTINEL EVENT REPORTING**

I. REQUIREMENT:

“The Michigan [Department of Health and Human Services] will require CMHSPs and CAs to report, review, investigate, and act upon sentinel events for persons living in 24-hour specialized settings and those living in their own homes receiving ongoing and continued personal care services as outline in Appendix B.4. of the Waiver Document. This information will be reported to DCH semiannually.” (Health Care Financing Administration approval letter, June 1998)

II. DEFINITIONS:

1. Incident is any of the following which should be reviewed to determine whether it meets the criteria for Sentinel event in #2 below.
  - death of 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)
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 recipient 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. Accidents resulting in injuries which required visits to emergency rooms, medi-centers and

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urgent care clinics/centers and/or admissions to hospitals should be included in the reporting. In many communities where hospitals do not exist, medi-centers and urgent care clinics/centers are used in place of hospital emergency rooms.

7. 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.
8. 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."
9. 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 recipients have refused medication.

### III. APPLICATION

All incidents (from the list in II.1 above) involving the population described in I. above should be reviewed to determine if the incidents meet the criteria and definitions (in II. above) 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.

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." (JCAHO, 1998) A root cause analysis (JCAHO) or investigation (per HCFA approval and MDHHS/CMHSP contractual requirement) is "a process for identifying the basic or causal 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." (JCAHO, 1998)

Following completion of a root cause analysis or investigation, a CMHSP/SUD Provider must develop and implement either a) a plan of action (JCAHO) or intervention (per HCFA approval and MDHHS contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when, and how implementation will be monitored or evaluated.

### IV. MDHHS MANAGEMENT OF SENTINEL EVENT REPORTING

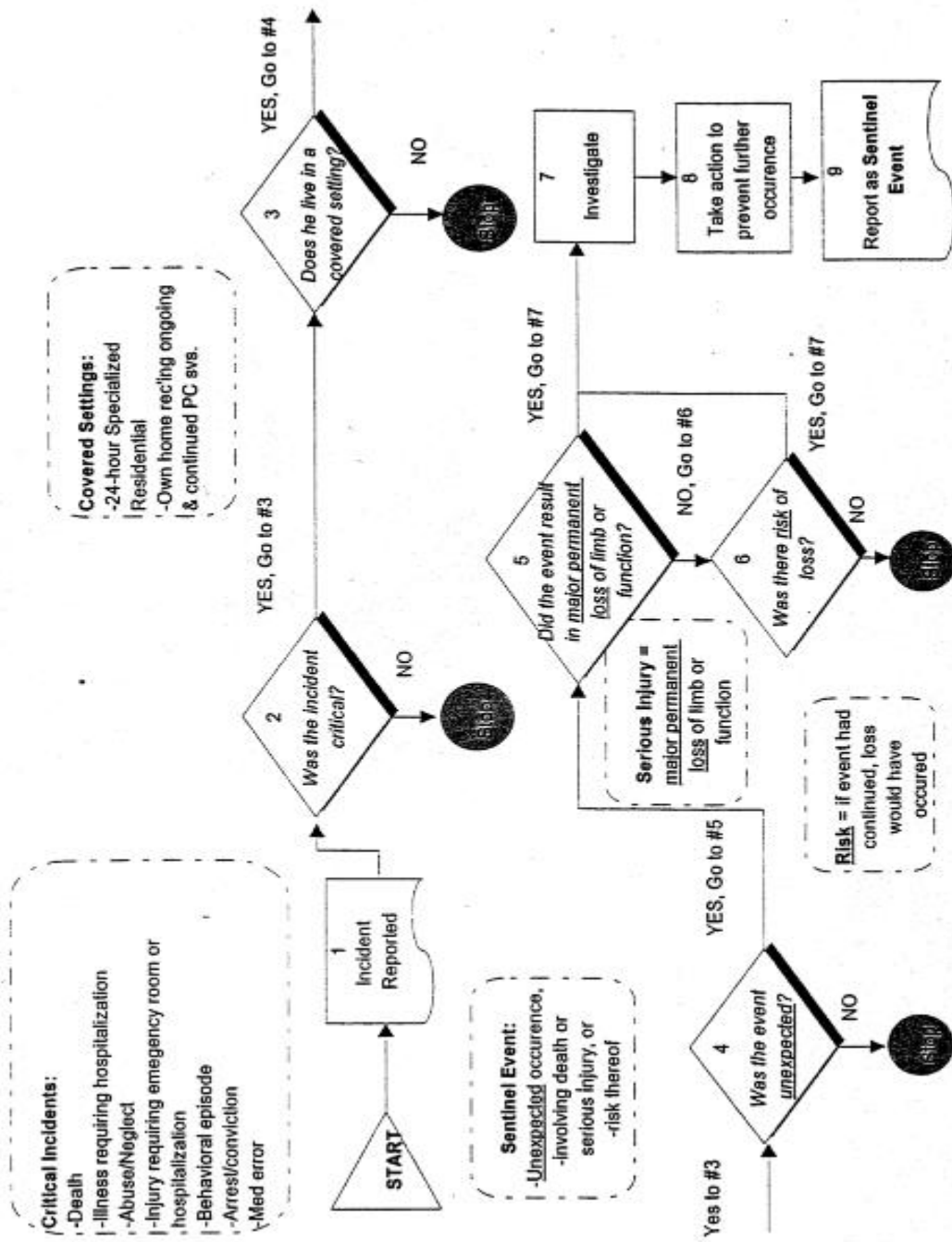
1. Data collection: CMHSPs and SUD Providers will submit semiannually aggregate data by event category for number of sentinel events and plans of action or interventions which occurred during the 6 month period. MDHHS will analyze the data and prepare a report on the # of sentinel events (by category) per thousand persons served who meet the population definition. As with all performance indicators, MDHHS will review performance, with potential follow-up by contract

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managers to determine what quality improvement action is taking place; and/or to develop performance objectives aimed at reducing the risk of sentinel events occurring; and/or to impose other sanctions.

2. Site visitation of CMHSPs: MDHHS review team nurses annually review the CMHSP's process for the 1) review of critical events; 2) investigation (or root cause analysis) of sentinel events; and 3) intervention (or action plan) conducted in response to sentinel events or 4) the rationale for not pursuing an intervention. The CMHSP must provide evidence of the sentinel event process, the organizational units and staff involved in the process, and presentation of actual examples of how the process was implemented. As with all elements of the MDHHS review, incidents of non-compliance by the CMHSP in responding to sentinel events per contractual requirement are cited by the team in the site visit report with requirements for submission of remedial action plans. Monitoring of the CMHSP's implementation of remedial action plans is the responsibility of MDHHS contract managers.

# DETERMINING A SENTINEL EVENT





## EXHIBIT B

Region 10 Sentinel Event Review Committee Summary Form			
A Sentinel Event is an unexpected occurrence involving death or serious injury, i.e. loss of limb or function, or risk thereof.			
Consumer Number:	Local Process		SERC Review
The local process determined whether a SE-Suicide occurred, i.e. the person	Yes	No	
- Was actively receiving services at the time of their death			
- Received an emergency service within the last 30 calendar days			
- Lived in a 24-hour specialized setting (or SUD residential treatment)			
- Lived in own home but received ongoing personal care services, i.e. assistance with ADLs minimum once weekly for six at least six months (refer to Appendix B.4)			
The local process indicated whether the critical incident involved the person's	Yes	No	
- Unexpected death			
- Serious illness requiring admission to hospital			
- Alleged case of abuse or neglect			
- Accident resulting in his/her injury requiring ER visit or admission to			
- hospital/urgent care clinics			
- Behavioral episode, i.e. those not already addressed in the treatment plan, PD greater than \$100, acts/attempts at harm to self or others, and elopement			
- Arrest and/or conviction			
- Medication error (resulting in death or serious injury or risk)			
The local process performed an appropriate response to the Sentinel Event	Yes	No	
- Thorough and credible Root Cause Analysis (focusing primarily on systems or processes) was completed			
- A systems-based improvement plan was implemented (to reduce risk, identify who, when, how implementation will be monitored)			
- There is monitoring of the effectiveness of those systems improvements			
The local process has complied with reporting requirements to the PIHP	Yes	No	
- If an improvement plan is ruled-out, a rationale is discussed (leave blank if an improvement plan is in place)			
- The initial SE summary report on RCA activity was submitted to the PIHP within 14 calendar days			
- The RCA status report is being submitted to the PIHP every 30 days until final disposition is reported to the PIHP			
Findings and Disposition:			
Recommendations:			
Date:			