

<b>COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN</b>	<b><i>Policy and Procedure</i></b>		
<b>Department</b> Clinical Services	<b># of Pages: 52</b>		
<b>Policy Name</b>  <b>SENTINEL EVENTS</b>	<b>Type of Policy:</b>  [ ] WCHO [ <input checked="" type="checkbox"/> ] Affiliation [ ] Network		
<b>Policy Number</b>	<b>Effective Date</b>	<b>Revision Date</b>	<b>Approval Date</b>
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## I. PURPOSE

To establish a peer review process for collecting and reviewing sentinel event and adverse event information. This is a retrospective system analysis using a case specific analysis to improve services or enhance treatment for clients. This policy will also ensure that any recommended changes will be implemented and monitored in a timely, thorough and credible way. This policy will assist the CSSN Executive Directors in determining which Sentinel Events must also be reported to the WCHO as the PIHP for CMHPSM, other accrediting organizations, and MDCH or other entity per contractual requirements.

## II. APPLICATION

All staff, students, volunteers and staff of the CMHPSM and contractors. This includes all CSSN Providers and Residential Substance Abuse Providers.

## III. DEFINITIONS

CSSN Providers: An organization that is certified as a CMHSP, including a recipient rights systems, services across all populations, a publicly appointed Board of Directors, and has accreditation from an accrediting organization.

Director: For the purpose of this policy, Director is defined as: 1. the Executive Directors of Monroe, Livingston, Lenawee CMHSPs and the Executive Director of Washtenaw County Community Support and Treatment Services; 2. the Executive Director of the WCHO; and 3. the Directors of all contractual substance abuse providers who provide residential treatment services.

Sentinel Event Coordinator Designee: A member of the Senior Management team that is designated by the Director to implement and oversee the sentinel event process.

Sentinel Events Review Committee (SERC): An ad hoc committee, whose membership will include individuals familiar with agency processes under review and agency leaders,

organized for the purpose of analyzing the root cause of a Sentinel Event and strategizing appropriate agency response to minimize risk of recurrence. This is a retrospective peer review process using a case specific analysis to improve services or enhance treatment for clients.

**The following definitions are shared by the Joint Commission and MDCH:**

Action Plan: A plan designed to address and correct any problems identified through the root cause analysis process.

Adverse Event: Events that do not qualify as Sentinel events but are serious and could identify process improvements. The Director will determine if an event is an adverse event when the event does not qualify as a Sentinel Event.

Root Cause Analysis: A process for identifying the basic or causal factors that underlie variation in performance, including the occurrence, or possible occurrence, of a sentinel event.

Sentinel Event: 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. Put another way—if the event had continued or were to recur, the individual would risk death or major permanent loss of function.

**The following two definitions are defined by Joint Commission:**

Major Permanent Loss of Function: Sensory, motor, physiologic, or intellectual impairment not present before the incident, requiring continued treatment or lifestyle changes. When major permanent loss of function cannot be immediately determined, reporting to the Joint Commission is not expected until either the individual is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

Rape: the determination of “rape” is to be consistent with applicable law and regulation. Rape includes staff-recipient and recipient-recipient allegations. For purposes of Joint Commission reporting, the five day time-frame for reporting does not begin until a determination\* is made that a rape has occurred. Reporting of a rape to the Joint Commission is not expected where such reporting is prohibited by law.

\*Per a Joint Commission opinion, this determination should be made within the agency and does not require action by the court system.

**These remaining definitions are defined by MDCH:**

24 Hour Specialized Setting: a specialized residential home certified by the Michigan Department of Consumer and Industry Services for persons with mental illness or developmental disabilities, or substance abuse residential treatment facility.

Accident Resulting in Serious Injury: those serious physical injuries which result from accidents and which require a visit to an emergency room, medical center, or urgent care clinic/center and/or an admission to a hospital.

Activities of Daily Living: bathing, eating, dressing, personal hygiene, shopping, money management and medication monitoring. \*This definition adapted from Children's Waiver language.

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

Medication Errors: include any of the following which result in death or serious injury, or risk thereof, to a recipient. It does not include instances in which recipients have refused medication.

- a. wrong medication
- b. wrong dosage
- c. double dosage
- d. missed dosage

Ongoing and Continuous In-Home Assistance: assistance with Activities of Daily Living provided in the recipient's own home at least once a week, for a period of at least six months.

Own Home: a supported independent placement or a client's own home or apartment, regardless of who holds the deed, lease, or rental agreement. This does not include a family's home in which the child or adult recipient is living.

Physical Illness: Any unexpected physical illness which resulted in permanent loss of limb or function, or the risk thereof, and results in admission to a hospital. This 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.

Serious Challenging Behaviors: are not already addressed in a treatment plan. They include the following if they result in death or serious physical injury or the risk thereof:

- a. attempts at self-inflicted harm
- b. attempts to harm others
- c. unauthorized leaves of absence
- d. property damage in excess of \$100

Serious Psychological Injury/Emotional Harm: impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology and as determined by a mental health professional.

Serious Physical Injury: 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.

### **Sentinel Event Guideline Definitions:**

Joint Commission Reportable Sentinel Events include those Sentinel Events that affect recipients of care (patients, clients, residents) and meet one of the following criteria (See attachment IX. Sentinel Event Decision Tree):

1. Unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition, or
2. Any instances of the following regardless of whether it resulted in death or major permanent loss of function.
3. Suicide of a patient who lives in a 24 hour setting or within 72 hours of discharge.
4. Rape (as defined above.)
5. Abduction of any individual receiving care, treatment or services.

MDCH Reportable Sentinel Events include those Sentinel Events that affect recipients of care (patients, clients, residents) and meet the following criteria (See attachment X. Sentinel Event Decision Tree page two):

1. The recipient lives in a 24 hour Specialized Setting, OR the recipient lives in their Own Home and receives Ongoing and Continuous In-Home Assistance (as defined above.) OR the recipient receives Targeted Case Management or Habilitation Supports Waiver Supports Coordination Services.
2. The event has resulted in Serious Physical Injury, Serious Psychological Injury, or the risk thereof (as defined above.)

Any of the following events shall be reviewed to determine if they meet the above criteria for an MDCH Reportable Sentinel Event. If these criteria have been met, then MDCH Reportable Sentinel Events include the following events as defined above:

- a. Death of a recipient
- b. Serious illness requiring admission to a hospital
- c. Alleged case of abuse or neglect resulting in death, serious injury or the risk thereof.

- d. Accident resulting in serious injury to recipient requiring emergency room visit or hospital admission
- e. Seriously challenging behavior/Behavioral episode
- f. Arrest and/or conviction – Report arrests and convictions as separate incidents
- g. Any injury or death that occurs from the use of any behavior intervention
- h. Medication error resulting in death, serious injury or the risk thereof

This policy refers to all sentinel events (as defined by this regional policy) occurring in the organization or associated with services for which the organization provides directly or has contractual arrangements. Appropriate response includes conducting a timely, thorough and credible root cause analysis, implementing improvements to reduce risk, and monitoring the effectiveness of those improvements. This is a retrospective system analysis using a case specific analysis to improve services or enhance treatment for clients. Hospitals/providers that contract with the WCHO and/or a CSSN and do not provide services that meet the criteria of MDCH Reportable Sentinel Events (24 hour Specialized Setting, or the recipient lives in their Own Home and receives Ongoing and Continuous In-Home Assistance (as defined above.) or the recipient receives Targeted Case Management or Habilitation Supports Waiver Supports Coordination Services) should follow the policy and procedures of their accrediting body/other regulatory entities for reporting any Sentinel Events that occur at their facility and are not subject to reporting to MDCH

The Root Cause analysis should:

1. Include participation by the leadership of the organization and by the individuals most closely involved in the processes and systems under review.
2. Ensure that persons involved in the review of sentinel events have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.
3. Focus on systems and processes, rather than on individual performance.
4. Progress from special causes in clinical processes to general organizational processes and systems.
5. Seek out root causes through a process of asking “Why?” questions until logical problems/answers can be identified.
6. Identify opportunities to change systems or processes to improve performance levels while reducing the risk of future events from recurring.
7. Include consideration of any relevant literature.
8. Be internally consistent, i.e., not contradict itself.
9. Not leave obvious questions unanswered.
10. Not include the recipient’s name or the names of caregivers involved in the event.

The Action Plan Must Identify:

1. Changes that can be implemented to reduce risk, or formulates a rationale for not undertaking such changes.
2. Who is responsible for implementing the change.
3. When the change will be implemented.
4. Who is responsible for monitoring whether the change has been implemented.
5. At what frequency the monitoring will occur.
6. Any pilot testing.
7. How the effectiveness of the change will be evaluated, including who will be responsible and what indicators will be used.

#### **IV. POLICY**

The Sentinel Event Review process is a retrospective peer review process using a case specific analysis to improve services or enhance treatment for clients. Any records, data and knowledge collected in this process are confidential; therefore this information is not available under the Freedom of Information Act (FOIA).

##### **A. Review of Sentinel Events**

The Director will review any potential Sentinel Event to determine whether it qualifies as a Sentinel Event as defined in this policy. The Director will use guidelines in the definitions section of this policy to determine whether the event under review requires reporting to accrediting entities, MDCH, and/or other entities per contractual requirements.

At a minimum, sentinel events must be reviewed and acted upon as appropriate, with root cause analyses to commence within two (2) business days of the sentinel event and/or determination of the sentinel event.

Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

If the review determines that a Sentinel Event has occurred, all CSSN/Residential Substance Abuse Providers will report each Sentinel Event to the CMHPSM as described below and will analyze the root cause of each Sentinel Event.

Joint Commission accredited CSSN/Residential Substance Abuse providers shall select the appropriate reporting option allowable within Joint Commission standards. CSSN/Residential Substance Abuse providers accredited by bodies other than Joint Commission shall still perform a root cause analysis, develop an action plan, and report the findings to the CMHPSM; they are not expected to report sentinel events to Joint Commission.

It shall be the affiliation policy that any events that do not qualify as sentinel events but are serious could be identified as adverse events. These adverse events shall be identified by the Director. The Director will determine if the Sentinel Event Review Committee shall conduct a root cause analysis of an adverse event and notify the Sentinel Event Coordinator Designee if a root cause analysis is needed.

Additionally, the CSSN/Residential Substance Abuse Provider will form a Sentinel Event Review Committee (SERC) to analyze the root cause of each Sentinel Event and strategize any appropriate agency responses required to minimize risk of recurrence.

Members will use the standard affiliation approved instrument for a Root Cause Analysis and Action Plan in Response to a Sentinel Event to guide the team through the root cause analysis and action planning activities.

A root cause analysis of a sentinel event may result in the conclusion that a plan of action will not be pursued. In such instances, a rationale must be documented.

In the event that the root cause analysis determines that a CMHPSM policy or procedure or a contracted provider was a contributing factor to the Sentinel Event, the CSSN/Residential Substance Abuse provider shall report these findings to the CMHPSM. The CMHPSM will then evaluate the findings to determine any necessary action, using the performance improvement process of the CMHSPM.

CSSN/Residential Substance Abuse Provider will make support systems available for staff that have been involved in an adverse or sentinel event.

Each Director will maintain a single, locked location for the storage of files and documents pertinent to sentinel event response activities.

## **B. Reporting of Sentinel Events**

The CSSN/Residential Substance Abuse provider is not required to submit the root cause analysis to the CMHPSM/PIHP; however, the CSSN/Residential Substance Abuse Provider shall provide documentation to the CMHPSM PI Coordinator that appropriate processes were followed.

Each CSSN sentinel event coordinator shall report MDCH sentinel event data to the WCHO as the PIHP of CMHPSM on a quarterly basis. The CMHPSM PI Coordinator will then submit PIHP sentinel event data (for Medicaid beneficiaries) on behalf of the CMHPSM to MDCH with the frequency based on MDCH contractual requirements.

Each CMHSP shall report their own MDCH sentinel event data for CMHSPs (Non-Medicaid beneficiaries) to MDCH. Each CMHSP is also responsible for any direct reports of sentinel events to Joint Commission/other accrediting body when required by their accreditation.

The local sentinel event coordinator shall report both MDCH and Joint Commission general sentinel event and adverse event data and basic information regarding improvements in systems to the local performance improvement coordinator.

Sentinel event information and data shall be reported to the CMHPSM in accordance with an established annual calendar for the MDCH reporting as a part of the Performance Improvement System. CMHSP's shall report Child Waiver data directly to MDCH and send a copy to WCHO as the PIHP.

At least once a year, each CSSN/Residential Substance Abuse Provider the CMHPSM PI Committee will ensure that the AEC and the WCHO Board are provided sentinel event-related written reports on the following: organization provides governance with written reports on the following:

1. All system or process failures
2. The number and type of sentinel events
3. Whether the individuals served and the families were informed of the event
4. All actions taken to improve safety, both proactively and in response to actual occurrences

#### C. Lessons Learned/Information Sharing

Sentinel event/PI coordinators of CMHPSM will to discuss any general trends or lessons learned on an annual basis at least, and will report their findings to the CMHPSM PI Committee for review of performance improvement opportunities.

CSSNs, Residential Substance Abuse Provider, and CMHPSM where appropriate, will disseminate lessons learned from root cause analyses, system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation.

The CMHSM encourages, but does not require, external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs. (examples of voluntary programs include The Joint Commission Sentinel Event Database and the U.S. Food and Drug Administration (FDA) MedWatch)

#### D. Mandatory Reporting

Any information related to sentinel/adverse events that is also required to be reported under mandatory reporting laws shall be reported jointly by the client service manager/supports coordinator and their supervisor/program administrator. Contracted providers shall also report in accordance with licensing requirements and laws. If a consumer resides in a 24 hour licensed setting, Michigan Department of Human Services Licensing Division shall be notified. Adult Protective Services, Child Protective Services and the Police Department shall be notified in accordance with the law. Reports shall also be made to the Office of Recipient Rights; a verbal report shall be made to the Office of Recipient Rights regarding any apparent or suspected sentinel event and/or rights issue by no later than the next business day.

**EXHIBITS**

- A. Sentinel Event Policy Flowchart
- B. Joint Commission Sentinel Event Determination Form
- C. MDCH Sentinel Event Determination Form
- D. Joint Commission Reportable Sentinel Events Timeline Check-off.
- E. MDCH Sentinel Events Timeline Check-off
- F. Regional Root Cause Analysis Form
- G. Regional Root Cause Follow Up Tracking Form

**VI. REFERENCES**

Joint Commission “A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event”  
 Joint Commission “Accredited Organization Self-Report Sentinel Event Form”  
 Joint Commission Sentinel Event Policy and Procedures.  
 Joint Commission Prospectus “Changes to Definition of Reviewable Sentinel Events”  
 MDCH Contract and Guidance on Sentinel Event Reporting  
 Michigan Mental Health Code  
 Michigan Public Act 258 of 1974; Section 722 & 723  
 Michigan Public Act 238 of 1975  
 Michigan Public Act 519 of 1982  
 MDCH Administrative Rules 1987: R 330.7001  
 Michigan Compiled Laws: 331.531, 331.532, 331.533, 333.20175, 333.21513, and 333.21515

**VII. MANDATORY AFFILIATION SENTINEL EVENT PROCEDURES**

**WHO**

**DOES WHAT**

Staff working for any contractor of CMHSP’s      a. If applicable, takes action to protect,

that witness or are informed of a possible sentinel/adverse event.

- b. Makes a verbal report of the possible Sentinel Event/suspected Rights violation to the Office of Recipient Rights immediately. but no later than the next business day.
- c. Notifies immediate supervisor.
- d. Writes Incident Report (IR) and faxes/delivers a copy to Rights Officer by the end of the shift during which the incident occurred, forwarding the original IR through the normal process.

All WCHO staff, CMHSP/CSTS staff, students and volunteers that witness or are informed of a possible sentinel/adverse event.

- a. If applicable, takes action to protect, comfort and get treatment for the recipient.
- b. Makes a verbal report of the possible Sentinel Event/suspected Rights violation to the Office of Recipient Rights immediately. but no later than the next business day.
- c. Notifies immediate supervisor of a possible Sentinel Event immediately thereafter.
- d. Writes detailed account of incident on IR.
- e. Documents actions taken in Progress Notes.

**WHO**

**DOES WHAT**

CMHSP/CSTS Immediate Supervisor that witness or are informed of a possible sentinel/adverse event.

- a. Ensures appropriate documentation, ORR notification and support of recipient have occurred.
- b. Notifies applicable administrator immediately.

CMHSP/CSTS Immediate Supervisor that witness or are informed of a possible sentinel/adverse event.

- a. Ensures appropriate document, ORR notification and support of recipient have occurred.
- b. Notifies applicable administrator immediately.
- c. Provides support to staff as necessary.

CMHSP/CSTS Applicable Administrator

- a. Ensures the Director (CSSN decision maker) is informed and the WCHO/PIHP

Executive Director (In cases involving Medicaid Recipients) is informed of a possible Sentinel Event verbally as soon as possible so that a determination and root cause analysis can be determined within 2 days of the event for MDCH purposes.

- b. Ensures that the Recipient Rights Office has been notified of the possible Sentinel Event.

Recipient Rights Officer

- a. Addresses potential Rights violations per the Michigan Mental Health Code.

Director /Designee

- a. Notifies the assigned sentinel event coordinator/designee of event.
- b. Determines if event qualifies as a Sentinel Event under this policy and reviews a Sentinel Event Determination Form (Exhibit B or C) with the Sentinel event coordinator/designee.
- c. Determines if this is a reportable Sentinel Event per Joint Commission/ other accrediting organization standards. May consult with other agency administrators and Corporation Counsel on whether to report to Joint Commission/accrediting organization.

Sentinel Event Coordinator Designee

- a. Ensures Sentinel Event Determination Form is completed.
- b. If this is a Joint Commission/other accrediting organization reportable Sentinel Event, ensures a completed copy of the “Accredited Organization Self-Report Sentinel Event Form” arrives at Joint Commission/accrediting organization if the CMHSP decides to report the event to TJC.

**WHO**

**DOES WHAT**

Sentinel Event Coordinator Designee

- a. Notifies members appointed to SERC of a Sentinel Event and their assignment to the

- committee.
- b. Arranges first meeting of the SERC and assures it commences within two business days from the sentinel event/ determination of the sentinel event
- c. Chairs SERC.
- d. Starts appropriate Sentinel Event Timeline Check-off sheet. (Exhibit D or E.)

Sentinel Events Review Committee

- a. Convenes within two business days of notification of assignment of a sentinel event
- b. Uses root cause analysis process to develop an Action Plan, or provides a rationale for not pursuing a plan of action.
- c. Meets as often as necessary to insure completion of a credible and thorough root cause analysis and action plan within 40 calendar days from the date first notified of the Sentinel Event.

Medical Director

- a. Is a mandated member of the Sentinel Event Review Committee (SERC).
- b. Attends SERC meetings to ensure that all clinical issues are identified and adequately addressed.

Designated CMHSP Staff

- a. If regarding a Joint Commission Sentinel Event, informs Director on progress of and issues involved in Root Cause Analysis on or before 30th calendar day from date first notified of a Reportable Sentinel Event.

Director

- a. If regarding a Joint Commission Sentinel Event ,on or before the 30th day from date CSSN was first notified of a Joint Commission Reportable Sentinel Event, Director will decide whether to implement alternative methods of notifying Joint Commission of the process involving this Sentinel Event (see attachment E).

**WHO**

**DOES WHAT**

Sentinel Event Coordinator Designee

- a. Submits Root Cause Analysis and Action

Plan to the Director for review and approval within 40 calendar days from the date CMHSP/CSTS was first notified of the Sentinel Event.

- b. Provides written rationale if the Root Cause Analysis does not conclude with a plan of action.

Director

- a. Reviews Root Cause Analysis and Action Plan, asking the SERC for any needed clarifications/revisions.
- b. Approves of Root Cause Analysis and Action Plan no later than 45 calendar days from the date first notified of the Sentinel Event.
- c. If regarding a Joint Commission Sentinel Event and if an alternative reporting method was not used, sees that the Root Cause Analysis and Action Plan arrives at Joint Commission 45 calendar days from the date first notified of the Sentinel Event.

Sentinel Event Coordinator Designee

- a. Ensures implementation of the Action Plan by the appropriate staff/committee.
- b. Reviews with the Management Team who will then monitor implementation of the action plan.
- c. Notifies contract manager of any provider changes needed.
- d. Ensures that the local PI Coordinator receives Sentinel Event/Adverse Event data and required information that must be reported to the CMHPSM PI Committee.
- e. Notifies the designated CSSN staff person of a MDCH Sentinel Event or completes semi-annual report to MDCH if appropriate.

Contract Manager

- a. Communicates to the provider any changes or response needed.
- b. Follows up to ensure completion of the required changes.

Contacted Providers

- a. Implements any needed changes or responds as required.

## WHO

## DOES WHAT

Designated CSSN staff  
(if not completed by SE Coordinator)

- a. Includes Sentinel Event information in semi-annual aggregate Sentinel Event data Report to MDCH if appropriate.

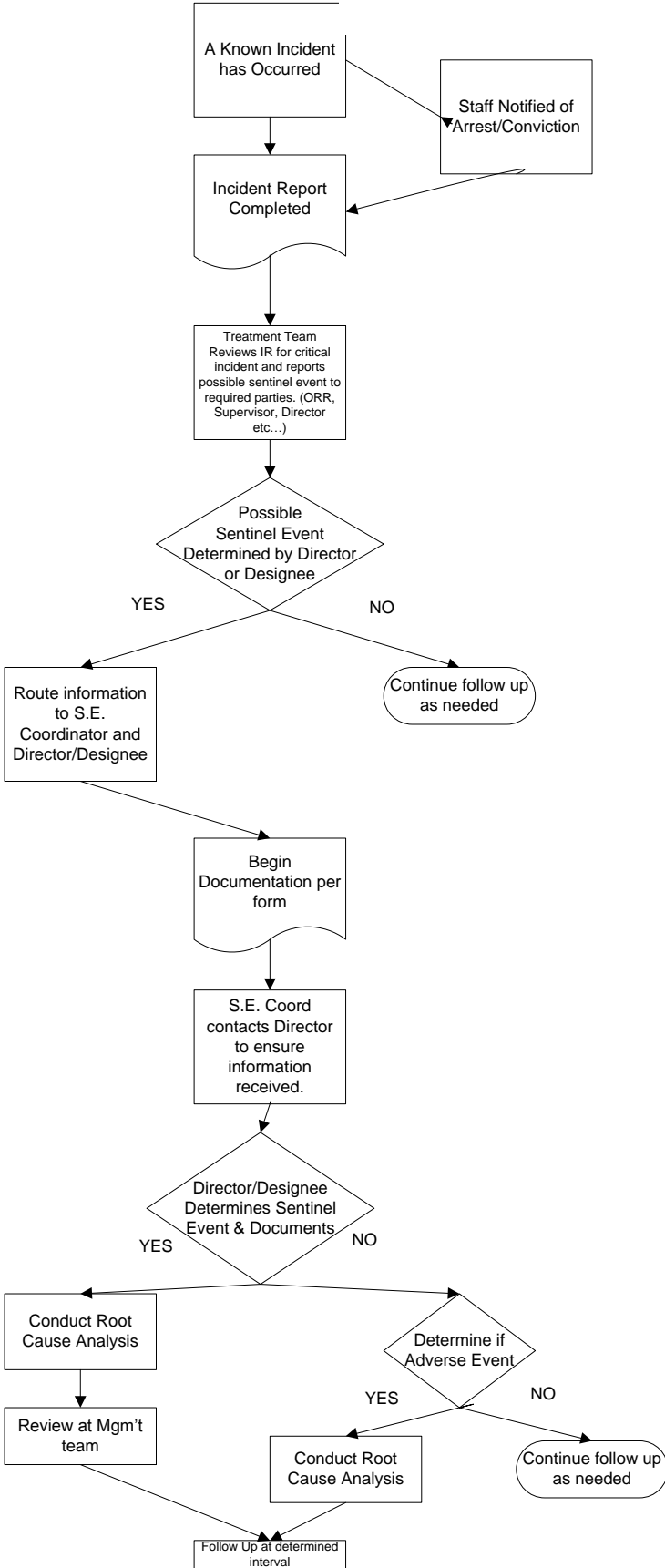
Senior Management Team

- a. Appoints the responsible party for oversight and monitoring of the Action Plan at a frequency which ensures that the implementation is affecting the targeted deficiency successfully.
- b. If regarding a Joint Commission Sentinel Event, this monitoring activity will include the follow-up activity assigned in Joint Commission's "Official Accreditation Decision Report," which they produce after reviewing Root Cause Analysis and Action Plan.
- c. Creates a report on the success of the intervention within six months from the approval of the Action Plan by the Director or within Joint Commission's Decision Report timeline if applicable.
- d. Gives report to the Director five business days prior to the six month/Joint Commission mandated due date.

Director

- a. Reviews report; ensures any needed clarifications/revisions are made with the PI Committee.
- b. Approves report within the six month or Joint Commission mandated due date and sends to Joint Commission if required by an "Official Accreditation Decision Report."

EXHIBIT A  
Sentinel/Adverse Event Flow Chart



## Joint Commission Sentinel Event Determination Documentation

Date: \_\_\_\_\_ Name of Consumer: \_\_\_\_\_ Consumer ID: \_\_\_\_\_

**Please check the appropriate population:**

**Medicaid:**      YES      NO

- Adults with MI                       Persons with DD                       Child Waiver  
 Children with MI/SED               Habilitation Waiver

		Please briefly explain any items checked:
1	Possible Sentinel Event is reported. <i>List what is the event, who reported it and when.</i>	
2	Was the incident? <input type="checkbox"/> Rape <input type="checkbox"/> Suicide in an 24 hour setting <input type="checkbox"/> Abduction of any individual receiving care, treatment or services If yes to any, this is a TJC sentinel event. Document information and then go to item 5. If no continue to #3.	
3	<input type="checkbox"/> Death of recipient <input type="checkbox"/> Major permanent loss of function= sensory, motor, physiological or intellectual impairment not present before the incident, requiring continued treatment or lifestyle changes. If yes to either, document information and go to step 4. If no to both=not SE Stop process and go to Item 5 and document that this was not a sentinel event!	
4	Was the outcome related to the natural course of the patient's illness or underlying condition? If no, this is a TJC sentinel event. Document information and go to step 5. If yes= not SE Stop process and document that this was not a sentinel event in step 5!	
5	Was this event determined to be TJC sentinel event? Document here if determined to be Sentinel Event. If SE, proceed to investigate via root cause analysis and use exhibit D- TJC Sentinel Event Timeline Check off. If not document as NO and go to step 6.	
6	See Director or Designated Representative to review this information and to determine if this shall be deemed an Adverse Event. Document here if determined to be Adverse Event. If AE, proceed to investigate via root cause analysis.	

## MDCH Sentinel Event Determination Documentation

Date: \_\_\_\_\_ Name of Consumer: \_\_\_\_\_ Consumer ID: \_\_\_\_\_

**Please check the appropriate population:**

- Adults with MI       Persons with DD       Child Waiver  
 Children with MI/SED       Habilitation Waiver

**Medicaid:**      YES      NO

<b>Please briefly explain any items checked:</b>	
<b>1</b>	Possible Sentinel Event is reported. List what is the event, who reported it and when.
<b>2</b>	Does this person: <input type="checkbox"/> Living in 24 hour specialized residential setting or child caring institution <input type="checkbox"/> Living in own home and receiving community living supports <input type="checkbox"/> Receiving targeted case management, ACT, home-based, Wraparound or HSW If yes to any, document which applies and continue to next question. If no to all=not SE. Stop process and go to step 7!
<b>3</b>	Was this person: <input type="checkbox"/> Arrested <input type="checkbox"/> Convicted If yes to either this is automatic SE, document information and go to step 7!
<b>4</b>	Was the incident? (check any that apply) <input type="checkbox"/> Death of recipient <input type="checkbox"/> Injury requiring ER visit and/or admission to hospital <input type="checkbox"/> Physical illness requiring admission to hospital <input type="checkbox"/> Serious challenging behaviors (that are not addressed in the current treatment plan)- including property damage in excess of \$100, attempt to harm self/others or unauthorized leave of absence <input type="checkbox"/> Any injury or death that occurred from the use of any behavior intervention <input type="checkbox"/> Medication error If yes to any, document information and continue to next question. If no to all=not SE. Stop process and go to step 7!
<b>5</b>	Was the incident UNEXPECTED? If yes, document information and continue to next question. If no= not SE. Stop process and go to step 7!
<b>6</b>	Did this event result in death, serious physical or psychological injury or the risk there of? <u>Serious injury</u> =major permanent loss of limb or function <u>Risk</u> =if event had continued, loss would have occurred If yes to any of above, document information and continue to next question. If no to all=not SE. Stop process and go to step 7!
<b>7</b>	If you have answered yes to 1-6, this is an MDCH reportable event. Document here if determined to be Sentinel Event. If SE, proceed to investigate via root cause analysis and use exhibit E- MDCH Sentinel Event Timeline Check off.
<b>8</b>	If at any point in 1-6 no was answered, this is not MDCH reportable event. See Director or Designated Representative to review this information and to determine if this shall be deemed an Adverse Event. Document here if determined to be Adverse Event. If AE, proceed to investigate via root cause analysis.

**Washtenaw Community Health Organization  
Joint Commission Reportable Sentinel Events Timeline Check off**

(use only if a Sentinel Event will be self-reported directly to Joint Commission)

Recipient I.D. # \_\_\_\_\_ FY \_\_\_\_\_

		Date	Staff
1	Date CMHSP/WCHO notified of Possible Sentinel Event		
2	Accredited Organization Self-Reported Sentinel Event Form if CMHSP decides to report to TJC		
3	Date and method above form was sent (mailed/faxed)		
4	Date reports due to TJC (45 calendar days from line 1.)		
5	First meeting of S.E.R.C. (within five business days of line 1.)		
6	S.E. Coord. informs Director of progress of S.E.R.C. (within 30 calendar days of line 1.)		
7	Director considers whether to use alternative reporting method. (within 30 calendar days of line 1.)		
8	Reports due to Director (40 calendar days from line 1.)		
9	Date and method Reports sent to TJC (45 calendar days from line 1.)		
10	Date that follow-up activity required by TJC's "Official Accreditation Decision Report" is due. (typically 6 mo from line 9.)		
11	Q.I. report to Dept. Head due (five business days before line 10.)		
12	Date Follow-up action completed per the "Official Accreditation Decision Report."		

**\*Note: If TJC is made aware of a sentinel event, Joint Commission standards state that the requested materials arrive in Joint Commission's within 45 calendar days of the known occurrence of the event.**

**Washtenaw Community Health Organization  
Sentinel Events Timeline Check off**

(for MDCH Sentinel Events, and Joint Commission Sentinel Events that are not directly self reported)

Recipient I.D. # \_\_\_\_\_ FY \_\_\_\_\_

		Date	Staff
1	Date CMHSP/WCHO learned of Possible Sentinel Event		
2	First meeting of S.E.R.C. (within two (2) business days of line 1.)		
3	Reports due to Director (40 calendar days from line 1.)		
4	Director approval date (within 45 calendar days of line 1.)		
5	Q.I. report to Director due (six months minus five business days from line 4.)		
6	Director approves Q.I. Report. (six months from line 4.)		



#### IV. Root Cause Analysis

##### A: Assessment Process

The following should be reviewed by the Core RCA Team, MD, Program Director, and Nurse Manager:

- Hospital Record       Autopsy Report       Utilization Review Manual
- Medical Record       Incident Report       Policies & Procedures
- Reports to/from Outside Bodies       Staff Interviews

A1. Was the behavioral assessment process comprehensive? Y  N   
Review the assessment for at least a year prior. If NO, describe:

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A2. Does the current assessment adequately assess risk? Y  N   
If NO, describe:

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A3. Was the psychiatric evaluation timely and thorough? Y  N   
If NO, describe:

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A4. Was the mental status well documented with comments explaining positive findings? If NO, describe: Y  N

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A5. Where was the information for the assessment obtained?

Patient       Family       Others

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A6. Was there additional information received from a referent (i.e. hospital discharge, primary care physician) or other source?

Was that reviewed? If YES, by whom?

If YES, how was information used, if at all? If NO, describe: Y  N

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A7. Were there any changes in the consumer's behavior or clinical presentation?

Did staff respond to the change? Y  N  Describe:

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A8. If the behavioral assessment is found less than comprehensive are there updates or attempts to obtain more information? Y  N   
If NO, describe:

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A9. Was a failure in the Behavioral Assessment Process a contributing factor to the Sentinel Event? If YES, describe: Y  N

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A10. How can the Behavioral Assessment process be improved to reduce the risk of such an incident in the future?

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**B: Physical Assessment Process**

B1. Was the physical assessment timely? If NO, describe: Y  N

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B2. Was the physical assessment complete? If NO, describe: Y  N

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B3. Was there evidence of coordination with Primary Care? Y  N   
If NO, describe:

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B4. Was the Personal Health Review completed and any questionable/abnormal findings appropriately pursued? Y  N   
If NO, describe:

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B5. Were all requested consultations/tests obtained as requested?

If NO, describe:

Y  N

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B6. Were all consultations/test reports reviewed by appropriate treatment providers? If NO, describe:

Y  N

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B7. Were there any consultations that should have been requested and were not? If YES, describe:

Y  N

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B8. Was the assessment of consumer's medical condition at time of incident adequate? If NO, describe:

Y  N

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B9. Was medical response to incident appropriate?

If NO, describe:

Y  N

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B10. Was medical response to incident timely? Y  N   
If NO, describe:

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B11. Was a failure in the Physical Assessment Process a contributing factor to the Sentinel Event? If YES, describe: Y  N

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B12. How can the Physical Assessment Process be improved to reduce the risk of such an incident in the future?

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C: Consumer Identification Process, i.e. right patient for right procedure/medication

C1. Was there any identifying information that was not obtained or available but should have been obtained or made available? Y  N

If No, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



D1. Were consumer observation policies/procedures followed by staff? Y  N   
If NO, describe:

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D2. Were consumer observation procedures appropriately documented? Y  N  If NO, describe:

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D3. Was the level of observation appropriate for this consumer? Y  N   
If NO, describe:

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D4. Was the level of supervision appropriate to the setting? Y  N   
If NO, describe:

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D5. Was a failure in the Consumer Observation procedures a contributing factor to the Sentinel Event? Y  N  If YES, describe:

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D6. How can the Consumer Observation process be improved to reduce the risk of such an incident in the future?

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E: Care Planning Process

E1. Was the level of care appropriate for this consumer? Y  N

If NO, describe:

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E2. Were the problems and goals identified on the treatment plan consistent with the diagnosis and information? Y  N

If NO, describe:

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E3. Were there any known medical conditions, and if so, were they included in the diagnosis and treatment plan? Y  N   
If NO, describe:

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E4. Was there documentation of discussion of the treatment plan with consumer/family? If NO, describe: Y  N

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E5. Was there documentation of any necessary instructions provided to the consumer/family? Y  N  If NO, describe:

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E6. Was treatment plan completed/reviewed/updated according to required time frames? Y  N  If NO, describe:

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E7. Was the diagnosis accurate? Y  N  If NO, describe:

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E8. Were the methods of treatment and interventions appropriate to the treatment goals? If NO, describe: Y  N

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E9. Was medication prescribed as the medical and psychiatric diagnosis and symptoms warranted? If NO, describe: Y  N

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E10. Was medication prescribed in a timely manner? If NO, describe: Y  N

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E11. Were all medications storage, labeling and administration policies/procedures followed? If NO, describe: Y  N

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E12. Were prescribed medications at therapeutic levels? Y  N   
If NO, describe:

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E13. Were labs ordered and reviewed appropriately? Y  N   
If NO, describe:

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E14. Was there documentation that the consumer's progress was monitored adequately and changes in the treatment were made, if indicated? If NO, describe: Y  N

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E15. If special treatment procedures were used were the required organizational procedures followed during implementation?

Restraint	Y <input type="checkbox"/>	N <input type="checkbox"/>	N/A <input type="checkbox"/>
Seclusion	Y <input type="checkbox"/>	N <input type="checkbox"/>	N/A <input type="checkbox"/>
Time Out	Y <input type="checkbox"/>	N <input type="checkbox"/>	N/A <input type="checkbox"/>
Hold	Y <input type="checkbox"/>	N <input type="checkbox"/>	N/A <input type="checkbox"/>

If NO, describe:

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E16. Was this case reviewed by Behavioral Management?

Y  N

Should it have been?

Y  N

Describe:

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E17. Were there any new medical or psychiatric conditions or symptoms that were manifested? If YES, describe:

Y  N

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E18. Was a failure in the Care Planning Process a contributing factor to the Sentinel Event? If YES, describe:

Y  N

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E19. How can the Care Planning Process be improved to reduce the risk of such an incident in the future?

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F: Staffing Levels

F1. How many of what kinds of staff were working at the time of the incident?

Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_

F2. Where was each of them when the incident took place?

Employee: _____	Location: _____
Employee: _____	Location: _____
Employee: _____	Location: _____
Employee: _____	Location: _____
Employee: _____	Location: _____
Employee: _____	Location: _____
Employee: _____	Location: _____
Employee: _____	Location: _____

F3. Who was assigned to this specific consumer at the time of the incident?

Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Employee: \_\_\_\_\_

Employee: \_\_\_\_\_

Employee: \_\_\_\_\_

F4. Were staffing levels and frequency of contacts of involved services provided adequate for consumer's activity? Y  N

If No, describe:

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F5. Was the staffing level and or frequency of services provided contacts effective for consumer activity? If NO, describe: Y  N

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F6. Was minimum staffing and or frequency pattern met? Y  N

If NO, describe:

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F7. Is there a plan that would allow for staff and/or contacts to increase if necessary? Y  N  If NO, describe:

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F8. Would more changes in staffing or a change in intensity reduced the risk of this incident occurring? Y  N  If YES, please explain:

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F9. Was a failure in staffing level or intensity of service a contributing factor to the Sentinel Event? Y  N  If YES, describe:

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F10. How can the staffing level or intensity or service be improved to reduce the risk of such an incident in the future?

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G: Orientation, Training, Competency, Credentialing

The following should be reviewed: Professional Development, Competencies, Personnel Files, Credentials Files, Staff Interviews.

G1. Had the staff completed the required orientation and competency training? Y  N  If NO, describe:

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G2. Where applicable were staff trained on an individual person centered plan and retrained on any changes to the plan of service? Y  N   
Please describe:

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G3. At the time of the incident, was staff able to use their training effectively to address the needs of the consumer/emergency/incident? Y  N  If NO, describe:

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G4. Was staff appropriately credentialed? Y  N   
If NO, describe:

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G5. Was a failure in the Orientation, Training, Competency, Credentialing process a contributing factor to the Sentinel Event? Y  N  If YES, describe:

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G5. How can the Orientation, Training, Competency, Credentialing process be improved to reduce the risk of such an incident in the future?

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H: Supervision of Staff

H1. Was staff appropriately supervised? Y  N   
If NO, describe:

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H2. Can the staff involved be categorized by any of the scenarios listed?

Are people involved aware of appropriate policy/procedure? Y  N

Are staff involved "floating" (staff going to unfamiliar settings)? Y  N

Based on those answers, what systemic improvements need to be made?

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H3. Was the assigned supervisor available at the time of the incident?  
Describe location and accessibility to staff:

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H4. What systemic Supervision of Staff improvements can be made to reduce the risk of such an incident in the future?

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I: Communication with Family

I1. Were appropriate releases on file? Y  N

If NO, describe:

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I2. Was critical information shared appropriately ? Y  N

Over the course of treatment?

Y  N

If NO, describe:

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13. When was the first contact with the family in relationship to the event?

Date	Time	Person Placing Call	Person Contacted	Documented Where?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

14. Was pertinent information imparted at the time of the initial phone call? If NO, describe: Y  N

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Did other staff follow up with family and document? If YES, describe: Y  N

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Was a failure in Communication with the Family a contributing factor to the Sentinel Event? If YES, describe: Y  N

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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K2. Was available information technology used as intended? Y  N

If NO, describe:

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K3. Is it possible to redesign information technology to reduce the risk in the future? Y  N

If so, what are the recommendations?

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K4. Was a failure in the Availability of Information a contributing factor to the Sentinel Event? If YES, describe: Y  N

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K5. How can the Availability of Information be improved to reduce the risk of such an incident in the future?

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L: Equipment Maintenance/Management and Physical Environment, Security Systems and Processes (Drill Logs, Other Logs) Please list:

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L1. Were there any equipment maintenance/management issues that played a role in the incident? Y  N   
If YES, describe and identify the recommended changes:

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L2. Did any components in the physical environment (or lack thereof) play a role in the incident? Y  N

Consider:

- Furnishings Y  N
- Hardware (bars, hooks, rods) Y  N
- Lighting Y  N
- Distractions Y  N
- Monitor Y  N
- Generator Y  N

If YES, describe and identify the recommended changes:

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L3. Were all security systems and process in appropriate operation?  
If NO, describe: Y  N

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L4. Would redesigning the physical environment reduce the risk  
of this type of event? If so, what is the recommendation? Y  N

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L5. Was the needed equipment available and used appropriately?  
If NO, describe: Y  N

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L6. Was a failure in the Equipment Maintenance/Management and Physical  
Environment, Security Systems process a contributing factor to the  
Sentinel Event? If YES, describe: Y  N

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L7. How can the Equipment Maintenance/Management and Physical Environment, Security Systems processes be improved to reduce the risk of such an incident in the future?

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M: Control of Medications: Storage/Access and Labeling of Medications  
Review as applicable:

- Formulary
- Medical Record
- Pharmacy Manual
- Pharmacy Records for Consumer
- Incident Report

M1. Were all medications appropriately labeled, controlled and stored?  
If NO, describe: Y  N

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M2. Were there any medication errors throughout the course of treatment?  
If YES, describe: Y  N

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M3. Were the internal controls (e.g. MD orders, Medication Reconciliation policies and procedures about noting doctor's orders, Pharmacy Supply, Individual Consumer Supply) to reduce medication errors followed? If NO, describe: Y  N

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M4. Were National Patient Safety Goals followed? Y  N   
If NO, describe:

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M5. Was a failure in the Control of Medications process a contributing factor to the Sentinel Event? Y  N   
If YES, describe:

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M6. How can the Control of Medications process be improved to reduce the risk of such an incident in the future?

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N: Continuity of Care Process

N1. Was the consumer's admission to the service (i.e. discharge from the hospital) effected in a smooth manner and according to policy/procedure? If NO, describe: Y  N

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N2. Were transfers/handoffs effected in a smooth manner and according to policy/procedure? If NO, describe: Y  N

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N3. Was the consumer's discharge from the agency effected in a smooth manner and according to policy/procedure? Y  N   
If NO, describe:

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V. Corrective Action Plan

1A. Risk Reduction Strategy:

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Responsible Party:

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Time Frame:

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Measure of Effectiveness (How will we know if this works?):

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1B. Risk Reduction Strategy:

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Responsible Party:

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Time Frame: \_\_\_\_\_

Measure of Effectiveness (How will we know if this works?): \_\_\_\_\_

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1C. Risk Reduction Strategy:

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Responsible Party:

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Time Frame: \_\_\_\_\_



## ROOT CAUSE ANALYSIS (RCA) – RECOMMENDATIONS AND FOLLOW UP

Consumer ID # and Initials: \_\_\_\_\_  
 Date of Sentinel / Advrs Event: \_\_\_\_\_  
 Date of Commencement of RCA Team: \_\_\_\_\_  
 Date of Completion of RCA: \_\_\_\_\_  
 Date Rec. Reviewed by Admin: \_\_\_\_\_

Recommendation	Results of Admin Team Review/ Additional Recommend.	Outcome	Measure of Success (MOS) / Target %	Implementation Plan					
				Chp	Who	Will Do What	By When	Progress Review	MOS Results
1.								Date: _____ Progress: _____ _____ Date: _____ Progress: _____ _____	
2.								Date: _____ Progress: _____ _____ Date: _____ Progress: _____ _____	
3.								Date: _____ Progress: _____ _____ Date: _____ Progress: _____ _____	
4.								Date: _____ Progress: _____ _____ Date: _____ Progress: _____ _____	