Washtenaw County Community Mental Health

SENTINEL EVENT - (policy)

PURPOSE

To assist the WCCMH Executive Director in determining which Events meet the Joint Commission Sentinel Event definition.

POLICY

In the event of a Sentinel Event occurrence, analysis of the underlying causes will lead to an understanding of what system/process changes may be necessary to reduce the risk of future recurrences. This procedure will also insure that any recommended changes will be implemented and monitored in a timely, thorough and credible way.

STANDARDS

Events meeting the Michigan Department of Health and Human Services (MDHHS) definitions of sentinel, critical or risk event will be addressed per the Community Mental Health Partnership of Southeast Michigan (CMHPSM) Event Policy. These events undergo a review process by the Performance Improvement Department. The review process will help define if the event meets the Joint Commission definition and if so, is addressed according to the Joint Commission standards.

The WCCMH Executive Director or Medical Director may request a review of any event, regardless of how it is defined. Events that are possible Sentinel Events will be reviewed by the formation of an ad hoc Sentinel Event Review Committee (SERC) to analyze root causes, clarify if the event occurred due to practice of care, and strategize any appropriate agency responses required to minimize future risk of recurrence. Members of the SERC will include individuals familiar with the processes under review and will also include relevant agency leaders.

Members will use an agency approved process or instrument (such as the Joint Commission's "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event"- Exhibit A) 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.

DEFINITIONS

The following definitions are shared by the Joint Commission and MDHHS:

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.

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

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof as a result of practice of care. 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 definitions are specific to the Joint Commission Standards for a Sentinel event that occurs at a location owned and operated by WCCMH:

Major Permanent Loss of Function: Sensory, motor, physiologic, or intellectual impairment not present before the incident, requiring continued treatment or lifestyle changes that is not related to the natural course of the individual's illness or underlying condition. When major permanent loss of function can not be immediately determined, reporting to the Joint Commission is not considered or 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.

Suicide of any individual served receiving care, treatment, or services in a staffed around-the-clock setting or within 72 hours of discharge.

Abduction of any individual served receiving care, treatment, or services.

Elopement (that is, unauthorized departure) of a patient from a staffed around the clock care setting owned and operated by WCCMH leading to the death, permanent harm or severe temporary harm of the individual served.

Sexual Abuse/Rape/ Assault (leading to death, permanent harm, or severe temporary harm), or homicide of any individual served receiving care, treatment, or services while on site at the organization. The determination of "rape" is to be consistent with applicable law and regulation. Sexual abuse/rape/assault is defined as nonconsensual sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the organization including oral, vaginal, or anal penetration or fondling of the patient's sex organs by another individual's hand, sex organ, or object. One or more of the following must be present to determine that it is a sentinel event:

- Any staff-witnessed sexual contact as described above
- Admission by the perpetrator that sexual contact, as described above, occurred on the premises
- Sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact
- 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 within the agency (but does not require action by the court system) that a rape has occurred. Reporting of a rape to the Joint Commission is not expected where such reporting is prohibited by law.

Rape/ Assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization.

Event Review: As needed, the PI Designee will assign an Event review, including a review of the client's chart. Minimally, the following will be reviewed and documented (this is considered the initial stages of the Sentinel Event investigation):

A. Client ID
B. Client Name
C. Type of Event
D. Date of Notification
E. Cause of Death (when appropriate or known)
F. Primary Team assignment
G. Diagnoses
H. If the client is receiving Targeted Case Management, Supports Coordination, Community Living Service, Residential Group Home Placement, Assertive Community Treatment, Home Based services, HAB Waiver services, Children's Waiver services
I. If the individual has a Substance Abuse Diagnosis, do progress notes indicate the team members are addressing problems related to this diagnosis?
J. If an Incident Report was written
K. If the Incident Report is Coded
L. List all team members that have implemented a service
M. Last date of face to face service of Case Manager
N. Last date of attempt to contact client
O. Date of last Medication Review
P. Date of last injection
Q. All individuals who delivered care in the past twelve months
R. Determine if coordination of care with Primary Care physician Occur
S. Determine if the Personal Health Review conducted within the past year
T. Identify outstanding questions, concerns or notes as a basis of review and discussion

PROCEDURES

See procedures manual

REFERENCES

A. Joint Commission's Sentinel Event Standards Relating to Sentinel Events (revised 2013).
B. Community Mental Health Partnership of Southeast Michigan (CMHPSM)
C. MDHHS Performance Improvement Sentinel Event Code Definitions
D. MDHHS Contract, Michigan Mental Health Code, third-party payer requirements, county, state and federal regulations and laws, WCCMHA Policies and Procedures.