

**CENTRA WELLNESS NETWORK
PROCEDURE 04.02 RISK EVENTS, CRITICAL INCIDENTS AND SENTINEL
EVENTS**

I. PURPOSE STATEMENT:

Centra Wellness Network's (CWN) Governing Body establishes and evaluates policies and related procedures as required by statutory and contractual obligations.

CWN reserves the right in its sole discretion to adopt and implement policies and procedures that ensure a safe, functional and professional workplace that operates with integrity using person-centered focus and planning, trauma informed practices and respect of others, cultural sensitivity and transparency in communication and practice. Organizationally and in practice, CWN is responsive to the needs of clients, community and staff.

Any statements and procedures are subject to review and/or unilateral change, modification, suspension or cancelation in whole or in part of any published/unpublished policies or procedures without notice and without having to give cause, justification, or consideration to any employee. Recognition of these rights and prerogatives of CWN is a term and condition of and maintaining employment.

Policies and Procedures are approved by the Board and/or upon recommendation by the Executive Director or his/her designee.

II. APPLICATION:

Agency Wide, including employees, affiliated providers, and interpreters.

III. DEFINITIONS:

Incident:

The beginning points of the process to determining a critical incident or sentinel event which is reported by any staff and includes any of the following:

- death of a recipient, including suicide
- serious illness requiring admission to hospital
- attempted suicide
- alleged cause of abuse or neglect
- sexual assault
- overdose
- accident resulting in injury to recipient requiring emergency room
- visit or hospital admission
- behavioral episode
- wandering and/or elopement
- use of seclusion or restraint
- arrest and/or conviction
- communicable disease
- infection control
- medication error
- use of and unauthorized possession of weapons
- unauthorized use and possession of legal or illegal substances
- vehicular accidents
- biohazardous accidents

Unusual Incident:

Risk Event:

An event that puts a client, who is in a reportable population, at risk of harm. A risk event is reported and an internal analysis is completed to determine actions are needed to remediate the problem or situation and to prevent reoccurrence. The events include the following:

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- **Harm to Self:** An action taken by a person that causes physical harm that requires emergency medical treatment or hospitalization (e.g., pica, head banging, self-mutilation, biting, suicide attempt).
- **Harm to Others:** An action taken by a person that cause physical harm to an individual(s) (family, friend, staff, peer, public, etc.) that requires law enforcement intervention and/or emergency medical treatment or hospitalization of the injured person(s).
- **Police Call:** A call to police by a staff of CWN or of a specialized residential setting, or general (AFC) residential home, or other provider agency requesting assistance with a client during a behavioral crisis, regardless of whether contacting law enforcement is addressed in a Behavior Treatment Plan.
- **Emergency Use of Physical Management:** The use of physical management /restriction of movement, by a trained staff in response to a behavioral crisis.
- **Physical Management:** Specific techniques used as an emergency intervention to restrict the movement of a person by continued direct physical contact despite resistance, to prevent them from physically harming self or someone else. "Physical management" does not include brief contact with client to comfort or demonstrate support or caring. Such contacts are brief and should be agreeable to the person. Such examples include, holding their hand, a "pat on the back", or arm around their shoulder.

Critical Incident:

An incident pertaining to the specific population identified and includes one of the following:

- **Suicide: death caused by injuring oneself with the intent to die.** A suicide attempt is when someone harms themselves with any intent to end their life, but they do not die because of their actions.
- **Non-Suicide Death:** A death reportable on any individual receiving services within the past 30 days (including crisis contacts) and all persons living in specialized residential or receiving CLS, CSM, ACT, Wraparound, or waiver services or any other CWN services.
- **Emergency Medical Treatment due to injury or medication error:** These events include a medication error defined as a mistake and not an individual's refusal to take a medication. The event is reportable on individuals in specialized residential, receiving waiver services or on medications reviewed and prescribed by CWN Med Services Providers.
- **Hospitalization due to injury or medication errors:** These events are reportable on individuals in a specialized residential, an individual receiving waiver services and persons on medications prescribed and managed by CWN Med Services providers.
- **Arrest:** An arrest is reportable on individuals receiving specialized residential, waiver services or actively receiving any other CWN services.

Sentinel Events:

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. The following circumstances are considered sentinel events:

- **Death of Recipient:** The death of a beneficiary that is not the result of natural causes. An unexpected death includes any death that results from

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suicide, homicide, an undiagnosed condition, accident, or where it appears suspicious for possible abuse and/or neglect.

- **Accidents requiring emergency room visits and/or admissions to hospitals:** Serious damage suffered by a beneficiary that a physician or nurse determines caused, or could have caused, the death of the beneficiary, the impairment of his/her bodily functions, loss of limb, or permanent disfigurement. An injury caused by actual or suspected abuse or accident must be treated at a medical facility. The treating medical facility must be noted on the incident report.
- **Physical illness requiring admission to hospitals:** The unexpected hospitalization of a beneficiary for a previously unknown or undiagnosed illness. A planned surgery, whether outpatient or inpatient, is not considered and unexpected occurrence and, therefore, not included in reporting under this definition. A hospital admission for an illness directly related to a beneficiary's chronic or underlying illness is also not reported as sentinel event.
- **Arrest or conviction of recipients:** Any arrest or conviction of a beneficiary who is in a reportable population at the time of the arrest or conviction. An arrest or conviction must be reported as a sentinel event (through the MDHHS Performance Indicator system) but does not require a Root Cause Analysis.
- **Serious Challenging Behaviors:** A behavior that results in significant (over \$100) property damage, an attempt at self-inflicted harm or harm to others, or an unauthorized leave of absence. A serious challenging behavior includes behaviors not previously addressed in a Behavior Treatment Plan.
- **Medication errors:** The delivery of medication to a beneficiary that is the wrong medication, wrong dosage, or double dosage, or failure to deliver medication that resulted in death or serious injury or the risk thereof. An instance where a beneficiary refused medication is not a medication error.

Root Cause Analysis:

The process of identifying the basic or causal factors that underlies variation of performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determine, after analysis, that no such improvement opportunities exist.

IV. POLICY STATEMENT:

The intent of this policy is to ensure the completion internal analysis of critical, sentinel, and risk events. The analysis may further promote application of a root cause analysis in determining causal factors and to address these issues. root causes analysis and appropriate and timely reporting of critical incidents, sentinel events, and risk events.

V. PROCEDURES:

- a. Staff, volunteer, or contract providers involved in, or observing an unusual incident will follow incident reporting procedures identified in CWN policy 3.31 (Reporting of Unusual Incidents). Assuring they complete an Incident Report with 24 hours of the event. All staff members will notify their Supervisor or Program Director immediately upon suspicion of a Sentinel Event.
- b. Upon receipt of the incident report it will be reviewed and determine if the incident identified is classified as Unusual Incident, Risk Event, Critical Incident or Sentinel Event. Event not requiring further review will be forwarded to Supervisor, Director,

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Recipient Rights, Compliance Officer and reporting staff. Incidents determined to need further review due to concern or are potential critical or sentinel events will be forwarded to the CAPS Director for review and determination of classification.

- c. The Director of Customer and Provider Services (CAPS), or designee, will review IR and determine whether the incident meets reporting criteria as a critical incident or sentinel event.
- d. The Director CAPS, or designee, will immediately notify the prepaid inpatient health plan (PIHP) of any event that meets the PIHP's standards for event reporting, including without limitation sentinel event, critical incident, and risk event reports, all as defined by the Michigan Department of Health and Human Services (MDHHS) and written in the PIHPs Critical Incident and Sentinel Event policy.

If an incident is A suicide determined through CMHSP review or death certificate indicating suicide as a cause of death. The event is reportable on any individual actively receiving services **or** anyone who received crisis services within past 30 days.

Classification of Incident Reports requiring Root Cause Analysis (RCA)

1. A root cause analysis will commence within two business days of receiving an Incident Report determined to need review.
2. A request for additional information, such as a coroner's report or death certificate, constitutes the start of a Root Cause Analysis. Staff participating in reviewing and analyzing sentinel events will include a minimum of the following:
 - i. CAPS Director
 - ii. Clinical Director
 - iii. Medical Director/Medical Representative
 - iv. Quality Assurance/Quality Review
 - v. Risk Management/Compliance Office
 - vi. Chief Operating Officer

Other members of the team will be those pertinent to the situation or have knowledge or skills in specific areas of concern. For example, a behavioral specialist for incidents involving outbursts, loss of control, etc... A Case Manager who may know the person, and their family. The additional review team members may be more specific to the person(s) involved in the incident if the team determines it necessary.

3. The root cause analysis will include a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrences of a sentinel event. The analysis focuses primarily on systems application or design, organizational process and practices.
4. Based on the outcome of the analysis or investigation, the review team will make recommendations in a plan of action/remediation. The recommendations in the plan of action will be assigned to the appropriate department/person for development and implementation, and monitoring to meet the expected outcomes of the POA.
5. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan and submit their rationale in writing to the review committee.
6. The Director of CAPS, or designee will be responsible to assure the implementation, oversight, pilot testing as appropriate, timelines and strategies for measuring the effectiveness of the plan and actions taken and shared with committee members

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7. The Director of CAPS, or designee, will report the findings and the action plan to the Northern Michigan Regional Entity (NMRE) Chief Executive Officer (CEO), CWN Executive Director and/or their designee, and the Department of Health and Human Services as required.
8. Decision to submit any portion of the Root Cause analysis to any regulatory body by administration will be done with the advice of Legal Counsel.
9. All proceedings of the Review Committee, Root Cause Analysis and Plan of Action will be maintained as confidential Peer Review Documents.
1. The Director of CAPS, or designee, will report Critical Incident and Sentinel Event Data to the PIHP according to Schedule E, contractor reporting requirements, of the contracts.

VI. EXHIBITS:

Root Cause Analysis Document
Plan of Action outline

VII. REFERENCES:

Authority and Related Directives Trace	
Federal	42 CFR § 438.10, § 438.400, §438.330; 42 CFR § 438.240 BBA – Quality Assessment and Performance Improvement
State	MDHHS/CMHSP Managed Mental Health Supports and Services Contract: Attachment C6.8.1.1 MDHHS/PHIP Contract State of Work Contract Activities (1)(N)(12) MDHHS Guidance on Sentinel Event Reporting
NMRE	Administrative Manual Policy: Critical Incident, Risk Event, Sentinel Event, and Death Reporting
County	
CARF	CARF 2022 Behavioral Health Standards
Other	CWN Board By-Laws, Section 7E