CENTRA WELLNESS NETWORK

Board Adopted Procedure		
Procedure 04.02	**Policy Title: 04.00 Quality Improvement**	
Effective Date: 2/10/2011	**Subject: Risk Events, Critical Incidents and Sentinel Events**	
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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to review and/or unilateral change, modification, suspension or cancelation in whole or in part of any published/unpublished policies or procedures without notice and without having to give cause, justification, or consideration to any employee.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:

Risk Events Management: A process for analyzing risk events that put individuals at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.

Critical Incident: An incident that meets the state reporting definition of: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, arrest of a client, injury as a result of physical management. Populations that qualify:

- Individuals who live in Specialized Residential facility (per Administrative Rule R330.1801-09); or
- Individuals who live in a Child Caring institution; or
- Individuals who receive Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver Services
- For suicide: any individual actively receiving services at the time of death and any who have received services within 30 days prior to death.
- For non-suicide related deaths: any individuals who were activity receiving services and were living in a Specialized Residential facility; or in a Child Caring institution; or were receiving community-based living supports, supports coordination, targeted case management, ACT, home-based, wraparound, Habilitation Supports Wavier, SED Waiver or Children's Waiver services.

Sentinel Events:
A sentinel event is an "unexpected occurrence" involving death or serious physical or psychological injury or risk thereof. Serious injury specifically includes loss of limb or function. (The phrase "risk thereof" includes any process variation that most likely would result in a sentinel event if it reoccurred). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Root Cause Analysis:
A 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 exit.

IV. POLICY:

The Centra Wellness Network (CWN) Governing Board shall establish policies and related procedures to ensure that all services, supports, and administrative functions are conducted with the highest quality possible. All such functions shall be based on the obligations under the Michigan Mental Health Code, and all pertinent accreditation criteria. The intent of this procedure is to enable the development of actions for improvement to prevent or reduce the likelihood of similar events occurring in the future.

V. PROCEDURE:

A. Any staff member will notify their Supervisor or Program Director immediately upon suspicion of a critical incident or sentinel event.
B. Supervisor or Program Director will notify the Executive Director and Medical Staff immediately for critical incidents or sentinel events.
C. The person reporting the potential sentinel event will complete an Incident Report Form.
D. The Director of Customer and Provider Services (CAPS) or designee will review the critical incident report and make a determination if the incident meets the sentinel event standard within three (3) working days of the incident begin reported.
E. The Director of CAPS, or her/his designee, shall immediately notify the NMRE of the following events:
   1. Sentinel events and other critical incidents and events that put people at risk of harm; or
   2. Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of recipient rights, licensing or police investigation.
      i. CWN shall submit a report in writing to the NMRE that a rights, licensing, and/or police investigation has commenced.
      ii. The notification shall include:
         1. Name of the beneficiary
         2. Beneficiary ID number (Medicaid)
         3. Client ID (CONID) if there is no beneficiary ID number
         4. Date, time, and place of death (if a licensed foster care facility, include the license number)
         5. Preliminary cause of death
         6. Contact person's name and e-mail address
F. For incidents qualifying as a sentinel event, The Director of CAPS or her/his designee, will initiate a root cause analysis team composed of those close to the process and with the appropriate credentials for the review including participation from the administrative staff. This team will meet within two (2) working days of the sentinel event determination.
G. A thorough and credible root cause analysis will be completed within 45 days of the event and will be coordinated by the Director of CAPS or her/his designee.
H. Regardless of the method used for the Root Cause Analysis, the product is an action plan that identifies the strategies that CWN intends to implement to reduce the risk

of a similar event occurring in the future. The action plan will include responsibilities and timelines for implementation of the plan, oversight, pilot testing as appropriate, and strategies for monitoring the effectiveness of the plan.

I. Consideration of relevant literature will be made during the root cause analysis and will be made part of the Root Cause Analysis file.
J. Responsibility for implementation, oversight, pilot testing as appropriate, timelines and strategies for measuring the effectiveness of the plan and actions taken will be the responsibility of the Director of CAPS or her/his designee.
K. The Director of CAPS will report the findings and the action plan to the Northern Michigan Regional Entity (NMRE) Chief Executive Officer (CEO) and the Department of Health and Human Services as required.
L. Outcomes from the action plan will be reported to the NMRE CEO within six months and thereafter as deemed appropriate.
M. 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.
   All proceedings of the Root Cause Analysis and action plan will be maintained as confidential documents.
N. Risk event management review will be completed on a monthly basis for qualifying population identified in critical incident definition.
O. Risk event data to be reviewed will minimally include:
   1. Actions taken by individuals who receive services that cause harm to themselves.
   2. Actions taken by individuals who receive services that cause harm to others.
   3. Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural source of a chronic illness, such as when an individual has a terminal illness) within a twelve (12) month period.
P. The Clinical Director or designee(s) will review and complete a risk event management summary document, including identification of what action need to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.
Q. The Director of CAPS or designee will submit aggregate data to the PIHP, if required.

VI. EXHIBITS:

N/A

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/PIHP Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract Attachment P.7.7.1.1 R330.1801-1809
NMRE	Administrative Manual Policy #04-01-002 and Procedure #04-02-002
County	Interlocal Agreement of December 1992 Section IX(j)
CARF	CARF 2018 Behavioral Health Section 1.H
Other	CWN Board By-Laws, Section 7.E.