CENTRA WELLNESS NETWORK

Board Adopted Procedure			
Procedure	04.02	**Policy Title: 04.00 Quality Improvement**	
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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to review and/or unilateral change, modification, suspension or cancelation in whole or in part of any published/unpublished policies or procedures without notice and without having to give cause, justification, or consideration to any employee.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:

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

- **Suicide:** 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.
- **Non-Suicide Death:** A death reportable on any individual actively receiving services **and** living in specialized residential or receiving CLS, CSM, ACT, Wraparound or waiver services.
- **Emergency Medical treatment due to injury or medication error:** These events include a medication error is only defined as a mistake and not an individual's refusal to take a medication. The event is reportable on individuals in specialized residential **or** receiving waiver services
- **Hospitalization due to injury or medication errors:** These events are reportable on individuals in a specialized residential **or** an individual receiving waiver services.
- **Arrest:** An arrest is reportable on individuals receiving specialized res **or** receiving waiver services.

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 used and possession of legal or illegal substances
- vehicular accidents
- biohazardous accidents

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

- **Harm to Self**: An action taken by a beneficiary that causes him/her 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 beneficiary that cause physical harm to an individual(s) (family, friend, staff, peer, public, etc.) that requires emergency medical treatment or hospitalization of the injured person(s).
- **Police Call**: A call to police by a staff of a specialized residential setting, or general (AFC) residential home, or other provider agency requesting assistance with a beneficiary during a behavioral crisis, regardless of whether contacting law enforcement is addressed in a Behavior Treatment Plan.
- **Emergency Use of Physical Management**: The of physical management by a trained staff in response to a behavioral crisis.
- **Physical Management**: A technique used as an emergency intervention to restrict the movement of a beneficiary by continued direct physical contact despite his/her resistance, to prevent him/her from physically harming him/herself or someone else. "Physical management" does not include briefly holding a beneficiary to comfort him/her or demonstrate affection or holding his/her hand.

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 exit.

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

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.

IV. POLICY STATEMENT:

The intent of this policy is to ensure the completion of root causes analysis and appropriate and timely reporting of critical incidents, sentinel events, and risk events.

V. PROCEDURES:

A. Any staff, volunteer, or contract providers involved in, or observing an unusual incident will follow incident reporting procedures identified in CWN policy 3.31
B. The incident report will be reviewed and routed to appropriate clinical, Recipient Rights and reporting staff immediately.
C. The Director of Customer and Provider Services (CAPS), or designee, will 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.
E. If an incident is determined to be a sentinel event:
    1. A root cause analysis will commence within two business days.
    2. A request for additional information, such as a coroner's report or death certificate, constitutes the start of a Root Cause Analysis.
    3. Staff involved in reviewing and analyzing the sentinel events must have the
    appropriate credentials to review the scope of care. For example, sentinel

events that involved death or serious medical conditions, must involve a physician or nurse.

4. 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 occurrents of a sentinel event. The analysis focuses primarily on systems and processes, not individual performance.
5. Based on the outcome of the analysis or investigation, the provider must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan.
6. The Director of CAPS, or designee will be responsible for the implementation, oversight, pilot testing as appropriate, timelines and strategies for measuring the effectiveness of the plan and actions taken.
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) 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 Root Cause Analysis and action plan will be maintained as confidential Peer Review Documents.

F. 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:

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/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