

SUBJECT: REPORTING AND INVESTIGATING OF SENTINEL EVENTS

EFFECTIVE
DATE: 01-11-11 (replaces 01-11-10)

APPROVED BY:

Reviewed (no changes): _____

Executive Director

POLICY

It is the policy of McIntosh Trail CSB to investigate immediately all sentinel events to determine the root cause of the event and how it can be prevented in the future. A root cause analysis will be conducted, an action plan developed, and a monitoring method established to determine if outcomes have been met and maintained. Results will be reported to the appropriate regulatory authorities. Additional goals are to improve treatment, care and services provided to consumers, and to maintain public confidence in McIntosh Trail CSB and in its national accreditation process.

DEFINITIONS:

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, meeting the following criteria:

1. The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the consumer's illness or underlying condition, or
2. The following events are considered "sentinel events":
 - a. Suicide of any individual receiving care, treatment or services in a staffed around-the-clock setting or within 72 hours of discharge.
 - b. Rape of consumer in our "active care" (confirmed by local law authorities as having occurred).
 - c. Abduction of any individual receiving care, treatment, or services.
 - d. Any elopement, that is unauthorized departure, of a consumer from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function.
 - e. Assault, homicide, or other crime resulting in consumer death or major permanent loss of function.
 - f. A consumer fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.
3. "Active care" means in staffed around-the-clock residential services, on-site in a CSB service, during provision of services in the community, or in the company of staff.

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DEFINITIONS: (CONTINUED)

Root Cause Analysis: A risk management process to identify the basic or causal factors that underlie variation in performance. The analysis has the following characteristics:

- Focuses primarily on systems and processes, not individual performance; and
- Progresses from special causes in clinical processes to common causes in organizational processes and systems; and
- Identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future; or determines, after analysis, that no such improvement opportunities exist.

Action Plan: The product of the root cause analysis which:

- Identifies strategies that the organization intends to implement to reduce the risk of similar events occurring in the future; and
- Addresses responsibility for implementation, oversight, pilot testing (as appropriate), timelines, and strategics for measuring the effectiveness of the actions.

PROCEDURES

1. Staff will report sentinel events per the "Reporting of Consumer Deaths and Critical Incidents" (Policy 1015).
2. The identification of an adverse event as a sentinel event will be made by the appropriate Director, the CARF Coordinator, the Medical Director, and the Executive Director. The Executive Director will notify the Chair of the governing board.
3. The Executive Director, after consultation with the agency's attorney and Board Chair, will decide if the sentinel event is reportable to CARF and the Department of Behavioral Health and Developmental Disabilities Services. If reportable, the Executive Director will be responsible for reporting.
4. Sentinel events will be investigated immediately by the Risk Management Review (RMR) Committee. The RMR Committee will complete a root cause analysis investigation within forty-five (45) calendar days from the date of the sentinel event or when senior leadership becomes aware of the event. The committee will develop an appropriate action plan.

Note: In the case of an unanticipated death, the RMR Committee Chair will obtain a provisional cause of death from the individual's physician or the county coroner and a death certificate when available. Both reports will be reviewed by the Medical Director, who will report the results to the RMR Committee Chair and the Executive Director. Procedures in the Reporting of Consumer Deaths and Critical Incidents policy (1015) will be followed.

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PROCEDURES (CONTINUED)

5. The action plan will be implemented by the designated Director, the Medical Director, and/or the Executive Director.
6. Documentation will be filed in the RMR Committee Chair's office and in the office of the Executive Director.
7. The Executive Director, after consultation with the agency's attorney and Board Chair, will decide if the root cause analysis results and action plan will be forwarded to CARF. If indicated, the root cause analysis and action plan will be provided to CARF within 45 calendar days of the known occurrence of the event.
8. The designated Associate Director, the Medical Director, the RMR Committee Chair, and/or the Executive Director will systematically monitor and evaluate the improvement actions implemented and provide confidential reports to the Chair of the Leadership Team through the Risk Management Review Committee and to the Board Chair.
9. "Sentinel Event Alerts" are reviewed and responded to according to CARF standards. The Medical Director is responsible for this practice.