

PATHWAYS CMH

POLICY TITLE: Event/Death Reporting, Notification & Monitoring	CATEGORY: Quality Assessment & Performance Improvement	
EFFECTIVE DATE: August 6, 2014	BOARD APPROVAL DATE: August 6, 2014	
REVIEWED DATE:	REVISION(S) TO POLICY STATEMENT: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	OTHER REVISION(S): <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
RESPONSIBLE PARTY: Quality Improvement Coordinator	CEO APPROVAL: John Basse, CEO	

APPLIES TO:

Pathways CMH Personnel
Pathways Contract Providers

POLICY:

All applicable parties, or their designee, shall report sentinel events, critical events, risk events and immediately reportable events (event notification) to Pathways CMH as required by MDCH and outlined in the procedures below.

PURPOSE:

To establish a process that ensures due diligence as well as responsible and appropriate oversight and reporting of critical events, sentinel events, risk events and event notification.

DEFINITIONS:

1. *24-hour Specialized Setting:* Specialized residential home certified by Michigan Department of Consumer and Industry Services for persons with mental illness or developmental disabilities. For purposes of sentinel events reporting by Substance Abuse Coordinating Agencies, it means substance abuse residential treatment programs.
2. *Accidents:* Reportable accidents that result in injuries which require a visit to emergency rooms, medi-centers and urgent care clinics/centers and/or admissions to hospitals.
3. *Adverse Incident:* An undesirable and usually unanticipated event. Examples: a death of a person served, an employee, a volunteer, or a visitor in a provider organization. Incidents such as a fall or improper administration of medications are also considered adverse incidents if there is no permanent effect on the individual. Adverse incidents are reviewed to determine whether it meets the criteria for a reportable sentinel event. Adverse incidents include, but are not limited to:
 - Death of a recipient
 - Serious illness requiring admission to hospital
 - Alleged case of abuse or neglect
 - Accident resulting in injury to the recipient requiring emergency room visit or admission to hospital
 - Serious challenging behavioral episode

4. *Critical Incident*: Term utilized in the new Event Reporting system; identifies events similar to historical “sentinel” event with some modified definitions.
5. *Death*: Reportable death that does *not* occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age.
6. *Immediately Reportable Events*: Also referred to as “Event Notification” in the PIHP-MDCH Contract.
7. *Medication Errors* means a) wrong medication, b) wrong dosage, c) double dosage, or d) missed dosage which resulted in death or serious injury or the risk thereof. It does not include instances in which consumers have refused medication.
8. *Ongoing and continuous in-home assistance* means assistance with activities of daily living provided in the person’s own home at least once a week, and 6 months or longer.
9. *Own Home*: For purposes of sentinel event reporting means *supported independence program* for persons with mental illness or developmental disabilities regardless of who holds the deed, lease, or rental agreement; as well as own home or apartment for which the consumer has a deed, lease, or rental agreement in his/her own name. Own home does not mean a family’s home in which the child or adult is living.
10. *Physical illness resulting in admission to a hospital* does *not* include planned surgeries, whether inpatient or outpatient. It also does *not* include admissions directly related to the natural course of the person’s chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.
11. *Risk Events* refer to events that put individuals (in the same categories as critical events) at risk of harm. At a minimum, these events include actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm to others; and two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness) within a 12 month period.
12. *Sentinel Event*: “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.” Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. (per Attachment P.1.4.1 Behavior Treatment Plan Review Committee Tech Requirement (H))
13. *Serious challenging behaviors* are those not already addressed in a treatment plan and include significant (in excess of \$100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence. Serious physical harm is defined by the administrative rules for mental health (330.7001) as

“physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.

14. *Unexpected Death*: Includes those that resulted from suicide, homicide, and undiagnosed condition, were accidental or were suspicious for possible abuse or neglect.

REFERENCES:

- MDCH/PIHP Contract
- MDCH Sentinel Event Reporting Guidance
- Determining a Sentinel Event Flow Chart – MDCH
- MDCH/PIHP Contract Attachment P.6.7.1.1 – (QAPIP) Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans
- MDCH/PIHP Contract, Section 6.1.1 Event Notification
- Medicaid Subcontracting Agreement (PIHP/CMHSP)
- MI Mental Health Code (Act 258 of the Public Acts of 1974 as amended) Section 330.1748 (9)

HISTORY:

Dates Reviewed:

Dates Revised:

Dates Approved:

PROCEDURES:

Pathways has the responsibility to review, investigate, and act upon sentinel events, critical events, risk events and immediately reportable events. Pathways will utilize the Incident Reporting Module in the electronic record system (ELMER) which was developed and went live January 1, 2014. Using a standardized tool to report critical incidents, sentinel events, risk events and immediately reportable events will allow standard regional and local reports to be available in a timely manner.

A. Review of Events

All incidents are reviewed by the Office of Recipient Rights. Those incidents that have the potential to meet the criteria and definitions of a sentinel event, critical event, risk event, or an immediately reportable event are then sent to the QI department for review. Events may meet criteria for more than one category.

B. Reporting of Events

1. *Sentinel Events*

Sentinel events, as defined in the MDCH/PIHP contract and the MDCH Sentinel Event Reporting Guideline, must be identified within three (3) business days after an adverse incident occurred. Pathways has two subsequent business days to commence a root cause analyses of the event.

A thorough and credible Root Cause Analysis (RCA) must be completed in

order to identify systemic casual factors, probable re-occurrence, and to determine a plan to mitigate risk. Information regarding arrests and convictions must still be tracked for reporting purposes. Pathways maintains the sentinel event definition by the state to determine if a root cause is needed. This means that a root cause analysis is only completed when there is loss, or serious risk, of bodily function, serious injury, or preventable death. Arrests are not cause to complete a root cause analysis.

Sentinel events are reviewed and acted on as appropriate by individuals possessing the appropriate credentials to review the scope of care. Participation by a physician or nurse will be required in any instance that involves a serious medical condition or death. Pathways' Medical Director is available for consultation purposes and to review sentinel events as deemed necessary.

Following the root cause analysis which is to be sent to NorthCare upon completion, Pathways will implement either a plan of action to prevent further occurrence of the sentinel event or presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement the action, when it will occur, and how implementation will be monitored or evaluated.

Sentinel event reviews and RCAs are a professional/peer review as well as quality assurance documents. They are protected from disclosure pursuant to the provisions of MCL 333.20175, MCL 333.21515, MCL 331.531, MCL 331.533, MCL.21513, MCL 330.1143a, and other State and Federal Laws. Unauthorized disclosure or duplication is absolutely prohibited.

2. *Critical Event Reporting*

Pathways reports the following events, except suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services.

- a. Suicide for any individual actively receiving services at the time of death, and any who have received an emergency service within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which suicide was determined. If 90 calendar days have elapsed without a determination of cause of death, the CMH must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
- b. Non-suicide deaths are to be reported for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children's Waiver services. If reporting is delayed because the CMH is attempting to determine whether the death was due to suicide, the submission is due

within 30 days after the end of the month in which the CMH determined the death was not due to suicide.

- c. Emergency Medical treatment due to Injury or Medication Error are to be reported for people who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services or Children's Waiver services.
- d. Hospitalization due to Injury or Medication Error are to be reported for individuals who living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child- Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.
- e. Arrest of Consumer for individuals who living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

3. *Immediately Reportable Event*

The CMHSP/MDCH contract requires that Pathways immediately notify NorthCare of the following events:

- a. Consumer death that occurs within 12 months of the individual's discharge for a state facility; or a death that occurs as a result of suspected staff member action or inaction. Pathways must notify NorthCare within 24 hours of the death or of receipt of notification of the death.
- b. Relocation of a consumer's placement due to licensing issues.
- c. An occurrence that requires the relocation of any CMHSP panel service site, governance, or administrative operation for more than 24 hours.
- d. The conviction of a CMHSP or panel provider staff member for any offense related to the performance of their job duties or responsibilities.

Except as otherwise instructed, Pathways will provide notification of these events telephonically or in writing within three (3) business days to NorthCare Network's Chief Executive Officer. NorthCare Network is required to report these events to MDCH within five (5) business days.

4. *Risk Events*

Risk Events are reported via the regional Incident Report Module as they occur. Pathways will analyze all event data that may put individuals at risk of harm and use this to ensure the health and welfare of those served by network providers. This analysis will be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional incidents.

5. *Unexpected Death Reporting*

All unexpected deaths of individuals, who at the time of their death, were receiving specialty supports and services, must be reviewed and reported to NorthCare Network.

6. *Monitoring of Events*

Pathways will analyze Incident Report data and take corrective action, as Applicable, to protect the health and welfare of all individuals served. This will be done through regular review and analysis of aggregate reporting to identify patterns and trends of risk factors at the individual consumer and AFC home provider entity level. When necessary, findings will be reported to the appropriate staff person and or department. Work groups will be established as needed to address specific issues concerning the health and welfare of individuals served.