3.08 OPERATING POLICY & PROCEDURE

Subject: **Consumer Death and Sentinel Event Reporting**		Application: **All Departments**
First Effective 10/01/98	Revised 5/23/16	Supersedes 11/19/13

PURPOSE

To define agency response to a sentinel event in order to improve care through prevention of, and response to, sentinel events. This policy is written in conjunction with Southwest Michigan Behavioral Health Policy 03.05 on Incident, Event and Death Reporting.

DEFINITIONS

Critical Incident:
An incident that meets the state reporting definitions listed: Suicide, Non-Suicide Death, Emergency Medical treatment due to Injury or Medication Error, Arrest of Consumer, or Injury as a result of physical management.

Sentinel Event:
An "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or functions, i.e. sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or life-style change. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response. (Reference - CARF Standards Manual Glossary)

Root Cause Analysis:
A process for identifying the most basic or causal factors of problems or events. By directing corrective measures at root causes, it is more probably that reoccurrence will be prevented, or at least reduced. Persons involved in a Root Cause Analysis must have the appropriate credentials to review the scope of care. For example, sentinel events that involve an individual's death or other serious medical conditions, must involve a physician or nurse.

POLICY

Pivotal will respond quickly and professionally to any reported death and sentinel event, consistent with CARF and the Michigan Mental Health Code. The response will be part of the quality improvement process and will always attempt to minimize the likelihood of reoccurrence of the event (or similar events).

PROCEDURE

1. All unusual and adverse events, including sentinel events, will continue to be reported through the Incident Reporting Process to the Office of Recipient Rights. Agency Operating Policy and Procedure 3.07 on Incident Reporting.
2. All client deaths must be reported immediately (verbally) to the appropriate supervisor and to the Office of Recipient Rights.
3. A Death report is to be completed with as much information as is available within 24 hours.
4. The agency designee will notify SWMBH of any death of a Medicaid beneficiary that is the subject of recipient rights, licensing, or police investigation electronically upon receipt of notification of the death, or upon notification that a recipient rights, licensing, or police investigation has commenced. The information to be included is:
   a. Beneficiary ID number (Medicaid, MI Health, MI Child)
   b. Consumer ID, if there is no beneficiary ID number
   c. Date, time and place of death (if a licensed foster care facility, include the license #)
   d. Preliminary cause of death
   e. Contact person's name and E-mail address
5. Within 10 days of the client death, staff will attempt to obtain any remaining information not completed on original **Report of Death Form** and forward to the Office of Recipient Rights unless autopsy or police investigation warrants an extension.
6. All client deaths will be reported to the Department of Health and Human Services by the SWMBH Quality Management Department.
7. Within **three days** of a critical incident, a determination will be made if it meets the sentinel event standard, if it does meet that standard a root cause analysis will start within **two days**
8. The Supervisor who is responsible for the client reported will coordinate the root cause analysis, in conjunction with the Clinical Director, which is to be completed within 45 days of the start of the root cause analysis, as stated above. Persons involved in the review of sentinel events will have the appropriate credentials to review the scope of care. The product of the root cause analysis is an action plan that identifies the strategies that the agency intends to implement to reduce the risk of similar events occurring in the future, or determines, after analysis, that no such improvement opportunities exist.
9. The Executive Director will be given the Corrective Action Plan of the responsible person(s) based on the findings and recommendations in root cause analysis. The corrective action plan will include time frames for implementation and evaluation of the effectiveness of the plan.
10. As follow-up to the root cause analysis, there will be documentation that action has been taken to correct the causes identified in the root cause analysis and that the corrective action plan has been implemented.

REFERENCES

- Michigan Mental Health Code

EXHIBIT

- 03.07C Recipient Death Report