

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES
POLICY AND PROCEDURE

SUBJECT: SENTINEL EVENTS

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APPROVAL: _____ Rosalyn Reynolds {s} _____, Agency Director

I. PURPOSE

The purpose of this policy is to identify Northern Nevada Adult Mental Health Services (NNAMHS) Sentinel Event review and intervention plan. This plan is designed to ensure maximum risk-prevention and loss-reduction activities on the part of the organization in response to a Sentinel Event. The occurrence of a Sentinel Event identifies an opportunity for improvement. A quality improvement/peer review process will be used to intensively assess the root cause of the event and opportunities for improvement.

II. POLICY

It is the policy of Northern Nevada Adult Mental Health Services (NNAMHS) that all potential Sentinel Events, as defined by the criteria in this policy, will be reported to the Agency Director or designee. Potential Sentinel Events will be investigated by an individual (or individuals) selected by the Agency Director or designee and a determination made if the event meets the criteria of a Sentinel Event.

III. REFERENCES

1. MHDS Policy 4.019 Performance Improvement: Review of Client Death
2. MHDS Policy 4.054 Sentinel Events
2. NRS 439.800-890 and NAC 439 Sentinel Event Registry at Bureau of Health Planning and Statistics, Division of Health

IV. DEFINITIONS

1. Sentinel Event: An unexpected occurrence involving facility-acquired infection, consumer death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, “the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
2. Division of Mental Health and Developmental Services (MHDS) reportable event: Any event which occurs on state property or in residential services with 24-hour awake staff and results in:
 - A. Death or unanticipated death, including suicide while hospitalized or within 48-hours of discharge.
 - B. Loss of limb or permanent loss of function
 - C. Sexual Assault (by another patient or staff member)
 - D. Paralysis, coma or other major permanent loss of function associated with a medication error or other treatment intervention
 - E. Any suicide of a consumer in a setting where the consumer is housed 24-hours daily, including suicides following elopement from such a setting or those within 48 hours of discharge from such a setting
 - F. Any elopement, i.e., unauthorized departure, of a consumer from a 24-hour care setting resulting in a related death (suicide or homicide) or major permanent loss of function

- G. Any procedure on the wrong patient that results in loss of the consumer's life or major permanent loss of function
 - H. Assault, homicide or other crime resulting in patient death or major permanent loss of function
 - I. Adverse outcomes that are directly related to the natural course of the consumer's illness or underlying condition are exempt from the reporting requirement.
3. Reporting requirements to outside entities: Some of the above events are reportable to the Joint Commission, the Nevada Bureau of Licensure and Certification and the Nevada State Sentinel Event Registry. Those reports are to be completed by the Agency Performance Improvement Coordinator and approved by the Agency Director , or designee, in accordance with the procedures of the agency receiving the report.

V. PROCEDURE

Notification Procedures

1. When any NNAMHS staff is aware of a Sentinel Event, as defined in this policy, they must notify their supervisor immediately, but no later than one hour of the event.
2. If NNAMHS staff is aware of any "near miss" that could have resulted in any of the above noted outcomes, they must notify their supervisor immediately, within one hour of the event.
3. The Supervisor must immediately, but no later than one hour after they were notified, notify the Agency Director/designee.
4. NNAMHS staff must complete a facility incident report before the end of their shift.
 - A. Included in the report is the immediate care rendered to the consumer contributing factors involved; the nature of any consumer injury
 - B. If equipment or a medical device was involved, the name, model number, and serial number for the device

- C. This report will be given to the Agency Director's Office no later than the next business day. The Performance Improvement Department will complete a division incident report in the AVATAR Incident Tracking system
 - D. Completion of the Incident Report should not delay consumer care.
5. The Agency Director is responsible for ensuring that the consumer (or their representative) is notified within seven days of the hospitals receiving notification of the event in accordance with NAC 439.
 6. The Performance Improvement Coordinator is responsible for reporting the event to the Nevada State Health Division, Sentinel Event Registry within 13 days of the hospital receiving notification of the event in accordance with NAC 439. The event is also to be reported to the Statewide Performance Improvement Director.

Agency Director/designee Responsibilities within the first 24 hours of the Event:

1. Ensure that NNAMHS is doing everything possible to provide follow-up care/services to ensure the best possible outcomes for injured parties and/or staff members.
2. Ensure that all parties to the event (i.e.: the consumer's physician, the consumer, family member, staff members, etc.) receive appropriate information to avoid miscommunications.
3. Appoint a spokesperson to provide updates to the consumer and/or the consumer's family as needed, using a designated spokesperson for consistency.
4. Whenever possible, the spokesperson will be a staff member familiar to the consumer and family.
5. Inform the appropriate members of the facility Leadership so they can consistently provide information to the appropriate parties.
6. Follow any immediate regulatory reporting requirements, e.g., the Occupational Safety and Health Administration (OSHA) in the case of any employee death.
7. Review policy to determine if the event fits the definition of a reportable Sentinel Event.
8. Consult with the Deputy Attorney General and other resources as needed.

9. Obtain, sequester or preserve appropriate evidence or cause someone to do so.
10. Instruct the Agency Director of Information Management to sequester the medical record and any other evidence (i.e.: photographs of the location of the injury or the equipment that malfunctioned).
11. Gather detailed information about the event or appoint someone to do so.
12. Remind staff of the confidentiality surrounding the event and the consumer.
13. Initiate availability of Critical Incident Stress Management (CISM) (debriefing for staff in need).

Investigation

1. Sentinel Events will be investigated by a duly appointed team, using the - Mental Health and Developmental Services Division review process and the Joint Commission Root Cause Analysis Model.
2. Upon notification of the event, the initiation of the Sentinel Event intervention is the responsibility of the Agency Director/designee, who has the authority to implement any of the following procedures applicable to the nature of the event.
3. The Agency Director/designee will appoint a sentinel event team including:
 - A. Facilitator
 - B. Staff who were involved with the care of the consumer
 - C. Representative(s) of the Leadership Team
4. Due to the unpredictable nature of a Sentinel Event, members of the Sentinel Event team (and their supervisor) must understand that these meetings take priority over usual business.

Sentinel Event Team Responsibilities

1. Within one week of the event the sentinel event team will:
 - A. Meet as necessary, and interview those staff involved with and/or familiar with the event
 - B. Obtain written statements to gather an accurate description of the sequence of events

- C. Determine root cause(s) of the event, including an analysis of all processes and systems related to its occurrence. Involve all appropriate staff in this analysis. Sentinel Event Facilitator should review the Joint Commission framework for conducting a root-cause analysis as a guideline for discussion.
 - D. Examples may include a change or revision in communication, forms, training, equipment, policies, and procedures. If no potential system improvements exist, indicate the analysis with the determination that no such opportunity exists.
 - E. If a piece of equipment is involved in the incident, the Sentinel Event Team, through the NNAMHS Safety Officer, will submit the appropriate forms to the Food and Drug Administration and manufacturer within 10 (ten) days of the incident. The team will preserve the equipment in its last-used state and have a qualified vendor review the equipment.
 - F. The Sentinel Event report will be sent to the Agency Director for review at the conclusion of the committee's meetings.
2. The Agency Director will present an overview of the root cause analysis to the Leadership Committee for discussion and prioritization of action.
- A. The Agency Director will establish a plan to address identified opportunities for improvement or formulation of a rationale for not undertaking such changes. Indicate time frame, person responsible, and criteria to evaluate effectiveness of the actions.
 - B. The Agency Director will establish a plan to follow up on the final recommendations.
3. The Sentinel Event will be filed and secured in the Performance Improvement Office when the Agency Director has completed review of the report.
- A. Requesting closure of the incident at an MHDS level is requested through the AVATAR incident tracking system.