Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Quality Improvement Other 06.03.02 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	_Signature on File__	__4/27/2023____

SUBJECT: Sentinel Events Review Committee

PURPOSE:

To establish a Sentinel Events review committee and process within Mental Health and Recovery Services (MHRS) that addresses quality improvement and clinical care occurrences for the purpose of improving the delivery of healthcare services.

POLICY:

MHRS will develop a Sentinel Event Review Committee that will assess and investigate sentinel events to:

I. Inform Quality Improvement efforts across MHRS.
II. Review and evaluate the adequacy, appropriateness, and effectiveness of the services provided to all beneficiaries/clients receiving mental health and substance use disorder services.
III. Identify possible system barriers that could be associated with the sentinel event.
IV. Identify staff, supervisory, or administrative issues needing to be addressed for quality improvement.
V. Prepare and submit a summary with recommendations to the Chief of MHRS for review. The recommendations will include any corrective or supportive actions, if necessary.

SCOPE:

This policy applies to active beneficiaries/clients receiving mental health and substance use disorder services in MHRS County and County contracted clinics who have been involved in situations or circumstances considered to be sentinel events.

REFERENCES:

Business and Professions Code – BPC Division 2, Healing Arts §§500 - 4999.129; Chapter 1. General Provisions [500 - 865.2] (Division 2 enacted by Stats. 1937, Ch. 399.). Chapter 1. General Provisions [500 - 865.2] (Chapter 1 enacted by Stats. 1937, Ch. 399)

Evidence Code – Evid. Division 9. Evidence Affected or Excluded By Extrinsic Policies [1100 – 1162]. (Division 9 enacted by Stats. 1965, Ch. 299)
MHRS P&P 06.01.01 Reporting of Unusual Occurrences to Department of Health Care Services

HCA P&P IV-1.03 Special Incident Report

HCA P&P IV-1.04 Reporting the Deaths of Agency Staff Members, Clients and Other Persons

DEFINITIONS:

Sentinel event - An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Such events are called "sentinel" because they signal the need for immediate investigation and response. Sentinel events *prompt a systemic review.* Examples of sentinel events include: beneficiaries/clients deaths; Suspected suicide; Suspected overdose; Sexual assaults in supervised settings (specify if beneficiaries/clients is alleged victim or alleged perpetrator); Serious physical assaults in supervised settings (specify if beneficiary/client is alleged victim or alleged perpetrator); beneficiaries/clients behavior causing serious damage to a treatment facility.

Trigger event - Is less serious and does not necessarily require *systemic* review and root cause analysis. It prompts a clinical case conference involving the treatment team as well as the beneficiary/client and significant others. This process would reexamine and refocus the service plan. Examples of trigger events would be: Significant self-injurious acts; Episodes of domestic violence or abuse involving children, dependent adults, or older adults; Repeated psychiatric hospitalization, crisis visits or incarcerations; Established beneficiary/client with a sudden severe psychosocial stressor; Medication related adverse events (reversible, no sequela).

Sentinel Event Flagging: the process of identifying an event that meets the definition and parameters of a sentinel event and prompt a systemic review by the Sentinel Event Review Committee

Sentinel Event Review - The process of reviewing a sentinel event. This includes gathering and studying information from all relevant sources. The focus of review is to identify potential opportunities for quality improvement.

Sentinel Event Review Committee - The Sentinel Event Review Committee is a group of behavioral health professionals designated by the Chief of MHRS that includes the Medical Director, Function Area Directors, and Director of Operations. . Upon request, the committee may ask any involved Associate Medical Directors, Function Area Managers, Service Chiefs, and direct service providers to participate in committee meetings.

PROCEDURE:

I. Sentinel Event Review Committee

A. Tasked with the process of reviewing selected sentinel events and preparing a summary for review by the Chief of MHRS.

B. Acts as a peer review body, as defined in Business and Professions Code (BPC) § 805.

C. The materials, records, and statements produced by Sentinel Event Review Committee are protected from discovery under Evidence Code (EC) §1157.

II. Sentinel Event Parameters

A. The Sentinel Event Review Committee will select and review sentinel events that meet the following parameters

1. The event occurred within the past twelve (12) months; AND,

2. Beneficiary/client received clinical services within MHRS within the past twelve (12) months; OR

3. Requested directly by the Chief of MHRS or by the Medical Director.

III. Sentinel Event Review Process

A. The Function Area Directors will screen Special Incident Reports (SIR) for the purpose of flagging (identifying) cases that meet the definition and parameters of a sentinel event. The Function are director will notify the Medical director of the case (s) in need for review by the Committee.

B. The Medical Director will request the necessary materials and coordinate a date for a Sentinel Event Review committee meeting. If there is a question on whether a case meets the definition and parameters of a sentinel event, the Function Area Director can consult with the Medical director prior to submitting the case for review.

C. Committee members will review Chart records/Electronic Health Records (EHR), SIRs, Coroner's report (if applicable and convene for discussion at a Sentinel Event Review Committee meeting.

D. During the Sentinel Event Review Committee meeting, the Medical Director or designated Associate Medical Director will provide a brief introduction of the purpose of the meeting and present the case and findings.

E. Once the case is presented, committee members will be able to ask questions, deliberate on the circumstances of the event, and propose action items.

F. At the conclusion of the Sentinel Event Review Committee meeting:

1. All materials produced during the review proceedings will be returned and stored in a centralized, designated, and locked location (hereby called the Sentinel Event Review Committee - secured location)

2. The event will be logged in a secured database and will be stored and only accessed by the Chief of MHRS or designee.

G. The Medical Director will prepare a summary of the case with committee recommendations for quality improvement and submit to the Chief of MHRS and Director of Operations for review.

H. Sentinel Event Review does not replace the Special Incident Report (SIR) (HCA P&P IV-1.03 Special Incident Report), MHRS P&P 06.01.01 Reporting of Unusual Occurrences to Department of Health Care Services requirements or any other required notifications or processes. This is strictly a Quality Improvement Activity.