# Monterey County Behavioral Health
# Policy and Procedure

| | |
|---|---|
| **Policy Number** | 146 |
| **Policy Title** | Sentinel Events |
| **References** | California Evidence Code 1040<br>California Evidence Code 1157<br>California Evidence Code 1157.5<br>California Evidence Code 1157.7 |
| **Form** | None |
| **Effective** | January 22, 2015 |

## Background

Generally, a sentinel event is an unexpected occurrence involving a client's death or serious physical or psychological injury, or the risk thereof. Monterey County Behavioral Health (MCBH) specifically defines sentinel events as:

1. A client's unanticipated death or permanent loss of function resulting from such causes including, but not limited to, a medication error or a delay or failure to provide services.
    a. Any and all client deaths or serious injuries occurring within an MCBH or contracted facility will undergo a sentinel event review.
2. Neglect as a result of the failure to provide a client the services necessary to avoid physical or psychological injury that seriously jeopardizes a client's health.
3. Homicide or suicide involving a client.
4. Sexual assault or rape of a client, especially in an MCBH or contract facility.
5. Abuse of a client inflicted by MCBH or contract staff resulting in physical harm or mental anguish that jeopardizes a person's health.
6. High profile events involving MCBH clients which may involve media coverage and/or police involvement.

Examples of sentinel events include, but are not limited to, suicides; serious suicide attempts; extremely unusual medical, clinical, or administrative incidents or incidents outside the standard of care; or acts of violence by or against a client.

The purpose of the sentinel event reviews is to evaluate the quality of care provided to MCBH clients and to develop plans of improvement for MCBH's quality of care, if necessary.

For the purpose of this specific policy, a client is considered to be anyone currently receiving care or services or who has received care or services in the last 12 months from MCBH or its contracted providers.

**Policy**

All MCBH programs and contractors are required to report sentinel events in compliance with MCBH unusual incident reporting policy (see Policy 123 – Unusual Incident Reporting).

MCBH Quality Improvement (QI) will conduct a review of the client's health records to track and assess services provided to a client involved in a sentinel event. MCBH QI may also directly interview staff involved in the sentinel event and also obtain a police report, coroner's report, or other reports concerning the client and the sentinel event. Additionally, MCBH QI may convene a Collaborative Case Conference to obtain further information about the sentinel event. Monterey County Counsel assigned to MCBH will be informed and will be involved in the review process as necessary. MCBH QI will also assess the appropriateness of presenting the event to the Health Department Safety Committee for further review.

All records directly related to this policy are covered by the confidential quality improvement process and are subject to quality improvement confidentiality (see California Evidence Code 1040, 1157, 1157.5, and 1157.7).

The filing of the MCBH Unusual or Incident Report as part of this sentinel event policy does not exempt any provider, entities, individuals, and programs from the necessary and or legal requirements to file other legally mandated reports including those required by the state or federal government; to complete their own internal QA/QI processes; or to file an incident report with their specific human resources/risk management departments if required.