

**Arizona Department of Health Services  
Division of Behavioral Health Services  
PROVIDER MANUAL  
NARBHA Edition**

**Section 10.7 Sentinel Events**

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**10.7.1 Introduction**

It is the expectation of NARBHA that providers have a process in place to identify, report, and review all Sentinel Events: 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 the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. NARBHA defines the following occurrences as “Sentinel Events”:

- Completed suicide by any NARBHA member
- Medication errors resulting in serious physical injury or death.
- Seclusion/Restraint resulting in serious physical injury or death.
- Elopements resulting in serious physical injury or death.

Confirmed cases of assaults, rapes, homicides (as determined by the Judicial System) occurring while the member is under the direct supervision of a provider.

**10.7.3 Scope**

**To whom does this apply?**

All NARBHA contracted SAAs and TAAs.

**10.7.4 Objectives**

To define the expectations and timeframes for the Sentinel Event review process

**10.7.5 Procedures**

Each NARBHA provider has a process in place which enables them to identify when one of the above events occur and a detailed process regarding their investigation of the sentinel event (i.e., who identifies the sentinel event, who initiates the investigation, who should be on the team, what data has to be acquired, who should do it and how, etc.)

Each NARBHA provider faxes written notification of the event’s occurrence through the Critical Incident Report process within 24hours hours via [PM Form 7.4.1](#). This does not preclude the submission of the Critical Incident Report Form to the required agencies. (For out-of-area providers, only sentinel events involving a NARBHA member are faxed to NARBHA)

The provider investigates each Sentinel Event and develops an investigative report. Depending on the event NARBHA may request to participate on the review team with the provider or the provider may request that NARBHA participate. The investigation includes a root cause analysis which addresses the following:

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- A determination of the proximate causes of the event. These may include human and other factors most directly associated with the sentinel event and the process(es) and systems related to its occurrence.
- Analysis of the underlying systems and processes through a series of “Why?” questions to determine where system redesign might reduce risk. (see attachment A and B).
- Identification of risk points and their potential contributions to this type of event.
- A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist.
- Establishment of a plan to address identified opportunities for improvement or formulation of a rationale for not undertaking such changes.
- Where improvement actions are planned, identification of who is responsible for implementation, when the action will be implemented, including any pilot testing and how the effectiveness of the actions are evaluated.
- Include participation by the leadership of the organization and by the individuals most closely involved in the processes and systems under review.
- Be internally consistent.
- Include consideration of any relevant literature.

Triggers for increased NARBHA interventions/participation in the investigative report may include:

- Lack of a clear plan.
- Focus of investigation on individual issues rather than a systems approach.
- Providers first time completing a sentinel event investigation.
- Provider history of incomplete reports.
- Noted trends of sentinel events or series of critical incidents.
- Any seclusion/restraint sentinel event.
- Any sentinel event occurring within the provider facility.

If it has been determined that NARBHA is not going to participate in the review, the NARBHA Performance Improvement Manager (or designee) contacts the provider QM contact person within five (5) working days regarding the status of the investigation and continues to monitor the provider’s progress through contacts with the provider to ensure that the above process is being adequately implemented.

Each Sentinel Event investigative report is submitted to the NARBHA Performance Improvement Manager within 35 days of the incident. In the event that the cause of death has not been determined when the critical incident report has been submitted the Root Cause Analysis is due 35 days from the date the provider receives the Medical Examiners Report. The Sentinel Event Report includes:

- Description of who participated in the Sentinel Event Root Cause Analysis- names, titles, and why they were involved (this includes participation by the leadership of the organization).

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- A summary of findings (proximate causes and processes/systems associated with the event). At a minimum providers are required to address all system issues (see attachment A and B) in their Root Cause Analysis.
- List of improvement activities identified (including who is responsible for implementation of the improvement activity and when the activity is to be implemented).
- Description of how the effectiveness of the improvement activities will be measured/evaluated.

NARBHA Mortality and Morbidity Committee reviews the report and determines if further action is required by the SAA/TAAAs.

The provider responds to NARBHA's questions /comments /recommendations by the requested due date.