	Sentinel Event Procedures			
	Chapter:	Board Services and Program Administration	**Policy #**	2-6-6
	Section:	Service Coordination	**Revision #**	2

I. **PURPOSE:** To establish policy and procedures for reporting and ensuring appropriate follow-up for sentinel events

II. **APPLICATION:** All programs and services operated by West Michigan Community Mental Health Governing Body, and all contracted service providers of West Michigan Community Mental Health.

III. **REQUIRED BY:** Michigan Department of Health and Human Services contract, accrediting bodies, and PIHP.

IV. **DEFINITIONS:**

1. Peer Review: A process in which mental health professionals evaluate the clinical competence, quality and appropriateness of care/services provided to the individuals served by WMCMH. The review may focus on an individual event or aggregate data and information on clinical practices. These processes are confidential in accordance with section 748(9) of the Mental Health Code Act 258 of 1974 and are based on criteria established by the facility or community mental health services program itself, the accepted standards of the mental health professions and the Michigan Department of Health and Human Services.

2. Root Cause Analysis (RCA): A process for identifying the most basic or causal factor or factors that underlay the occurrence of a sentinel event.

3. Sentinel Event: A sentinel event is an unexpected occurrence involving death (not due to the natural course of a health condition) or serious physical harm or emotional harm, or the risk thereof to an individual served. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. Per the MDHHS contract with the PIHP, for SUD services, only sentinel events occurring at Residential Service Programs are required to be reported.

4. Serious Physical Harm: Physical damage suffered by an individual served that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient. [MCL 330.7001 (r)]

5. Emotional Harm: Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology and as determined by a mental health professional. [MCL 330.7001 (g)]

V. **POLICY:** It is the policy of West Michigan Community Mental Health to assess the cause of sentinel events in order to determine how they can be avoided in the future. WMCMH will report all sentinel events to the PIHP, MDHHS and/or accrediting bodies as required.

VI. **PROCEDURES:**

1. A West Michigan Community Mental Health employee, volunteer, or agent of a

provider will complete a death report when he/she receives notice of a consumer death as detailed in Chapter 5, Section 2, Subject 9 of the Administrative Manual and submit it to Clinical Clerical Support to be filed in the clinical record and to the Recipient Rights Officer.

2. A West Michigan Community Mental Health employee, volunteer, or agent of a provider who encounters any circumstance involving an unexpected occurrence of death serious physical harm or emotional harm, or the risk thereof to an individual served will complete a Critical Incident Report in keeping with the WMCMH Critical Incident Reporting Policy and Procedures (see policy 2-12-8) and submit it to the Quality Assurance Specialist (QA).

3. The Recipient Rights Officer and/or the QA will be responsible for notifying and providing documentation to the Director of Network, Quality Improvement, and Compliance within 24-hours of being made aware of the possible sentinel event.

4. The Director of Network, Quality Improvement, and Compliance will ensure Senior Management is aware of the potential Sentinel Event within 24-hours of being made aware of the incident.

5. The Director of Network, Quality Improvement, and Compliance will facilitate determination if the sentinel event meets criteria for reporting to the PIHP, MDHHS and/or accrediting bodies and will make said report available within required timeframes:
   - PIHP – Initial notification of the event to PIHP CEO, or designee, as soon as WMCMH has become aware of the event and a summary of root cause analysis findings within 48 hours of completion of the RCA.
   - CARF – Written notification within 30 days if the event occurred in an accredited program.
   - MDHHS – For deaths, immediate notification to MDHHS Contract Manager.

6. In the event there may be a direct relationship between our service delivery and the sentinel event, the organization will attempt to obtain releases of information, police reports, death reports, autopsy results etc., for use in conducting a root cause analysis.

7. If it is unclear whether an event meets criteria for conducting a root cause analysis, the Director of Adult Services and Director of Network, Quality Improvement, and Compliance will jointly determine if a special case review or a root cause analysis is the most appropriate form of review.

8. The Director of Network, Quality Improvement, and Compliance will then take responsibility for organizing a root cause analysis of the event. The Director of Network, Quality Improvement, and Compliance has three (3) business days after an incident has occurred/or after we have been notified of the incident to determine if it is a sentinel event. If classified as a sentinel event, a root cause analysis will commence within two (2) business days.

9. The root cause analysis will take place through the Clinical Oversight Committee (COC) or an appointed subcommittee of appropriately credentialed individuals. The Continuous Quality Improvement Coordinator will facilitate the completion of the RCA, and at a minimum, participation in the root cause analysis will include staff with first-hand knowledge of the event, Recipient Rights Officer, the primary case holder, the Medical Director, as appropriate, and the relevant Coordinator. If the sentinel event involved death or other serious medical conditions, the root cause analysis must involve a physician or nurse. A completed written summary of the root cause analysis will be submitted to the Clinical Oversight Committee for review prior to submission to the accrediting body, PIHP and/or MDHHS. This will occur within 45 days of becoming aware of the sentinel event. Any identified recommendations for organizational improvement and/or systemic issues identified will be forwarded to the COC and potentially the Quality Improvement Steering Committee (QISCC) for discussion and recommended action. As a standing member of the COC, the Medical Director will be involved in the review of all Sentinel Events and Root Cause Analyses.

10. Even if an event is identified that does not meet reporting criteria for MDHHS, PIHP or accrediting body review, thorough analysis be conducted, as requested by COC, Senior Management, or the Office of Recipient Rights. At that time, the COC will conduct a timely and thorough special case review.

11. WMCMH declares sentinel event reports and/or root cause analysis reports as peer review functions.

    In accordance with the Michigan Mental Health Code 330.1143a, the Administrative Rules R.330.7046, Public Health Code Act 368 of 1968, Section 333.20175 and 333.21515, all records and information obtained during Peer Review functions are confidential and shall be used only for the purposes of reviewing the quality and appropriateness of care for improved practices. All documents created during and as a result of Peer Review functions shall not be public record or available through the Freedom of Information Act (FOIA) and are not subject to Court subpoena. Reports or forms completed as part of a peer review process shall be kept as peer review documents and shall not be kept as part of the recipient's clinical record.

12. The WMCMH Quality Improvement Steering Committee (QISC) will conduct a semi-annual review of the data on the frequency of sentinel events. Additionally, implementation of improvements based upon findings from special case review or root cause analysis will be monitored and measured for effectiveness by the COC and QISC.

VII. SUPPORTING DOCUMENTS:

See:
CIR Policy 2-12-8
Death Reporting Policy 5-2-9

VIII. **POLICY/PROCEDURE REVIEW:**

REV#	APPROVED BY	Policy/Procedure	DATE
			07/2012
			11/2014
			02/2015
			11/2015
			11/2016
			03/2018
			06/2019
2	COC	Procedure	06/2021
***Board Approval Date**: 07/20/1999*			

IX. **CHIEF EXECUTIVE OFFICER ENDORSEMENT:**

I have reviewed and approved of policy # 2-6-6 Revision # 2.

CEO: Lisa A. Williams Approval Signature:_____