	Sentinel Event Procedures		
Chapter:	Board Services and Program Administration	**Policy #**	2-6-6
Section:	Service Coordination	**Revision #**	5

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 the PIHP.

IV. **DEFINITIONS:**

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)]

Peer Review: A process in which mental health professionals evaluate the clinical competence of staff, and the 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.

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.

Root Cause Analysis (RCA): A process for identifying the basic or causal factors that underlies variation in performance, including the occurrence, or possible occurrence, of a Sentinel Event.

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.

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)]

Unexpected Death: Deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

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 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 (QA) Specialist.

2. The WMCMH case holder will complete a death report when he/she receives notice of a consumer death as detailed in policy 5-2-9. Using the "send to" feature in R3, the WMCMH staff person writing the death report will "send a copy" of the death report to Recipient Rights Officer.

3. The QA Specialist will immediately notify and provide documentation of a possible sentinel event to the Chief Operations Officer and Director of Network, QI, and Compliance.

4. The Chief Operations Officer 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, QI, and Compliance will facilitate determining if an event meets criteria for reporting to the PIHP, MDHHS and/or accrediting bodies and will ensure a report is made within the following timeframes:
   - To the PIHP: Initial notification of the event to PIHP CEO, or designee, within 24 hours of WMCMH becoming aware of the event.
   - To CARF: Written notification within 30 days if the event occurred in an accredited program.

6. In cooperation with the Chief Clinical Officer and Chief Operations Officer, the Director of Network, QI, and Compliance will determine whether an incident is a sentinel event within three (3) business days of WMCMH being notified of the event.

7. All sentinel events and unexpected deaths will be reviewed via a root cause analysis (RCA). The Director of Network, QI, and Compliance will commence an RCA within two (2) business days of the sentinel event determination.

8. In the event of a suspected direct relationship between WMCMH's 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 RCA.

9. The RCA will take place through the Clinical Oversight Committee (COC) or an appointed subcommittee of appropriately credentialed individuals. The Director of Network, QI, and Compliance or the COC Chair will facilitate the completion of the RCA.

10. At minimum, the RCA will include appropriately credentialed staff to review the scope of care and, for incidents involving death or serious medical conditions, a physician or a nurse. As a standing member of the COC, the Medical Director will be involved in the review of all Sentinel Events and RCAs.

11. A completed written summary of the RCA will be submitted to the COC 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.

12. Any identified recommendations for organizational improvement and/or systemic issues identified will be forwarded to the COC and potentially the Quality Improvement Steering Committee (QISC) for discussion and recommended action.

13. Events determined to not be sentinel events or reportable to the PIHP, MDHHS, or accrediting body may be recommended for analysis by COC, Senior Management, or the Office of Recipient Rights. If recommended, the COC and/or the Director of Network, QI, and Compliance will conduct a timely and thorough root cause analysis or special case review.

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

15. The WMCMH Quality Improvement Steering Committee (QISC) will conduct a semi-annual review of sentinel event data. Additionally, implementation of improvements based upon findings from special case review or RCA will be monitored and measured for effectiveness by the COC and, if appropriate, the 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
3	COC	Procedure	03/2022
4	COC	Procedure	03/2023
5	COC	Procedure	03/2024
6	COC	Minor Language	
***Board Approval Date**: 07/20/1999*			

IX. **CHIEF EXECUTIVE OFFICER ENDORSEMENT:**

I have reviewed and approved of policy # 2-6-6 Revision # 5.

CEO: Lisa A. Williams Approval Signature:_____