PROCEDURE # 7.3b		EFFECTIVE DATE	REVISED DATE
TITLE:	SENTINEL EVENTS	1/1/2015	9/9/2022
ATTACHMENT TO		REVIEW DATES	
POLICY #:	7.3	9/9/2022	
POLICY TITLE:	CRITICAL INCIDENT, SENTINEL EVENT, AND RISK EVENT REPORTING		
CHAPTER:	QUALITY IMPROVEMENT		

I. PURPOSE

Each LRE Member Community Mental Health Service Programs (CMHSPs) shall develop and implement a Critical Incident, Sentinel Event, and Risk Event Reporting policy and procedure consistent with Lakeshore Regional Entity (LRE) Policy 7.3: Critical Incident, Sentinel Event, and Risk Event Reporting and the Michigan Department of Health and Human Services (MDHHS) Medicaid Managed Support and Services Contract.

LRE delegates responsibility for initial identification, investigation and follow up of Critical Incidents, Sentinel Events, and Risk Events to its Member Community Mental Health Service Programs (CMHSP), with oversight and monitoring by the LRE. Member CMHSPs are responsible to report data to the LRE within the established time frames.

II. PROCEDURES

A sentinel event is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1988). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

A. CMHSP SENTINEL EVENT REPORTING

1. CMHSP staff will notify the LRE of a possible Sentinel Event within 24 hours of the occurrence or of knowledge of the occurrence.
2. Notification will be completed by sending a secure email to CIRE@lsre.org. The email should include the following:
   a. Date of incident
   b. Name and case number of individual
   c. Brief description of the incident

   If CMHSP prefers the Unexpected Death/Sentinel Event Form can be used and emailed. For this notification only complete the needed fields to inform LRE that a possible Sentinel Event has occurred.

3. All members have three (3) business days after a critical incident has occurred or three (3) business days of learning of the incident to determine if it is a Sentinel Event.
4. If the member classifies the critical incident as a Sentinel Event, the Member has two (2) subsequent business days to commence a Root Cause Analysis of the event.
5. Member CMHSPs shall complete the Root Cause Analysis within 45 days.
6. Member CMHSPs shall have the appropriately credentialed staff to review the scope of care when conducting a Root Cause Analysis.
7. Sentinel Events that involve a consumer death, or other serious medical conditions, must involve a physician or nurse. Within forty-eight (48) hours of the completion of the investigation, the Member shall forward a copy of the completed LRE Unexpected Death / Sentinel Event Report Form which includes a summary of the event and measures taken to prevent future occurrences of the event to the LRE Chief Quality Officer.
8. All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving Medicaid funded specialty supports and services, must be reviewed and must include:
    a. Screens of individual deaths with standard information (e.g., coroner's report, death certificate).
    b. Involvement of medical personnel in the mortality reviews.
    c. Documentation of mortality review process, findings, and recommendations.
    d. Use of mortality information to address quality of care.
9. Aggregation of mortality data over time to identify possible trends. All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving Medicaid funded specialty supports and services, must be reviewed and must include:
    a. Screens of individual deaths with standard information (e.g., coroner's report, death certificate.
    b. Involvement of medical personnel in the mortality reviews.
    c. Documentation of the mortality review process, findings, and recommendations.
    d. Use of mortality information to address quality of care.
    e. Aggregation of mortality data over time to identify possible trends.
10. Based on the outcome of the analysis or investigation, the Member CMHSP must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the Member CMHSP may prepare a rationale for not pursuing a preventive plan.
11. The LRE will immediately notify MDHHS of any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a

recipient rights, licensing, or police investigation. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a recipient rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:

a. Name of beneficiary
b. Beneficiary ID number (Medicaid, ABW, MIChild)
c. Consumer ID (CONID) if there is no beneficiary ID number
d. Date, time and place of death (if licensed foster care facility, include the license #)
e. Preliminary cause of death
f. Contact person's name and email address

III. CHANGE LOG

Date of Change	Description of Change	Responsible Party
9/22/22	NEW Procedure – removed from policy	CEO or Designee