INSTRUCTIONS: SENTINEL EVENTS DATA REPORT

Deliver this report electronically, by the due date, to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov.

Six-Month Reporting Period	Due Date for Data Submission
October 1 through March 31	April 30
April 1 through September 30	October 31

I. REQUIREMENT

The Michigan Department of Health and Human Services requires PIHPs to report, review, investigate, and act upon sentinel events for persons living in 24-hour specialized settings and those living in their own homes receiving ongoing and continued personal care services.

II. DEFINITIONS

A. Incident is any of the following which should be reviewed to determine whether it meets the criteria for sentinel event in B. below.

- death of a recipient
- serious illness requiring admission to hospital
- alleged cause of abuse or neglect
- accident resulting in injury to recipient requiring emergency room visit or hospital admission
- behavioral episode
- arrest and/or conviction
- medication error

B. Sentinel Event is 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 risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." (JCAHO, 1998)

C. 24-hour Specialized Setting means substance abuse residential treatment programs.

II. DEFINITIONS – continued

D. Own Home for purposes of sentinel event reporting means **supported independence program** for persons with mental illness or developmental disabilities regardless of who holds the deed, lease, or rental agreement; as well as **own home or apartment** for which the consumer has a deed, lease, or rental agreement in his/her own name. Own home does not mean a family's home in which the child or adult is living.

E. Ongoing and continuous in-home assistance means assistance with activities of daily living provided in the person's own home at least once a week, and six months or longer.

F. Death: that which is not by natural cause or does **not** occur as a natural outcome to a chronic condition (e.g. terminal illness) or old age.

G. Accidents resulting in injuries that result in death or loss of limb or function and which required visits to emergency rooms, rnedi-centers and urgent care clinics/centers and/or admissions to hospital should be included in the reporting. In many communities where hospitals do not exist, medi-centers and urgent care clinics/centers are used in place of hospital emergency rooms.

H. Physical illness resulting in admission to a hospital does **not** include planned surgeries, whether inpatient or outpatient. It also does **not** include admissions directly related to the natural course of the person's chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.

I. Serious challenging behaviors are those not already addressed in a treatment plan and include significant (in excess of $ 100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence that result in death or loss of limb or function to the individual or risk thereof. All unauthorized leaves from residential treatment are not sentinel events in every instance) Serious physical harm is defined by the Administrative Rules for Mental Health (330.7001) as "physical damage suffered by a recipient 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."

J. Medication errors mean a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage which resulted in death or loss of limb or function or the risk thereof. It does not include instances in which consumers have refused medication.

III. APPLICATION

All incidents should be reviewed to determine if the incidents meet the criteria and definitions (in II. above) for sentinel events and if they are related to practice of care. The outcome of this review is a classification of incidents as either a) sentinel events, or b) non-sentinel events.

An "appropriate response" to a sentinel event "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements." (JCAHO, 1998) A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

Following completion of a root cause analysis or investigation, a PIHP must develop and implement either a) a plan of action (JCAHO) or intervention (per CMS approval and MDHHS contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when, and how implementation will be monitored or evaluated.

IV. MDHHS MANAGEMENT OF SENTINEL EVENT REPORTING

Data collection: PIHPs will submit semiannually aggregate data by event category for number of sentinel events and plans of action or interventions which occurred during the 6-month period. As with all performance indicators, MDHHS will review performance, with potential follow-up by program or contract managers to determine what quality improvement action is taking place; and/or to develop performance objectives aimed at reducing the risk of sentinel events occurring; and/or to impose other sanctions.