COMMUNITY MENTAL HEALTH AUTHORITY CLINTON-EATON-INGHAM	POLICY: 1.1.14	REVIEWED	
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SUBJECT: Sentinel Events SCOPE: All CMH Programs	ISSUED BY: Director of Quality Customer Service and Recipient Rights		
	APPROVED BY: Board of Directors		
	Effective 9/27/98	Revised 06/23/05	

I. Purpose:

To establish organizational compliance with the policies of the Michigan Department of Community Health (MDCH), the federal Centers for Medicare and Medicaid Services (CMS) and all applicable accrediting bodies.

II. Policy:

It is the policy of the Board to report all sentinel events to the Michigan Department of Community Health (MDCH), the federal Centers for Medicare and Medicaid Services (CMS) and all applicable accrediting bodies within five (5) business days of occurrence (or within five days of learning of its occurrence).

III. Definitions:

For the purposes of understanding and implementing this policy, the following definitions of terms apply:

Sentinel Event: An unexpected occurrence or variation involving the death or serious physical or psychological injury-or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "of the risk thereof" includes any process variation for which a reoccurrence would carry a significant chance of a serious adverse outcome.

Reportable Sentinel Events:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The suicide of a patient/recipient in a setting where the patient/recipient receives around-the-clock care (e.g., hospital, residential treatment center, crisis stabilization center).
- Rape of a patient/recipient in a setting where the patient/recipient receives around-the-clock care.

Root Cause: The most fundamental reason for the failure or inefficiency of a process.

Root Cause Analysis: A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

IV. Responsibilities:

A. The Executive Director/designee is responsible for ensuring that procedures are in place to implement the intent of this policy.

B. The Executive Director/designee is also responsible for reporting within required time frames to accreditation organizations and regulatory bodies as required.

C. The Medical Director is responsible to ensure completion of the Root Cause Analysis within required time frames, and submission of the report to the Executive Director, the Board of Directors and the required regulatory bodies.

V. Monitoring and Review:

This policy is reviewed annually by the Director of Quality Customer Service and Recipient Rights. It is monitored internally through the Office of Recipient Rights and Quality Improvement, and externally by Michigan Department of Community Health (MDCH), the federal Centers for Medicare and Medicaid Services (CMS) and all applicable accrediting bodies.