The Right Door for Hope, Recovery and Wellness

Chapter Title Clinical	Chapter # C		Subject # 392.1
Subject Title **Sentinel Event Review Process**	Adopted 05/13/02	Last Revised 12/20/21	Reviewed 4/14/10; 05/16/06; 04/16/06; 11/29/05; 04/08/05; 1/13/14; 3/9/17; 8/23/19; 6/30/2020; 12/20/21; 12/2/22; 11/16/23

PROCEDURE

Application

This procedure shall apply to staff and contractual providers (if applicable) of The Right Door for Hope, Recovery and Wellness.

1.0 Purpose

The purpose of this procedure is to establish a process for reviewing and responding to identified sentinel events as required by the Michigan Department of Health and Human Services and the Commission on Accreditation of Rehabilitation Facilities (CARF).

2.0 Definition of Sentinel Event

2.1 An unexpected occurrence within a CARF-accredited program involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response.

3.0 Sentinel Event Review Process and Reporting

3.1 Upon suspicion of a Sentinel Event, the staff member shall notify his or her Supervisor/Program Manager immediately and complete an Incident Report form.

3.2 The Program Manager or Supervisor shall notify the CEO, Recipient Rights and Sentinel Event Chair immediately.

3.3 If the event meets the definition of a sentinel event, the CEO or Sentinel Event Chair shall convene a team to review the sentinel event. If a conflict-

Chapter Title Clinical	Chapter # C		Subject # 392.1
Subject Title **Sentinel Event Review Process**	Adopted 05/13/02	Last Revised 12/20/21	Reviewed 4/14/10; 05/16/06; 04/16/06; 11/29/05; 04/08/05; 1/13/14; 3/9/17; 8/23/19; 6/30/2020; 12/20/21; 12/2/22; 11/16/23

of-interest issue arises with any designated member of the Review Team, the CEO shall designate an appropriate alternative to the review team.

3.4 Each sentinel event shall have a root cause analysis or investigation, followed by an intervention, or action plan. The analysis and plan shall be conducted and completed in order to reduce risk; establish procedures for improvement; monitor the effectiveness of the improvements; and develop an intervention or plan to prevent further occurrence (or establish a rationale for not pursuing an intervention.)

3.5 The analysis, investigation, and action plan are documented and forwarded to the members of the review team.

3.6 The Right Door for Hope, Recovery and Wellness shall notify the Prepaid Inpatient Health Plan (PIHP) of sentinel events involving Medicaid consumers.

The Right Door for Hope, Recovery and Wellness shall report sentinel events to MDHHS and/or CARF according to MDHHS and/or CARF Standards.

3.7 All deaths, whether they meet the definition of Sentinel Event, shall be reviewed for quality improvement purposes.

4.0 Follow Up

The findings from the root cause analysis/investigation and action plan shall be reviewed within The Right Door for Hope, Recovery and Wellness Quality Improvement system and used by the organization to initiate changes in the process to prevent a reoccurrence of the sentinel event. Monitoring of improvements, further analysis, or ongoing vigilance will occur as needed.

5.0 Critical Occurrences Not Meeting Sentinel Event Definition

The Right Door for Hope, Recovery and Wellness

Chapter Title	Chapter #		Subject #
Clinical	C		392.1
Subject Title **Sentinel Event Review Process**	Adopted 05/13/02	Last Revised 12/20/21	Reviewed 4/14/10; 05/16/06; 04/16/06; 11/29/05; 04/08/05; 1/13/14; 3/9/17; 8/23/19; 6/30/2020; 12/20/21; 12/2/22; 11/16/23

The Right Door for Hope, Recovery and Wellness recognizes that some critical occurrences or incidences, although not technically reportable to any state organization or accrediting body, warrant a root cause analysis/investigation, plan of action, monitoring, and evaluation to reduce the risk of its reoccurrence.

Kerry Possehn, Chief Executive Officer	Date		