

Sentinel Event Reporting

Sentinel events must be reported by the facility or provider within one (1) business day from learning of the occurrence. A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury. Serious injury may include loss of limb or function.

The following are considered sentinel events:

- a. **Homicide or Serious Homicide Attempt** – Any act of a member, who has received care from the facility or provider within three (3) calendar days prior to the incident, which results in the death of another individual, or which was a serious attempt to kill another individual.
- b. **Serious Suicide Attempt** – Any act of self-harm by a member that results in stabilization in an intensive care unit. Consideration will be given to lethality of the attempt, intent of member and potential pattern of behavior.
- c. **Sexual Assault** – Nonconsensual sexual contact involving a member, including oral, vaginal, or anal penetration or fondling of the member or another patient's sex organ(s).
- d. **Unexpected Death/Completed Suicide** – Any unexpected death that occurs during treatment by the facility or provider; or a death that occurs within three (3) calendar days of the member receiving care from the facility or provider.

Incident Reporting

For incidents not meeting the definition of a sentinel event, but that could present a quality of care concern, the facility or provider must notify Lucet within two (2) business days from learning of the occurrence. Examples include but are not limited to:

- a. **Alleged or suspected abuse: verbal, physical, sexual, neglect**
- b. **Altercation with injury or without injury**
- c. **Elopement/unauthorized absence**
- d. **Falls with or without injury**
- e. **Medication error**
- f. **Self-harming behavior or suicide attempt with or without injury**

If you need to report a sentinel event or other adverse incident, please fill out and submit the Adverse Event Reporting Form. **Forms may be emailed to QMComplaints@lucethealth.com. The email must be encrypted, or please password protect the document. If you choose to password protect the document, please send the password to the document in a separate email. You may also print and fax the form to 1-816-237-2374.**

Please report the incident as soon as possible, even if all information is not yet available. Final submission of all information is required within five business days of the event. Though Lucet recommends using our reporting form, we will accept the information in any form or format. Should you wish to submit the information without using our recommended form, please ensure to include all the information requested in the form.

Note: when there is secondary coverage or denied care, reporting is still required.

If you have questions, please contact: QMComplaints@lucethealth.com



Adverse Event Reporting Form

<input type="text"/>	<input type="text"/>
Facility Name	Patient Name
<input type="text"/>	<input type="text"/>
Reporter Name	Patient DOB
<input type="text"/>	<input type="text"/>
Reporter Title	Patient Policy Number
<input type="text"/>	<input type="text"/>
Reporter Phone Number	Patient Phone Number
<input type="text"/>	<input type="text"/>
Reporter Email:	Coverage (if also secondary coverage):

<input type="text"/>	<input type="text"/>
Incident Date	Date of Report

Persons Involved

- Patient
- Staff
- Persons not associated with facility
- Other _____

Location

- In facility
- On grounds
- Off grounds
- Home
- Other _____

Incident Type

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Unexpected death: <ul style="list-style-type: none"> <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Accidental <input type="checkbox"/> Cause unknown <input type="checkbox"/> Self-harming behavior or suicide attempt (if checked, please complete injury section): <ul style="list-style-type: none"> <input type="checkbox"/> With injury <input type="checkbox"/> Without injury <input type="checkbox"/> Elopement/unauthorized absence <input type="checkbox"/> Medication error (if checked, please complete Medication Error section) <input type="checkbox"/> Other _____ | <ul style="list-style-type: none"> Expected death: <ul style="list-style-type: none"> Non-suicide Natural causes Fall <ul style="list-style-type: none"> With injury Without injury | <ul style="list-style-type: none"> <input type="checkbox"/> Altercation (if checked, please complete injury section): <ul style="list-style-type: none"> With injury Without injury <input type="checkbox"/> Alleged or suspected abuse (If any checked, please complete Abuse/Assault section): <ul style="list-style-type: none"> Verbal Physical Sexual Neglect |
|---|---|--|

1. ABUSE/ASSAULT SECTION

- Alleged or suspected sexual abuse/assault:
- | | |
|---|--|
| <input type="checkbox"/> Nonconsensual contact (peer to peer) | <input type="checkbox"/> Consensual contact (peer to peer) |
| <input type="checkbox"/> Nonconsensual contact with staff | <input type="checkbox"/> Consensual contact with staff |
| <input type="checkbox"/> Nonconsensual contact with other perpetrator | <input type="checkbox"/> Consensual contact with other perpetrator |
- If nonconsensual:
- Staff witnessed
 - Admission by the perpetrator
 - Sufficient evidence obtained to support allegations

2. MEDICATION ERROR SECTION

Medication error severity:

- None (no harm)
- Mild (monitoring)
- Moderate (treatment and monitoring)
- Serious (life threatening &/or permanent adverse consequences)

Medication error category:

- Failure to administer
- Wrong medication
- Wrong dose
- Wrong route
- Wrong time
- No MD order
- Administered w/o parental consent
- Adverse reaction
- Other _____

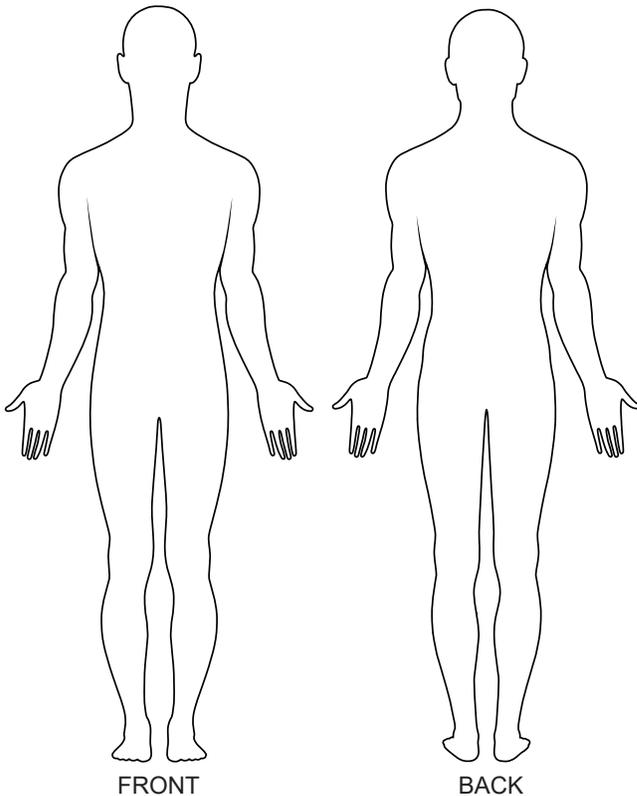
3. INJURY SECTION

Injury description:

- Abrasion
- Bite
- Burn
- Complaint of pain
- Contusion/bruise
- Dislocation
- Fracture/break
- Laceration/cut
- Puncture
- Scratches
- Strain/sprain
- Swelling
- Other: _____

Injured body parts:

- Head
- Face
- Eye - Left Right
- Ear - Left Right
- Nose
- Mouth
- Teeth
- Neck
- Back
- Chest
- Shoulder - Left Right
- Arm - Left Right
- Elbow - Left Right
- Wrist - Left Right
- Hand - Left Right
- Waist
- Belly
- Hip
- Genitals
- Buttock - Left Right
- Thigh - Left Right
- Calf - Left Right
- Knee - Left Right
- Shin - Left Right
- Ankle - Left Right
- Foot - Left Right
- Other: _____



<input type="text"/>	<input type="text"/>
Family/Guardian Name	Date/Time Contacted
<input type="text"/>	<input type="text"/>
Physician Name	Date/Time Contacted
<input type="text"/>	<input type="text"/>
Law Enforcement	Date/Time Contacted
<input type="text"/>	<input type="text"/>
Department of Child Services	Date/Time Contacted
<input type="text"/>	<input type="text"/>
911	Date/Time Contacted
<input type="text"/>	<input type="text"/>
Other	Date/Time Contacted
<input type="text"/>	<input type="text"/>
Other	Date/Time Contacted

Summary of Incident

Immediate Action Taken

Exam Information

<input type="text"/>	<input type="text"/>	<input type="text"/>
Date	Time	Provider Type
<input type="text"/>	<input type="text"/>	
Medication	Date/Time Contacted	

Medically Cleared

Yes

No

Date Cleared

Medical Treatment

Location/Facility Name

Medical Admission

Yes

No

Date and Facility Name

Medication Changes: new, change, or discontinued (name of medication, dosage, route, frequency)

Precaution or Restriction Modification

Action steps taking to prevent recurrence

I _____, the reporter, attest the information in this report to be accurate.

