


GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER		
TITLE: Sentinel Events Policy	POLICY NO: AD-RM-03	Page 1 of 4
RESPONSIBILITY: Health and Safety		
APPROVED BY:  DIRECTOR	EFFECTIVE: DEC 27 2017	
	LAST REVIEWED/REVISED:	

PURPOSE:

To provide a process for identifying sentinel events and responding appropriately by; conducting a timely review and analysis, developing an action plan designed to implement improvements to reduce risk and monitoring the effectiveness of those improvements.

POLICY

- A. Guam Behavioral Health and Wellness Center seeks to improve consumer care by reviewing and responding to Sentinel Events as set forth by The Joint Commission (TJC) Sentinel Event Policy.
- B. GBHWC shall identify and respond appropriately to all sentinel events. It shall carefully investigate and analyze all sentinel events and shall provide corrective actions to reduce risk and prevent harm to its consumers.

DEFINITIONS:

Sentinel event: a consumer safety event (not primarily related to the natural course of an illness or underlying condition of the consumer) that reaches the consumer and results in any of the following:

- 1. Death
- 2. Permanent harm
- 3. Severe temporary harm – is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care setting or monitoring for a prolonged period of time, transfer to higher level of care for life-threatening condition, or additional surgery.

An event is also considered sentinel if it is one of the following:

- 1. Suicide of any individual served receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharged.
- 2. Abduction of any consumer receiving care, treatment or services.
- 3. Any elopement (unauthorized departure) of a consumer from a staffed around-the-clock care setting leading to death, permanent harm or severe temporary harm.
- 4. Rape, assault (leading to death, permanent harm or severe temporary harm), or homicide of a consumer receiving care, treatment, or services while on site at the organization.
- 5. Rape, assault (leading to death, permanent harm, or severe harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization

RESPONSIBILITIES:

Lead Provider/Staff with the knowledge or involved in the incident

- A. Shall inform his/her supervisor and the Health and Safety Officer immediately of the sentinel incident.
- B. Shall complete the incident report form in the Electronic Behavioral Health record (EBHR) within 24 hours of the incident.

Health and Safety Officer/Risk Management Officer

- A. Shall inform the Director of the sentinel event
- B. Shall investigate and convene a committee to debrief the staff involved in the sentinel event or has knowledge of the incident.
- C. Shall conduct a root cause analysis of the sentinel event and a risk assessment.
- D. Shall report to the Quality Improvement Committee all sentinel event findings.

Debriefing/Review Committee: shall be handpicked by the Director

- A. Shall review and investigate the sentinel event.
- B. Shall come up with a root-cause analysis of the sentinel event.
- C. Shall provide recommendation and corrective actions for implementation.

Quality Improvement Committee

- A. Shall review the Health and Safety Officer's report and shall make recommendations or develop actions for improvement to prevent similar events from occurring in the future.

PROCEDURE:

Reporting and Documentation of Incidents:

- A. The staff involved in an incident or most knowledgeable of the incident shall inform his/her supervisor and the risk management officer of the said incident with in the following time frames;
 - a. Immediately if the incident is a sentinel event.
 - b. Within twenty-four (24) hours or at the end of the shift for all other types of incident.
- B. The staff reporting an incident shall complete the incident form in the Electronic Behavioral Health Record (EBHR) within twenty-four (24) hours of the incident.
- C. A progress note must be made in the consumer's electronic medical record regarding the incident.

Internal Incident Investigation:

- A. All sentinel events require an internal investigation, and all other incidents will be investigated as deemed necessary by the Health & Safety Officer and or the director.
- B. The internal investigation must be completed within ten (10) working days after the request for an internal investigation or debriefing was made.

- C. Recommendation and or internal incident investigation findings shall be documented in the Incident Follow –up Review Report in EBHR.

Debriefing/Review Committee Assessment

- A. If necessary, debriefing of the staff involved in the sentinel event shall be conducted within forty- eight (48) – seventy – two (72) business hour of the event, and immediately if it's a sentinel event.
- B. The committee shall be formed by the Risk Management Officer and shall consist at a minimum the Supervisor and or Program Manager of the involved staff.
- C. The findings of the debriefing or investigation shall be reported to the Director, and documented in the incident report under the Incident Follow-up Review Report Field in the EBHR.
- D. Root cause analysis shall be conducted, identifying the causal and contributory factors, which focuses on systems and process.
- E. A Root cause analysis and recommendation for corrective action shall be reported to the Quality Improvement Committee or the Management Team for implementation as appropriate.

Reporting to External Agencies:

- A. Staff is required to follow Guam Public Law (*10GCA Chap. 2 and 19 GCA Chap.13*) to report the suspected or alleged abuse, neglect, and or exploitation to Adult Protective Services (APS) or Child Protective Services (CPS).
 - a. All incidents involving abuse, neglect, exploitation or abandonment require an immediate oral report to APS or CPS followed by a written report on the approved APS or CPS from within forty-eight (48) hours
 - b. If the incident of abuse, neglect, or exploitation is suspected to be a crime, the staff's immediate supervisor shall consult with the risk management officer and the director and immediately contact the Guam Police Department.

REFERENCE(S):

CARF International. (2017). Health and Safety: Critical Incidents. In *Behavioral Helath Standards Manual 2017* (pp. 68-69).

The Joint Commission. (2016). Sentinel Events. In *Comprehensive Accreditation Manual Behavioral Health Care* .

RELATED POLICY (IES):

AD-RM-02 Critical Incident Reporting

SUPERSEDES:

Sentinel Events Protocol 6/12/2012; Wilfred Aflague DMSHA Director

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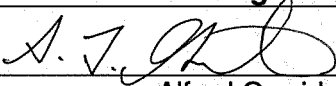
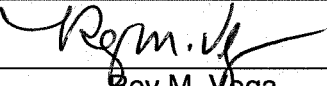
**GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER
REVIEW AND ENDORSEMENT CERTIFICATION**

DEC 19 AM 10:38

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The signatories on this document acknowledge that they have reviewed and approved the following:

- Policies and Procedure Submitted by: Quality Management
- Protocol/Form Policy No: AD-RM-03
- Bylaws Title: Sentinel Events Policy

<input type="checkbox"/> Reviewed <input type="checkbox"/> Endorsed Title	Date	Signature
	12/19/17	
	Name Title Alfred Garrido Health & Safety Officer	
<input type="checkbox"/> Reviewed <input type="checkbox"/> Endorsed Title	Date	Signature
	DEC 27 2017	
	Name Title Rey M. Vega Director	