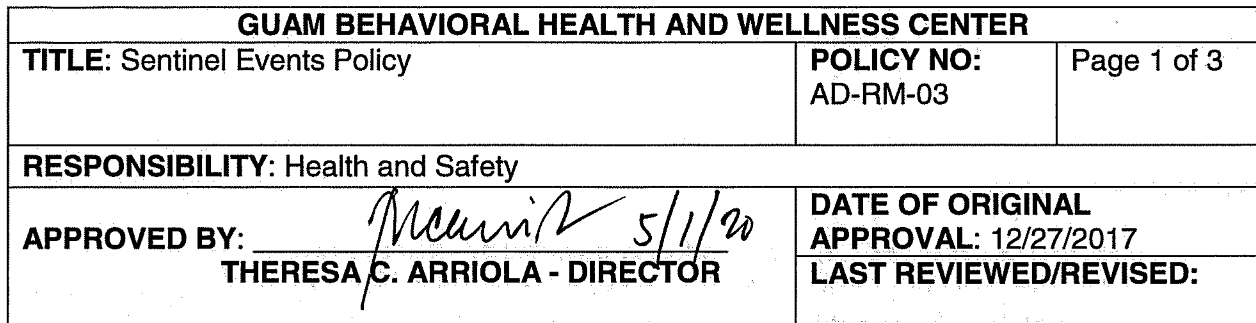

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER		
TITLE: Sentinel Events Policy	**POLICY NO:** AD-RM-03	Page 1 of 3
RESPONSIBILITY: Health and Safety		
APPROVED BY: 5/1/20 **THERESA C. ARRIOLA - DIRECTOR**	**DATE OF ORIGINAL APPROVAL:** 12/27/2017 **LAST REVIEWED/REVISED:**	

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:

A. Lead Provider/Staff with the knowledge or involved in the incident
   1. Shall inform his/her supervisor and the Health and Safety Officer immediately of the sentinel incident.
   2. Shall complete the incident report form in the Electronic Behavioral Health record (EBHR) within 24 hours of the incident.

B. Risk Management Officer
   1. Shall inform the Director of the sentinel event
   2. Shall investigate and convene a committee to debrief the staff involved in the sentinel event or has knowledge of the incident.
   3. Shall conduct a root cause analysis of the sentinel event and a risk assessment.
   4. Shall report to the Quality Improvement Committee all sentinel event findings.

C. Debriefing/Review Committee: shall be handpicked by the Director
   1. Shall review and investigate the sentinel event.
   2. Shall come up with a root-cause analysis of the sentinel event.
   3. Shall provide recommendation and corrective actions for implementation.

D. Environments of Care Committee
   1. Shall review the Risk Management Officer report and conduct a root cause analysis and develop actions or recommendations for improvement to prevent similar events from occurring in the future.

PROCEDURE:

A. Reporting and Documentation of Incidents;
   1. The staff involved in an incident or most knowledgeable of the incident shall inform his/her immediate 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.
   2. The staff reporting an incident shall complete the incident form FAD-RM-02.1 within twenty-four (24) hours of the incident.
   3. A progress note must be made in the consumer's electronic medical record regarding the incident if appropriate.

B. Debriefing by the Immediate Supervisor
   1. If necessary, debriefing of the staff involved in the sentinel event shall be conducted within twenty- four (24) – seventy – two (72) business hour of the event.
   2. The findings of the debriefing or investigation shall be reported to the Director or Deputy Director and documented in the incident report form FAD-RM-02.1 under the Immediate Supervisors Review Report.

C. Internal Incident Investigation:
   1. All sentinel events require an internal investigation, by the Risk Management Officer and the Environments of Care Committee
   2. The internal investigation of the Risk Management Officer must be completed within ten (10) working days after the request for an internal investigation or debriefing was made.
   3. Root cause analysis shall be conducted, identifying the causal and contributory factors, which focuses on systems and process. Analysis report shall be submitted to the quality improvement coordinator within 30 days of the incident.
   4. A Root cause analysis and recommendation for corrective action shall be reported to the Management Team for implementation as appropriate.

D. Reporting to External Agencies:
   1. 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. (2019). Health and Safety: Critical Incidents. In *Behavioral Helath Standards Manual 2019* (pp. 74-75).

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

RELATED POLICY (IES):

AD-RM-02 Incident Reporting

SUPERSEDES:

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

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REVIEW AND ENDORSEMENT CERTIFICATION

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

Policy Title: Sentinel Events Policy
Policy No: AD-RM-03
Initiated by: Environments of Care Committee

Date	Signature
2/26/2020	[signature]

Jeremy Lloyd-Taitano, RN-BC
Interim Environments of Care Chairperson

Date	Signature
	[signature]

Barsen Adelbai - EOC Member
Risk Management

Date	Signature
2/25/2020	[signature]

Cydsel Victoria Toledo- EOC Member
Quality Improvement Coordinator/Regulatory Compliance Officer

Date	Signature
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Shermalin Pineda - EOC Member
Residential Recovery Program Manager

Date	Signature
2/25/2020	[signature]

Alfred Garrido–EOC Member
Health and Safety Officer

Date	Signature
2-25-2020	[signature], MSN, RN-BC

Leonora Urbano MSN, RN-BC
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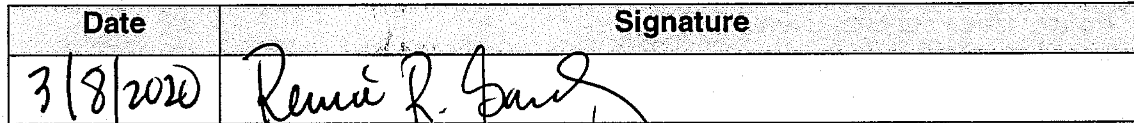
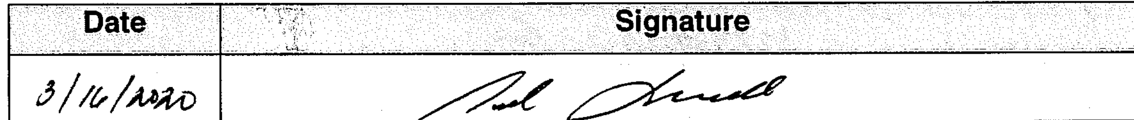


Date	Signature
3/8/2020	

Reina Sanchez, M.A
Clinical Administrator



Date	Signature
3/16/2020	

Dr. Ariel Ismael
Medical Director

Date	Signature
4/20/2020	

Carissa Pangelinan
Deputy Director