

**COMMUNITY MENTAL HEALTH CENTER  
OF EAST CENTRAL GEORGIA  
POLICY**

**SUBJECT:** Sentinel Events  
**POLICY NUMBER:** PIM-5.02  
**EFFECTIVE DATE:** 12/97  
**RESCISSION DATE:**

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<b>SUPERSEDES:</b> Policy #PI-2	<b>REVIEWED DATE:</b> <b>LAST REVISION DATE:</b>
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**POLICY:**

It is the policy of the Community Mental Health Center of East Central Georgia (CMHC) to ensure an organizational culture conducive to identification, reporting, analysis and prevention of sentinel events and for ensuring the consistent and effective implementation of a mechanism to accomplish these activities. When a sentinel event occurs, the CMHC completes a thorough and credible root cause analysis, implements improvements to reduce risk of recurrence and monitors the effectiveness of performance improvement efforts.

**DEFINITIONS:**

- I. **Sentinel events**: An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or 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. Such events also include any that may be subject to litigation.
- II. **Root Cause Analysis**: is a formal process for identifying the most basic or causal factors that under variation in performance, including the occurrence or possible occurrence of a Sentinel event. It focuses on organizational systems and processes and on changes that can be made to improve performance and reduce the risk of recurrence of a serious Adverse event.

**PROCEDURES:**

- I. Incidents involving persons served and/or deaths of persons served are reported in accordance with CMHC Policies #LD-9.01 and LD-10.01 respectively.
- II. The CMHC’s Chief Executive Officer (CEO) and /or the Regional Mental Health, Developmental Disabilities, Addictive Diseases Office’s Consumer Protection Manager may determine that an incident or a death is a sentinel event and that the Sentinel Event protocol be enacted.

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- III. The CMHC's CEO assigns an investigator to conduct an internal investigation of the incident/death.
- IV. The CEO assigns a team whose duties are to conduct a root cause analysis, develop a plan for corrective action and performance improvement and to monitor the effectiveness of the corrective action/performance improvement.
  - A. The Performance Improvement Director is responsible for planning and chairing team meetings.
  - B. Membership will include the CEO, the Client Advocate, the Safety Officer and the Program Services Manager for the program in which the incident/death occurred.
  - C. Members will include intra/interagency personnel who were involved with the care of the person(s) served or with processes related to the incident/death.
- V. The Sentinel Event Protocol is conducted in accordance with the procedures specified in The Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Diseases Providers.
- VI. The CMHC provides timely notification to community agencies, regulatory entities and accrediting bodies as required by standard, policy or law of the sentinel event.

**REFERENCES:**

- I. CARF: Behavioral Health Standards Manual, Section 1.E.10.c.7.
- II. The Provider Manual for Community Mental Health, Developmental Disabilities, And Addictive Diseases, Section V., Appendix H, Attachments 1 – 7.

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Acting Executive Director

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Date

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CSB Chair

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Date

**:JNP**