COBB COUNTY COMMUNITY SERVICES BOARD
DOUGLAS COUNTY COMMUNITY SERVICES BOARD

Policy # 1033	Sentinel Events
Origination Date: April 1998	
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Reviewed Date: February 20, 2007, April 15, 2013	
Approved:	
Tod W. Citron, Executive Director	

POLICY:

It is the policy and procedure of the Cobb County Community Services Board and the Douglas County Community Services Board (CCDCCSB) that a Clinical Care Review (CCR) will investigate sentinel events in accordance with this policy. The Executive Director will assign the CCR committee.

- Significant events must be communicated to state, provincial, and regulatory agencies that have the legitimate or legal authority to act upon such significant events. In addition to state, provincial, and regulatory agencies, significant events must be communicated to CARF, the Commission on Accreditation of Rehabilitation Facilities, within 30 days of their occurrence.
- A sentinel event is defined as 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 the 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.
- The purpose of investigating sentinel events, beginning with the initial report of an event, is to evaluate and improve the quality and efficiency of the health care provided by the Boards, to reduce morbidity and/or mortality.
- The terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error.
- The proceedings and records of a Clinical Care Review shall be confidential as provided in O.C.G.A. 37-7-133.

PROCEDURE:

The following procedures apply to all sentinel events, including some deaths.

1. The Clinical Care Review Committee shall interview staff and others when investigating the sentinel event as well as review the client's clinical record.
2. Results of "sentinel event" are reported to the Executive Director by the Clinical Care Review Committee chairperson as soon as information is available. The Executive Director or designee reports sentinel events to the Investigation Section of DBHDD and according to CARF standards.
3. The outcome of the Sentinel Event investigation is to have a positive impact in improving client care, understand the causes that precipitated the event and make changes in the organization's policies to reduce the probability of such an event occurring in the future.
4. The Regulatory Compliance Committee will suggest ways to improve the quality and efficiency of the health care provided by the Boards (directly and through other health care providers and others providing care to the Boards' clients) and to reduce morbidity and mortality.