ADULT MENTAL HEALTH DIVISION
Performance Improvement
Consumer Sentinel Event Report
Immediate Notification

Complete the blanks as thoroughly as possible. Use an X mark in the boxes ☒ as appropriate.

1. Consumer's Name: (Last) _____ (First) _____

2. Sex: Male ☐ Female ☐ 3. Date of Birth: ____/____/____ (mm dd yyyy)

4. AMHD Reference Number: _____

5. Date of Sentinel Event: _____/_____/_____ (mm dd yyyyy) & Date provider notified: ____/____/____ (mm dd yyyyy)

6. Sentinel Event Brief Description_____

_____
_____
_____
_____
_____
_____

Event List:

1. ☐ Suicide of a consumer.
2. ☐ Homicide of a consumer.
3. ☐ Homicide by a consumer.
4. ☐ Medication Error: any consumer death, paralysis, coma, or a permanent loss of function associated with a provider medication error.
5. ☐ Serious consumer injury resulting in permanent loss of limb or function or risk thereof.
6. ☐ Suspected abuse/sexual/neglect of a consumer.
7. ☐ Sexual assault of a consumer
8. ☐ Attempted suicide of a consumer that required medical attention.

9. ☐ Attempted homicide of or by a consumer.

10. ☐ Physical Assault of Staff/Citizen by a consumer resulting in permanent loss of limb or function or risk thereof.

11. ☐ Accidental Death of a consumer.

12. ☐ Elopement from Hawaii State Hospital (HSH) or AMHD contracted inpatient bed.

13. ☐ Non-adherence to HSH discharge plan, whereabouts unknown within 30 days of discharge from HSH/AMHD contracted bed.

14. ☐ Revocation of conditional release.

15. ☐ Readmission to HSH or AMHD contracted inpatient facility within 30 days of discharge from HSH or AMHD contracted bed.

16. ☐ Incarceration of a forensically encumbered consumer.

17. ☐ Psychiatric or medical hospitalization of a forensically encumbered consumer.

18. ☐ MH-1 evaluation of a forensically encumbered consumer.

19. ☐ Elopement from community placement by a forensically encumbered consumer.

7. Place of Sentinel Event: a. ☐ Hospital b. ☐ Treatment Program c. ☐ Consumer's residence d. ☐ Other_____

8. Legal Status: a. ☐ 704 - 404 b. ☐ 704 - 405 c. ☐ 704 – 406 d. ☐ 704 – 406 (1) (a) e. ☐ 704 – 411 (1) (a) d. ☐ 704 - 411(1) (b) e. ☐ 704 - 413 f. ☐ 704 - 415 g. ☐ 706-607 h. ☐ Parole i. ☐ Probation j. ☐ Voluntary m. ☐ MH4-MH6-MH9 n. ☐ Other (specify) _____

9. Date of discharge from HSH or AMHD contracted inpatient bed (if within 30 days of discharge) mm/dd/yyyy _____/_____/_____

10. Axis I Primary psychiatric diagnosis: _____

_____

11. Co-occurring disorder: a. ☐ ETOH b. ☐ drugs c. ☐ ETOH and drugs d. ☐ none e. ☐ unknown

12. Axis II: _____

_____

13. Axis III:
a. ☐ cancer
b. ☐ diabetes
c. ☐ respiratory
d. ☐ cardiac
e. ☐ obesity
f. ☐ stroke
g. ☐ malnutrition
h. ☐ brain injury
i. ☐ other (specify) _____

14. Number of medications taken daily (Add total psychiatric and non-psychiatric including over-the counter and herbal/vitamins):
a. ☐ 0
b. ☐ 1 - 2
c. ☐ 3 – 5
d. ☐ 6 - 8
e. ☐ 8 or more
f. ☐ unknown

15. Current Medications (List names and doses): _____

_____

_____

16. Level of Case Management:
a. ☐ Care Coordination
b. ☐ Crisis Support Management
c. ☐ Crisis Mobile Outreach
d. ☐ Targeted Case Management
e. ☐ Community Care Services (CCS)
f. ☐ Inpatient Hospital Services
g. ☐ Homeless Outreach

17. Case management agency: _____

18. Housing Agency: _____

19. Case management ratio (# of consumers per this consumer's case manager): _____

20. Date of last face-to-face contact with case manager prior to event: _____/_____/_____ (mm dd yyyy)

21. Date of last face-to-face contact with psychiatrist prior to event: _____/_____/_____ (mm dd yyyy)

22. Date of last face-to-face contact with housing staff prior to event: _____/_____/_____ (mm dd yyyy)

23. Psychiatrist:
a. ☐ POS
b. ☐ CMHC
c. ☐ HSH
d. ☐ Private psychiatrist
e. ☐ VAMHC

21. Area Services Received:
a. ☐ Oahu
b. ☐ Maui
e. ☐ Kauai
f. ☐ Molokai

c. ☐ East Hawaii
d. ☐ West Hawaii
g. ☐ Lanai

22. Housing:

a. ☐ Independent (living on their own of with family/boarding home/others
b. ☐ 8-16 hour group home
c. ☐ 24 hour group home
d. ☐ Supported Housing/Bridge Subsidy
e. ☐ Licensed Specialized Residential
f. ☐ Licensed Crisis Residential Services
g. ☐ Homeless
h. ☐ Homeless shelter
i. ☐ Care home
j. ☐ Nursing home
k. ☐ Hospital
l. ☐ Hospice
m. ☐ HUD rental subsidy (Section 8, Shelter Plus Care)

23. Name of facility of last psychiatric hospitalization prior to event and date of discharge:
_____ / _____ / _____
mm dd yyyy

24. Date of last non-psychiatric hospitalization prior to event: ____ / ____ / ____
mm dd yyyy

25. Facility Name of last non-psychiatric hospitalization: _____

26. Primary Care Physician (Last Name, First Name): _____

27. Date last seen by treating medical physician: ____ / ____ / ____
mm dd yyyy

* * * * * * * * * * * * * * * * *

Please complete the following information about your agency:

28. Agency completing the form: _____

29. Program name: _____

30. Reported by (Name, Title): _____ **Date:** ____ / ____ / ____
mm dd yyyy

31. Phone number: _____

32. Fax number: _____

33. Date form completed: _____ / _____ / _____