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**ADULT MENTAL HEALTH DIVISION**

**Performance Improvement**

**Provider/Consumer Thirty Day Sentinel Event Conference Report**

Complete the sections as thoroughly as possible.

Performance Improvement Fax Number: 808-453-6939 (Fax within thirty (30) business days of the event, when required by PI staff)

Consumer’s Name: (Last)       (First)

Sentinel Event Date:

mm/dd/yyyy

Sentinel Event #:

**Section I**

In accordance with the AMHD Sentinel Event policy, the Sentinel Event Conference and Sentinel Event Conference Reportare required from you within thirty (30) business days of the event. **Please provide the date of the conference and any future plans to address this event.** **Do not repeat information reported in the immediate notification**.

Remembering an important goal of sentinel event reporting and analysis is system improvement,please complete the form. Keep in mind any gaps that might have contributed to the event within 1) your provider system, 2) other provider systems that served the consumer, 3) the Legal system, and/or 4) the greater AMHD system.

**Address the following questions.**

1. What is the consumer’s outcome?

2. What may have contributed to the sentinel event?

3. What actions were taken in response to the sentinel event?

**Section II**

Use the table below to identify risk reduction plan actions. If an action does not apply, leave it blank.

From your causal analysis and risk reduction plan, which of the below (A-C) may have responsibility for each risk reduction action you identified? Check the boxes that apply.

From your causal analysis where the risk reduction plan is targeted for your organization, enter the target dates (D), persons responsible (E) and position of responsible person (F).

Table: Causal Analysis/Risk Reduction Plan

| **ACTION** | **A.**  **AMHD System** | **B.**  **Legal System** | **C.**  **Provider**  **Services** | **D.**  **Target Date** | **E.**  **Person Responsible** | **F.**  **Title of Responsible Person** |
| --- | --- | --- | --- | --- | --- | --- |
| 1. establish staff competency standards |  |  |  |  |  |  |
| 1. train staff |  |  |  |  |  |  |
| 1. educate family |  |  |  |  |  |  |
| 1. increase medication monitoring |  |  |  |  |  |  |
| 1. facilitate access to psychiatrist |  |  |  |  |  |  |
| 1. increase level of care |  |  |  |  |  |  |
| 1. collaborate with MISA Coordinator |  |  |  |  |  |  |
| 1. collaborate with Forensic Coordinator |  |  |  |  |  |  |
| 1. collaborate with Probation/ Parole Officer |  |  |  |  |  |  |
| 1. collaborate with other agencies |  |  |  |  |  |  |
| 1. communicate with court system |  |  |  |  |  |  |
| 1. revise recovery and crisis plans |  |  |  |  |  |  |
| m. increase participation in treatment team |  |  |  |  |  |  |
| n. increase clinical staff supervision |  |  |  |  |  |  |
| o. change agency policy and procedures |  |  |  |  |  |  |
| p. other (specify) |  |  |  |  |  |  |

**Section III**

Please add additional comments regarding this sentinel event (i.e. disciplinary actions taken against staff, AMHD Service Coordinator involvement, etc.)

Who completed this form?

Who attended the conference? (Include Full names, titles and agency)

**BE SURE THE FOLLOWING HAS BEEN ATTACHED AND SUBMITTED WITH THIS REPORT:**

* **Revised Recovery Plan**
* **Revised Crisis Plan**
* **Progress notes 30 days prior to and 30 days post event**
* **Supervision notes regarding this event**
* **Psychiatrist notes including any medication changes post event**
* **Police report**
* **Plan of Improvement if required**
* **Root cause analysis if required**

Program name:

Reported by (Name, Title):

Phone number:

Fax number:

Signature:

Date:

mm/dd/yyyy