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## 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*.*

**Performance Improvement Fax Number: 808-453-6939 (Fax within one (1) business day of the event.)**

1. Consumer’s Name: (Last)       (First)

2. Sex: Male  Female  3. Date of Birth:

mm/dd/yyyy

4. Last Four of Consumer’s Social Security Number:

5. Date of Sentinel Event:       Date Provider notified:

mm/dd/yyyy mm/dd/yyyy

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 or neglect of a consumer.
7. Sexual assault of or by a consumer.
8. Attempted suicide of a consumer that required medical intervention.
9. Attempted homicide of or by a consumer.
10. Physical assault of staff or citizen or another consumer, by a consumer, resulting in permanent loss of limb or function or risk thereof.
11. Accidental death of a consumer that resulted directly from a physical injury while in Hawaii State Hospital (HSH), an AMHD contracted inpatient bed, or in an AMHD contracted community residential placement.
12. Elopement (24 hours or more) from HSH or Kahi Mohala contracted inpatient bed only for consumers who are currently inpatient.
13. Revocation of Conditional Release.
14. Arrest or incarceration of a consumer.
15. Psychiatric hospitalization of a forensically encumbered consumer.
16. MH-1 evaluation of a forensically encumbered consumer.
17. Elopement (24 hours or more) from an AMHD contracted community residential placement by a forensically encumbered consumer.

7. Place of Sentinel Event:

8. Legal Status: a. 704 - 404 d.  704 - 411(1) (b) i.  Probation

b. 704 - 405 e.  704 - 413 j.  Voluntary

c. 704 - 406 f.  704 - 415 m.  MH4-MH6-MH9

d. 704 - 406 (1) (a) g. 706 - 607 n.  Other (specify)

e. 704 - 411 (1) (a) h. Parole

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

10. Primary Psychiatric Diagnoses:

11. Physical/Medical Conditions:

12. Current Medications (List names and doses):

13. Level of Case Management:

14. Case Management agency:

15. Housing Agency:

16. Date of last face-to-face contact with case manager prior to event:

mm/dd/yyyy

17. Date of last face-to-face contact with psychiatrist prior to event:

mm/dd/yyyy

18. Date of last face-to-face contact with housing staff prior to event:

mm/dd/yyyy

19. Psychiatrist:

a.  POS

b.  CMHC

c.  HSH

d.  Private Psychiatrist

e.  VAMHC

20. Island Services Received:

21. Housing Type:

**Please complete the following information about your agency:**

**22. Agency completing the form:**

**23. Program name:**

**24. Reported by (Name, Title):** **Date:**

**mm/dd/yyyy**

**25. Phone number:**

**26. Fax number:**

**27. Date form completed:**