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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* [x]  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:**