|  |  |  |
| --- | --- | --- |
| **Clinically Responsible Service Provider Agency:** | |  |
| Name of Consumer Involved in Sentinel Event: | MHWIN Number: | Age: |

|  |  |  |  |
| --- | --- | --- | --- |
| **POPULATION** | **LEVEL OF CARE** | **PLACE OF INCIDENT** | **CATEGORY OF SENTINEL EVENT** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of Incident: | Date SE entered in MHWIN: | Date RCA Prepared: | Date Submitted to DWIHN: | Revision Dates (if applicable) |
| Member Diagnosis: | | | Medications: | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | |  | Adults with Mental Illness | |  | Children with Mental Illness | |  | Persons with Dev. Disabilities | |  | SUD |  |  |  | | --- | --- | | **LIVING ARRANGEMENTS** | | |  | Own Home Private Residence | |  | AFC | |  | 24 Hour Specialized Setting | |  | Other: Room & Board | | |  |  | | --- | --- | |  | ACT | |  | CSM | |  | RSP | |  | Home Based Services | |  | HAB | |  | SED | |  | Outpatient – Children’s | |  | Outpatient - Adult | |  | Supports Coordination | |  | Other: | |  | Other: | | |  |  | | --- | --- | |  | 24 Hr. Specialized Setting | |  | On-going and Continuous in own home w/assistance in ADLs | |  | Own home | |  | Consumer at work site | |  | Provider Service Site: | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | | |  |  | | --- | --- | |  | Arrest of Recipient | |  | Death of Recipient – Suicide/Homicide/Accident | |  | Injuries requiring ER / Urgent Care/Doctor Office/Hospital | |  | Medication Errors requiring ER/ Urgent Care/Doctor Office/Hospital | |  | Not a Sentinel Event | |  | Physical Illness requiring admission to a hospital | |  | Abuse/Neglect/Sexual | |  | Serious challenging behaviors | |  |  | |

|  |
| --- |
| **DESCITPITON OF INCIDENT:** |

*Please describe the incident and the timeline of events*

|  |
| --- |
| **CAUSAL FACTORS: CHECK ALL THAT APPLY:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Method/Procedure** |  |  |  |  |
|  | 1. Was the clinical assessment adequate to address the needs of the individual? | Yes | No | N/A |
|  | 1. Was the individual’s plan consistent with best practices? | Yes | No | N/A |
|  | 1. Were the actions outlined in the Crisis Plan followed? | Yes | No | N/A |
|  | 1. Did the person involved implement the plan as written? | Yes | No | N/A |
| **Communication** |  |  |  |  |
|  | 1. Was the staff member involved aware of the individual’s plan, as evidenced by signature on plan or other documentation? | Yes | No | N/A |
|  | 1. Was the staff member involved aware of the organizational policies or protocols? | Yes | No | N/A |
|  | 1. Was the communication among participants adequate for the situation *(including verbal, written, electronic communication or lack thereof)*? | Yes | No | N/A |
|  | 1. Was all the necessary information available, accurate and complete when needed? | Yes | No | N/A |
| **Staff Related** |  |  |  |  |
|  | 1. How did actual staffing compare with ideal levels? | Yes | No | N/A |
|  | 1. Was the staff properly qualified and currently competent for their responsibilities at the time of the event? | Yes | No | N/A |
|  | 1. Did staff performance during the event meet expectations? | Yes | No | N/A |
|  | 1. Was employee adequately trained to fulfill assigned responsibility to prevent incident? | Yes | No | N/A |
|  | 1. Was there a written or known procedure for this job, and did the employee involved deviate from this procedure? | Yes | No | N/A |
| **Environment** |  |  |  |  |
|  | 1. Were environmental conditions a contributing factor (for example, physical space, illumination, noise levels, air contaminant, temperature extremes, ventilation)? | Yes | No | N/A |
|  | 1. Was there an environmental risk recognized prior to the event? If so, was it reported? | Yes | No | N/A |
|  | 1. What systems are in place to identify environmental risks in relation to the incident (e.g. monthly inspections, drills, safety inspections)? | Yes | No | N/A |
| **Equipment/Material** |  |  |  |  |
|  | 1. Was there equipment or materials performance issues that contributed to the event? | Yes | No | N/A |
|  | 1. Was there an equipment inspection procedure to detect the hazardous condition(s)? | Yes | No | N/A |
|  | 1. Did the existing equipment inspection procedure detect the hazardous condition? | Yes | No | N/A |
|  | 1. Was the correct equipment used? Was the equipment used properly? | Yes | No | N/A |

|  |
| --- |
| **Please explain the above responses:** |

|  |
| --- |
| **DESCRIPTION OF THE IDENTIFIED ROOT CAUSE ERROR:** |
|  |

|  |
| --- |
| **DOCUMENTATION OF THE DATES AND NATURE OF CONTACTS FOR THE QUARTER BEFORE AND AFTER THE SENTINEL EVENT:** |

*Please document the services and dates attended (or unattended) that the member was receiving prior to the event. Then, list of services and appointments enacted for the member following the incident with the respective dates.*

|  |  |  |
| --- | --- | --- |
| **PRINT NAME / TITLE /CREDENTIALS of Staff Developing & Implementing Action Plan** |  | **PRINT NAME / TITLE/CREDENTIALS of Staff Reviewing, Monitoring Action Plan** |
| 1. |  | 1. |
| 2. |  | 2. |
| 3. |  | 3. |
| 4. |  | 4. |
| 5. |  | 5. |
| 6. |  | 6. |
| 7. |  | 7. |
| 8. |  | 8. |
| 9. |  | 9. |
| 10. |  | 10. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***PLAN OF ACTION*** | | | | | |
| **Causal factor –** (identified from pg. 2& 3) | **Issue/Concern Identified** | **Description of Action To Be Taken** | **Staff Responsible** | **Date of Implementation** | **Measure of Effectiveness** |
|
|
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

*For DWIHN Internal Staff Only. Please Do Not Fill Out This Section*

SEC/PRC Event Review and Recommendations:

Copy to Contract Manager Date: