SENTINEL EVENT REPORTING FORM

State of New Hampshire
Department of Health and Human Services
Bureau of Quality Assurance and Improvement

Original Effective Date: September 2010
Revision Date: January 27, 2020

Individual's Name *[Individual on whose behalf the Sentinel Event Report is being completed.]*

Last Name:	**First Name:**	**Middle Initial:**
Date of Sentinel Event: Click or tap to enter a date.	**Report Date:** Click or tap to enter a date.	

I - BACKGROUND

1. Type of Sentinel Event [check all that apply]:

☐Unanticipated death is a sudden or accidental death. *Note: Does not include homicide or suicide; and, is not related to the natural course of an illness or underlying condition.*	☐Permanent loss of function, resulting from such causes including but not limited to: ▪ medication error; ▪ unauthorized departure or abduction from a facility providing care; or, ▪ delay or failure to provide requested and/or medically necessary services due to waitlists, availability, insurance coverage or resource limitations.
☐Homicide victim ☐Homicide perpetrator	☐Suicide
☐Serious physical injury, or risk thereof to or by a client (jeopardizing a person's health).	☐Serious psychological injury that jeopardizes the person's health that is associated with the planning and delivery of care.
☐Victim of rape or any other sexual assault ☐Perpetrator of rape or any other sexual assault	☐Injury due to physical or mechanical restraints.
☐Suicide attempt that has explicit or implicit evidence that the individual intended to die and medical intervention was needed.	☐High profile event such as media coverage, police involvement, etc.

2. Location of Sentinel Event:

☐Primary Residence ☐Other Residence ☐Business ☐Other:

Street Address: City/Town:

3. DHHS Agencies/Programs Serving the Client:

☐Adult Protective Services	☐Mental Health Services	☐Choices for Independence Waiver
☐Child Protective Services	☐Juvenile Probation and Parole	☐Sununu Youth Services Center
☐Drug and Alcohol Services	☐Elderly and Adult Services	☐Family Assistance
☐New Hampshire Hospital	☐Housing Supports	☐Employment Supports
☐Glencliff Home for the Elderly	☐Transitional Housing	☐Laconia BDS DRF
☐Child Development and Head Start Collaboration	☐Developmental Services	☐Other (specify):

SENTINEL EVENT REPORTING FORM

State of New Hampshire
Department of Health and Human Services
Bureau of Quality Assurance and Improvement

Original Effective Date: September 2010
Revision Date: January 27, 2020

Individual's Name *[Individual on whose behalf the Sentinel Event Report is being completed.]*

Last Name:	**First Name:**	**Middle Initial:**
Date of Sentinel Event: Click or tap to enter a date.	**Report Date:** Click or tap to enter a date.	

4. Individual's DHHS Case Status [check all that apply]:

☐Currently receiving DHHS-funded services.
☐Has received DHHS-funded services within the preceding 30 days.
☐Has received services through Emergency Services provided by a Community Mental Health Center.
☐Has received psychiatric hospitalization within the past year of the suicide death.
☐Is receiving services from Child or Adult Protective Services.
☐Other:

5. Reported by [check applicable box and complete the name or location if applicable]:

☐Adult Protective Services	District Office:
☐Mental Health Services	Community Mental Health Center:
☐DCYF – Child Protection	District Office:
☐DCYF – Juvenile Justice	District Office:
☐Choices for Independence (CFI)	Case Management Agency:
☐Designated Receiving Facility (DRF)	Name:
☐Developmental Services	Area Agency:
☐Drug and Alcohol Service	Agency:
☐Bureau of Housing Supports	Agency:
☐Division of Economic Housing Stability (DEHS) Other	Bureau: Click or tap here to enter text.
☐Managed Care Organization (MCO):	☐AmeriHealth Caritas NH ☐NH Healthy Families ☐Well Sense
☐New Hampshire Hospital (NHH)	
☐Harbor Homes	
☐Glencliff Home for the Elderly	
☐Sununu Youth Services Center	
☐Laconia BDS DRF	
☐Other (specify):	

6. Person Completing the Sentinel Event Reporting Form:

Last Name:	First Name:
Work Phone:	Mobile Phone:
Work Email:	Relationship to Individual:

7. Person to Contact for Additional Information:

Last Name:	First Name:
Work Phone:	Mobile Phone:

SENTINEL EVENT REPORTING FORM

State of New Hampshire
Department of Health and Human Services
Bureau of Quality Assurance and Improvement

Original Effective Date: September 2010
Revision Date: January 27, 2020

Individual's Name *[Individual on whose behalf the Sentinel Event Report is being completed.]*

Last Name:	**First Name:**	**Middle Initial:**
Date of Sentinel Event: Click or tap to enter a date.	**Report Date:** Click or tap to enter a date.	
Work Email:	Relationship to Individual:	

II – INDIVIDUAL'S DETAILS

[Individual on whose behalf the Sentinel Event Report is being completed.]

8. Demographics:

☐Male ☐Female ☐Other (specify):

Date of Birth: Click or tap to enter a date. Age:

Street Address: City/Town: Zip:

9. NH Medicaid Status:

Is the individual receiving Medicaid benefits? ☐No ☐Yes with Member ID#:

Date MCO Notified: Click or tap to enter a date. ☐AmeriHealth Caritas ☐NH Healthy Families ☐Well Sense

10. Legal Factors [Identify any legal factors(s) the individual may have.]:

Child Protection [check all that apply]:

☐Abused
☐Neglected
☐Guardianship
☐Co-Guardianship
☐Out-of-home care / physical custody
- ☐Foster family care
- ☐Relative/kinship care
- ☐Residential/congregate living
- ☐Individual Service Option (ISO)

Community Care [check all that apply]:

☐Authorized Representative (Individual has identified someone to act on his/her behalf for a specific purpose)
☐Conditional Discharge (Adult or child)
☐Court Involved Adult Protection Open Case
☐Durable Power of Attorney (DPOA)
☐DPOA for Health Care
☐Guardian of Estate
☐Guardian of Person

Juvenile Justice Services [check all that apply]:

☐Child in Need of Services (CHINS)
☐Delinquent
☐Detained
☐Committed to Sununu Youth Services Center
- ☐Furlough
- ☐Medical furlough
- ☐Administrative furlough
- ☐Administrative release
- ☐Detained pending revocation
- ☐Parole

Psychiatric hospitalization: New Hampshire Hospital, Designated Receiving Facility (DRF), or a behavioral/psychiatric unit in a general hospital [check all that apply]:

☐Involuntary Emergency Admission (IEA) up to 10 days
☐Involuntary commitment by probate (admission beyond 10 days)
☐Revocation of Conditional Discharge (CD)
☐Voluntary psychiatric admission

☐**Other (specify):**

SENTINEL EVENT REPORTING FORM

State of New Hampshire
Department of Health and Human Services
Bureau of Quality Assurance and Improvement

Original Effective Date: September 2010
Revision Date: January 27, 2020

Individual's Name *[Individual on whose behalf the Sentinel Event Report is being completed.]*

Last Name:	**First Name:**	**Middle Initial:**
Date of Sentinel Event: Click or tap to enter a date.	**Report Date:** Click or tap to enter a date.	

11. All Current Diagnosis(es):

Psychiatric	Medical

12. Individual's Services [List all services the individual is or was receiving if case was recently closed]:

a.	b.
c.	d.
e.	f.
g.	h.

III - SENTINEL EVENT DETAILS

13. Description of Event Details:

a. What happened?

b. If known, what were the precipitating factors?

c. When did it happen?

d. Where did it happen?

e. How did it happen?

f. Were there any witness(es)? ☐Unknown ☐No ☐Yes (answer 13.g)

g. Provide any relevant details about witness(es) *(name, contact information, etc.):*

h. Other relevant information:

14. Use of Restraints:

☐None Used ☐Physical ☐Mechanical ☐Chemical

If known, minutes in restraints:

SENTINEL EVENT REPORTING FORM

State of New Hampshire
Department of Health and Human Services
Bureau of Quality Assurance and Improvement

Original Effective Date: September 2010
Revision Date: January 27, 2020

Individual's Name *[Individual on whose behalf the Sentinel Event Report is being completed.]*

Last Name:	**First Name:**	**Middle Initial:**
Date of Sentinel Event: Click or tap to enter a date.	**Report Date:** Click or tap to enter a date.	

15. Individual's Housing:

Was the individual in a 24-hour residential facility, community residence, shelter, or institution within 30 days preceding the sentinel event? ☐No ☐Unknown ☐Homeless
☐Yes, then complete the next sections

Facility Name: Facility Location:

Facility Type [check the applicable box]:

☐Adult family care
☐Acute Psychiatric Residential Treatment Program (APRTP)
☐Community residence-certified (group home, shelter)
☐Group home
☐Psychiatric hospital or Designated Receiving Facility (DRF)
☐Medical/general hospital
☐Mid-level care facility
☐Skilled nursing facility
☐Other (describe):
☐Prison/jail
☐Residential care/assisted living
☐Respite *(type of facility):*
☐Residential treatment facility
☐Shelter
☐Substance use disorder treatment facility
☐Sununu Youth Services Center

IV - INITIAL NOTIFICATION

DHHS Division / Bureau:
DHHS Director / Administrator:
Date Notified: Click or tap to enter a date.
Method of Notification: ☐Telephone ☐Voice Mail (VM) ☐Other (specify):

V – ADDITIONAL INFORMATION

- Additional information regarding the sentinel event shall be reported as it becomes available, and upon the Department's request.
- As they are learned, additional details may include a change in status of the situation, links to relevant newspaper articles, etc.
    - To submit Additional Information for a previously reported Sentinel Event, upload a separate document to the eStudio application.
    - Use the following naming convention so that the Additional Information document remains part of the report history. For example:

PHI_SE_FIRSTNAME_LASTINITIAL_document description_YYYY-MM_DD