LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH Revised April 2017

CLINICAL EVENT NOTIFICATION/MANAGERIAL REVIEW – See DMH Policy 303.05, ATT. 1

In order to prevent discoverability, keep only one copy of this report and any attachment(s) in an Administrative File. Do not save them on a computer, e-mail them, include or reference them it or discussions with Clinical Risk Management in the client's record.

1. Client Last Name:	2. Client First Name:	3. DOB:	4. Age:	5. Gender:	6. IS#:	7. Event Date:

8. Service Area:	9. Provider #:	10. Special Prog. e.g. FSP/AB 109:	11. Prov. Name /Address	12. Event Location: (Address not needed.)

13. MD/DO/NP:	14. Psych. Diagnoses:	15. List frequency/ dosages of current psychotropic medications prescribed by you or another agency:

16. Current Medical Problem(s)? Y☐ N☐

Note that the response to item 17 will determine if the medication regimen in Item 15 is within DMH Parameters for Medications

Note: An "N" response to item 17. A-C requires the completion of item 25 on Page 2.

17. Is the regimen in item 15 above within DMH Parameters? Y☐ N☐ If N, check applicable boxes A-C below and submit pg.2.

A.☐ Use of Two or More Anti-psychotics	B.☐ Use of Two or More New Generation Antidepressants	C.☐ Use of a Benzodiazepine in a client with a Co-Occurring Substance Use Disorder

18. Select Clinical Event category: Submit Pg. 2 within 30 days of the report for asterisked categories below. Submit Pgs. 2 and 3 within 30 days of the report for **asterisked categories.

1. ☐ Death-Other than Suspected/Known Medical Cause	*5.☐ Client Self-injury Requiring EMT(Not Suicide Attempt)	*10. ☐ Threat of Legal Action
2. ☐ Death-Suspected/ Known Medical Cause	*6.☐ Client Injured Another Requiring EMT	*11. ☐ Client Assault by Another Client Requiring EMT
**3. ☐ Death-Suspected Known Suicide	**7.☐ Suspected/Alleged Homicide by Client	*12. ☐ Adverse Drug Reaction Requiring EMT
**4. ☐ Suspected/Known Suicide Attempt Requiring Emergency Medical Treatment (EMT)	*8.☐ Medication Error	*13. ☐ Alleged Client Assault By Staff
	*9.☐ Suspected/ Alleged Inappropriate Interpersonal Relationship with Client by Staff	*14. ☐ Inaccurate/Absent Lab Data Resulting in a Client Requiring EMT

19. **Describe the Event: Include important facts. If needed, use an additional sheet(s) that includes a statement of confidentiality (the last sentence at the bottom of this page). Attach other available, relevant information e.g. articles, post event team review.**

20. Reporting Staff:	21. Mgr's Name:	22. Mgr's Signature:	23. Mgr's Phone:	24. Rpt. Date:

- Mail Pg. 1 within 2 business days of the event to Roderick Shaner, M.D., Medical Director, Los Angeles County-Department of Mental Health, 550 S. Vermont Ave., 12th fl., Los Angeles 90020.
- Complete/mail Pg. 2 for *asterisked events and for any report with an "N" response to Item 17, or pgs. 2 and 3 for **double asterisked events within 30 days to the attention of Mary Ann O'Donnell or Doris Benosa.
- Contact Clinical Risk Management staff for questions at 213-637-4588, 213-639-6326 or 213-351-5095

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Client Last Name:	Client First Name:	IS #:	Mgr. Name:	Event Date:	Mgr. Report Date:

25. If Item 17 on Pg.1 is **"N" does the clinical record contain documentation of:**

A. The risks/benefits for the use of the medication(s)? Y☐ N☐ and, if applicable

B. A consultation with the furnishing supervisor if the medications were furnished by an N.P.? Y ☐ N ☐

Note: If either A or B are "N" please complete C and D below.

C. The Manager, supervising MD/furnishing supervisor has informed the MD/NP of the required documentation as stated in the DMH Guidelines for the Use of DMH Parameters, # 5. Y ☐ N ☐

D. The MD/NP has acknowledged the requirement and has agreed to comply with the requirement in the future. Y ☐ N ☐ If N, please explain on a separate sheet.

26. Was the client discharged from inpatient within the last 30 days prior to the event? Y ☐ N ☐

A. If Y, enter facility name, discharge date and reason for admission.

B. If yes, enter date and type of first appointment post discharge.

27. If past or current substance use (SU) was present OR was a factor identified in the event, was the client receiving co-occurring SU/MH treatment? **Y☐ N☐ If N, explain:**

28. Identify contributing factors/risk factors and/or stressors:

29. List any root cause(s) you identified as **relevant to this occurrence:**

30. List any systems, e.g. protocols/trainings that you have or will institute that may prevent a **similar event in the future:**

Note: For a **Category 3 event (Suicide),** a **Category 4 event (Suicide Attempt Requiring EMT), or** a **Category 7 event (Alleged/Suspected Homicide by Client), also complete items 31 -38 on Page 3. Otherwise, there** is **no need to submit page** 3.

Complete for a **Category 3 - Suicide, Category 4 -Suicide Attempt Requiring EMT, or Category 7 event - Alleged/Suspected Homicide by Client**

31. Describe the method used:

32. Was suicide/homicidal behavior risk assessed prior to this event? **Y ☐ N ☐**

A. If Y, was a standardized risk assessment tool ever used? Y ☐ N ☐

B. If A. is Y, specify the name of standardized tool and attach a copy:

C. If A. is N, check below which non-standardized method was used:
☐Non-standard tool (attach copy) ☐Other Specify type of assessment and what questions were asked.)

D. If the response to item 32. is Y, specify the date of the most recent suicide risk assessment:

E. If the response to item 32. is N, specify the reason:

33. In the assessment prior to the event, was the client determined to be at significant risk for suicide or homicide? **Y ☐ N ☐** (Note: For a definition of threshold homicide risk, see DMH Policy 303.01)

A. If Y, describe the interventions and follow-up actions, including a plan for safety and dates:

34. Was a **history of previous suicide attempts/aggressive behavior episodes taken? Y ☐ N ☐**

A. If N, specify reason:

B. If Y, was the history positive? Y ☐ N ☐

C. If B is Y, specify date(s), nature of attempt(s) and outcome, including hospitalizations:

35. If this was a **suicide or suicide attempt, was** a **history of the suicide(s) of family members taken?** **Y ☐ N ☐** A. If N, specify the reason:

B. If Y, was the history positive? Y ☐ N ☐

C. If B. is Y, describe:

36. Describe the client's treatment course:

A. Type(s) of services provided:

B. Frequency of services:

C. Date and type of last service provided prior to the event:

D. What was the date services were initiated?

37. List the documented goals of treatment:

A. What were the documented responses to each goal?

38. Was the client sufficiently engaged in treatment for addressing and managing the documented suicide/homicide risk? **Y ☐ N ☐**

A. Did the client keep appointments? Y ☐ N ☐ If N, explain, include interventions if any.

B. Did the client refuse any treatment recommendations? Y ☐ N ☐ If Y, specify:

C. Were there other signs of lack of engagement? Y ☐ N ☐ If Y, specify: