LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH **Revised 7/28/10**

CLINICAL INCIDENT (EVENT) NOTIFICATION (DMH Policy #202.18, , Attachment I,
You may complete this report on a computer or print, but do not e-mail this report.

1. Client Name:	2. Birth Date:	3. Sex:	4. IS #:	5. Event Date:	6. Report Date:	7. Service Area

8. Provider:#	9. MHSA/ other Special Program:	10. Provider Name: (Include address if contract agency.)	11. Event Location:	12. MD/ Psychiatric Mental Health Nurse Practitioner (PMHNP):

13. Diagnoses:	14. List the frequency and dosages of all current medications::

The response to item 15. below is to determine if the medication regimen in 14. above is within DMH parameters for the Prescribing of **Psychoactive Medications, http://dmh.lacounty.gov/Tools for Clinicians, Clinical Guidelines/Clinical Practice/practice parameters the response must be determined by the prescriber/ furnisher //supervising psychiatrist, or manager/designee.)**
Note: an "N" response **requires the completion of** item **22.** on page 2.

15. Is the regimen in item **14.** within DMH Parameters? ☐ Y ☐ N. If N, indicate the reason by checking applicable boxes A-D. The regimen includes:

☐ A. Two or more atypical antipsychotics	☐ B. Two or more new generation antidepressants	☐ C. A benzodiazepine in a client with a co-occurring substance use disorder.
☐ D. Other: Please specify:		

16. Clinical Incident Type: (Check): *Asterisked numbers require submission of pg. 2 within 30 days of the report date.

☐ 1. Death-Other than Suspected/ Known Medical Cause	☐ *4 Suicide Attempt Requiring Emergency Medical Treatment (EMT)	☐ *7. Homicide By Client
☐ 2. Death- Suspected/Known Medical Cause	☐ *5. Client Injured self (not suicide attempt) or was injured by another Client Requiring EMT	☐ *8 Medication Error/ Adverse Medication Event
☐ *3. Death- Suspected/Known Suicide	☐ *6. Client Injured Another requiring EMT	☐ *9 Suspected Client Abuse by Staff
		☐ *10 Possibility/ Threat of Legal Action

17. Description of the Incident: Include important facts. If needed, use an additional sheet(s) that includes a statement of confidentiality i.e., the last sentence at the bottom of this page. Attach newspaper articles.

18. Reporting staff:	19. Phone:	20. Manager's Signature:	21. Phone:

Send Pg. 1 to Roderick Shaner, MD, LAC DMH Medical Director, 550 S. Vermont Ave., 12th Fl., Los Angeles, CA 90020 within 1 business day for Directly-operated programs and 2 business days for contract agencies. Keep Only 1 copy. Do not file or reference the report or communication with the Clinical Risk Manager in the clinical record. Send **The Manager's Report of Clinical Review (Pg. 2) within 30 days to the Clinical Risk Manager for asterisked (*) categories 3-10 above and for a "N" response to Item 15.** Contact Mary Ann O'Donnell, RN, MN, Clinical Risk Manager for questions. Phone: 213637-4588. **This information is privileged and confidential under Evidence Code Section 1157.6 and Government Code 6254 [c.]**

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH **REVISED 7/28/10**
CLINICAL INCIDENT (EVENT) NOTIFICATION MANAGERIAL REVIEW
YOU MAY COMPLETE THIS REPORT ON A COMPUTER OR PRINT IT BUT DO NOT E-MAIL THIS REPORT.

SUBMIT THIS PAGE WITHIN 30 DAYS OF THE CLINICAL INCIDENT AFTER COMPLETING A CLINICAL REVIEW FOR INCIDENTS IN ASTERISKED CATEGORIES 3-10 ON PG. 1. OR FOR A "N" RESPONSE TO ITEM **15.** TO: MARY ANN O'DONNELL, LAC DMH CLINICAL RISK MGR., 550 S. VERMONT AVE., 12TH FL. LOS ANGELES, CA 90020. PH.:213-637-4588.

Client Name:	IS#:	Manager's Signature:	Date:

22. IF ITEM **15.** ON PG. 1 IS "N," DID THE CLINICAL RECORD CONTAIN:
☐Y ☐N A. THE RISKS/BENEFITS FOR THE USE OF THE MEDICATION(S)? AND (IF APPLICABLE)
☐Y ☐N B DOCUMENTATION OF A CONSULTATION WITH THE FURNISHING SUPERVISOR IF THE MEDICATIONS WERE FURNISHED BY A PMHNP?
IF EITHER A. OR B. ARE "N", PLEASE COMPLETE C. AND D. BELOW.

☐ C .THE MANAGER, SUPERVISING PSYCHIATRIST OR FURNISHING SUPERVISOR HAS INFORMED THE MD/ PMHNP OF THE REQUIRED DOCUMENTATION AS STATED IN THE DMH GUIDELINES FOR THE USE OF THE PARAMETERS, ITEM #. 5.

☐ D. THE MD/PMHNP HAS ACKNOWLEDGED THE REQUIREMENT AND HAS AGREED TO COMPLY WITH THE REQUIREMENT IN THE FUTURE.

23. WAS THE INCIDENT IN ITEM **16.** A SUSPECTED SUICIDE OR A SUICIDE ATTEMPT REQUIRING EMERGENCY MEDICAL TREATMENT (EMT)?
☐Y ☐N IF Y, ENTER

A. DATE OF LAST SERVICE PROVIDED: B. TYPE OF LAST SERVICE PROVIDED:

C. LIST DATE(S) AND **NATURE** OF PRIOR ATTEMPT(S) REQUIRING EMERGENCY MEDICAL TREATMENT:

D. ANY OTHER RELEVANT FACTORS:

24. IF SUBSTANCE ABUSE (SA) WAS A FACTOR IN ITEM **16.**, WAS THE CLIENT RECEIVING CO-OCCURRING SA TREATMENT? ☐ Y ☐ N
IF N, PLEASE EXPLAIN.

25. LIST ANY PRE-DISPOSING FACTOR(S) OR ROOT CAUSE(S) THAT MAY BE RELEVANT IN THIS TYPE OF EVENT, E.G. INCLUDE, IF RELEVANT, FACTORS IN THE TRANSFER OF CARE BETWEEN PROVIDERS, E.G., MEDICATIONS SUPPLIED FOR TRANSITION TO THE RECEIVING PROVIDER:

26. LIST ANY RECOMMENDATIONS FOR OPERATIONAL CHANGES OR MANAGERIAL ACTIONS IN YOUR CLINIC/AGENCY THAT MAY LESSEN THE IMPACT OR LIKELIHOOD OF THIS TYPE OF EVENT OCCURRING IN THE FUTURE:

27. LIST ANY CURRENT OR NEW SYSTEMS, PARAMETERS, POLICIES & PROCEDURES OR TRAININGS IN YOUR AGENCY OR THROUGH DMH, THAT MAY HELP YOUR STAFF DEAL MORE EFFECTIVELY WITH THE CLINICAL OR OTHER ISSUES INHERENT IN THIS TYPE OF EVENT:

KEEP ONLY 1 COPY. DO NOT FILE/REFERENCE THE REPORT OR COMMUNICATION WITH THE CLINICAL RISK MANAGER IN THE CLINICAL RECORD.
THIS INFORMATION IS PRIVILEGED AND CONFIDENTIAL UNDER EVIDENCE CODE SECTION 1197 AND GOV'T CODE 6254 [C.]