LOS ANGELES COUNTY-DEPARTMENT OF MENTAL HEALTH

CLINICAL INCIDENT REPORTING FLOW PROCESS – Directly-Operated Programs

Revised November 2013

The review of clinical incidents as defined below is a component of the Departmental Quality Improvement Process. All information generated by the DMH Clinical Incident Report (attachment to DMH Policy 202.18) and Managerial Review is privileged and strictly confidential under state law, including Evidence Code 1157.6 and Government Code Section 6254 [c} relating to personnel records. Contact Clinical Risk Management (CRM) at 213-351-6639, 213-637-4588 or 213-639-6326 for additional information.

Process: **Recognize, Report, Review Case, Respond, Resolve, Retain**

I. Being familiar with **DMH Policy 202.18,** "Reporting Clinical Incidents…" assists managers and staff to recognize reportable events when they happen. "**Clinical"** incidents as defined by the policy are:

RECOGNIZE

1. Death-Other Than Suspected or Known Medical Cause or Suicide
2. Death- Suspected or Known Medical Cause
3. Death- Suspected or Known Suicide
4. Suicide Attempt Requiring Emergency Medical Treatment (EMT)
5. Client Sustained Intentional Injury (Not Suicide Attempt) Requiring EMT
6. Client Injured Another Person Who Required EMT
7. Homicide By Client
8. Medication Error or Adverse Medication Event Requiring EMT
9. Alleged Client Abuse by Staff
10. Possibility or Threat of Legal Action

If the incident is **NOT** a clinical Incident, a report should be made to the appropriate person below rather than the CRM as this can create a delay in follow-up procedures.

1. Accidents (sips, falls, accidents involving county vehicles or mileage permitees): Incident Report Patient /Non-Patient MH #196/761302 should be sent via the Service Catalog. Contact Admin. Support, DMH 2nd Fl. Ph. 213-738-3079 for more information.
2. Threats to staff, health & safety incidents as listed on the DMH Security Incident Report (SIR.) Report to DMH Health and Safety, DMH 7th Fl. Ph. 213-738-4430.
3. Employee work-related injuries, illnesses, accidents: Contact DMH HRB, Leave Management Unit, 9th Fl. Ph. 213-738-4850.
4. Alleged Employee Misconduct: Contact DMH HRB, Performance Management. 9th Fl. Ph. 213-738-4054.
5. Subpoenas of staff to testify re PHI or for PHI, contact DMH Custodian of Records, Quality Improvement Bureau, 213-251-6722.

II. If the incident is a clinical incident, next review and determine if it is **critical** or **non-critical.**

A. A **critical clinical incident** is one that may require a report to the Board of Supervisors by the Director, e.g. one generating governmental and/or media attention. In this case, the manager should:

REPORT

1. **Call the CRM (or the Secretary to the DMH Medical Director if the CRM is not available) and transmit Page 1 of the DMH Clinical Incident Report by confidential fax procedure (See Policy 202.18 for details) to the DMH Medical Director immediately.** Phone: CRM-213-637-4588; Med. Dir. Sec'y-213-738-4603; FAX: 213-386-1297
2. Complete Section III below if the clinical incident is in categories 3-10 in Section I, otherwise, proceed to Section IV below.

B. If the incident is a **non-critical clinical incident**, the manager should:

1. Send Page 1 of the DMH Clinical Incident Report **(Marked Confidential)** within the next 48 hours to: Roderick Shaner, M.D., LAC-DMH, 550 S. Vermont Ave., 12th floor, Los Angeles, CA 90020.

2. Complete Section III below if the clinical incident is in categories 3-10 in Section I, otherwise, proceed to section IV below:

REVIEW CASE

III. A Managerial Review of the Case (Page 2 of the DMH Clinical Incident Report) should be completed within **30 days** of the event for clinical incidents in categories 3-10 on page 1, Section I and sent **(Marked Confidential)** to Mary Ann O'Donnell, LAC DMH Clinical Risk Management, 550 S. Vermont Ave., 12th Floor, Los Angeles, CA 90020. A copy of a Clinical Case Review, if done, should also be enclosed. The purpose of the Managerial Review is to determine factors that may prevent a similar occurrence in the future or to avoid a more serious occurrence for a particular client, e.g. one who has made a serious suicide attempt. Elements important to consider in completing page 2 include:

A. Review event chronology.
B. Determine risk factors that may have contributed to the incident.
C. Review parameters, policies, procedures and systems relevant to the event,
D. Suggest development or revision of relevant systems, parameters, policies and procedures,
E. Identify training needs and issues.
F. Re-review action items at a later period to ensure completion.
G. Monitor trends

IV. Clinical incidents are reviewed by the DMH Medical Director and CRM. Managerial Reviews are reviewed by the CRM, and DMH Medical Director. Autopsy reports are reviewed.

RESPOND

A. If further information or action is needed the following actions may be taken:
   1. A memo is sent or the manager contacted requesting further information within 30 days.
   2. An adverse outcome review may occur.

B If no further reporting is required:
   1. A memo is sent to the manager.
   2. The incident is trended by the CRM and reported to the Quarterly Clinical Risk Management Committee (QCRMC.)

RESOLVE

V. Resolution: Legal claims, adverse outcome reviews, clinical incidents trends, Managerial Reviews, and recommendations are reviewed by the QCRMC in order to:

A. Determine resolution of clinical incidents, i.e. develop recommendations/actions to be referred to DMH management, DMH Quality Improvement Council (QIC), Clinical Policy Committee (CPC), DMH Executive Committee, or to determine if no further actions are needed.
B. Develop recommendations/actions based on trends to be referred to DMH management, DMH QIC, CPC, and the DMH Executive Committee.
C. Finalize a Plan of Correction when requested by the Board of Supervisors.

RETAIN

VI. Retention

A. Clinical Incident reports and related materials are retained for the period of seven years or as otherwise established by Los Angeles County guidelines.