

North Sound Mental Health Administration

Critical Incident Review Committee

Semi-Annual Report

Third & Fourth Quarter 2007

NSMHA Semi-Annual Critical Incident Report

July - December, 2007

PURPOSE: To inform NSMHA Executive Board and Executive Director, county coordinators, CIRC, QMC, QMOC, and other stakeholders in the region interested in critical incident data and activities on a semi-annual basis.

INTRODUCTION

This NSMHA Semi-Annual Critical Incident Report is the first to reflect the revised CI categories required by MHD in the new contract language that went into effect July 1, 2007. It is expected that the revision of CI categories/sub-categories will continue to have the following implications on this and subsequent reports:

- An increase of MHD reportable subcategories from 9 to 18
- A decrease of NSMHA reportable (non-MHD reportable categories) from 15 to 2. The 2 NSMHA reportable subcategories have been maintained for internal, clinical quality improvement efforts despite their reporting not being required by MHD
- An apparent MHD shift toward “legalistic” and away from “clinical-focused” sub-categories has changed the usefulness of the historical data in the analysis of clinical quality
- As a quality improvement entity, NSMHA will revert to gathering baseline data for the next few years
- An increase in the rate of MHD reportable CI
- A decrease in the frequency of total reported CI

HIGHLIGHTS OF CI DATA FROM JULY THROUGH DECEMBER, 2007

- The total number of reported critical incidents dropped from 29 in the 3rd quarter to 18 in the 4th quarter, a 38% reduction (Chart 1)
- There was a reduction in total reported critical incidents in each of the North Sound Counties from the 3rd quarter to the 4th quarter except San Juan County, which recorded no incidents in either quarter, and Whatcom County which reported 6 incidents in each quarter (Chart 1)
- The number of deaths by unusual circumstances decreased from 2 in the 3rd quarter to 1 in the 4th quarter in both Whatcom and Snohomish Counties. None of the other counties reported any of this type of deaths in the 3rd or 4th quarters (Chart 2)
- Aside from San Juan County which reported no (0) suicide attempts in either quarter, the remaining 4 counties reported significant reductions in suicide attempts from the 3rd to the 4th quarter. Reported suicide attempts in the North Sound Region dropped from 18 to 5, a 72% decrease (Chart 3)

- The only category of reported critical incidents that showed an increase of more than 1 incident from the 3rd quarter to the 4th was the number of alleged rapes (victim) in Snohomish County where 1 was reported in the 3rd quarter, and 3 in the 4th quarter (Chart 4)
- No more than 1 critical incident were reported by any of the 5 counties, in any quarters, in any of the following categories:
 - a. Homicide (perpetrator)
 - b. Homicide (victim)
 - c. Assault of a client by staff
 - d. Alleged rape (perpetrator)
 - e. Alleged sexual assault (victim)
 - f. Non-fatal injury resulting in arrest (perpetrator)
- There were no (0) critical incidents reported in the following categories:
 - a. Attempted homicide (perpetrator)
 - b. Attempted homicide (victim)
 - c. Medicaid fraud
 - d. Financial exploitation (client)
 - e. Financial exploitation (provider)
 - f. Assault of staff by client resulting in hospitalization
 - g. Alleged sexual assault (perpetrator)
 - h. Non-fatal injury resulting in arrest (victim)
 - i. Arson
 - j. E&T elopement

CONCLUSIONS FROM ANALYSIS HISTORIC DATA

- Gains have been held in the quality improvement efforts to prevent elopements from E&Ts
- The recent joint effort by NSMHA and Providers to clinically evaluate and take steps to reduce the level of patient risk appears to have been successful in view of the sharp 4th quarter drop in reported suicide attempts

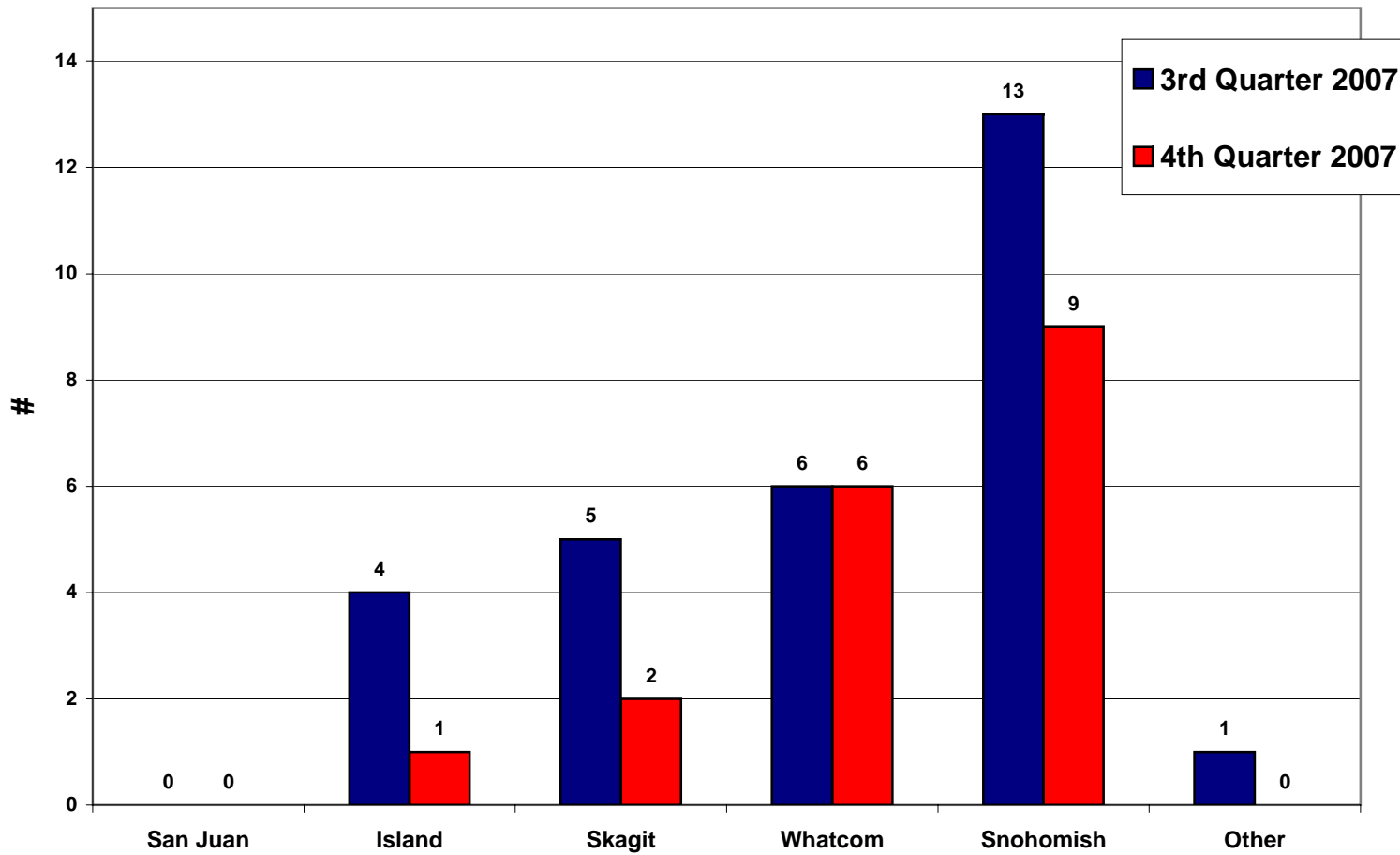
ONGOING CRITICAL INCIDENT QUALITY MANAGEMENT RECOMMENDATIONS AND REVIEW ACTIVITIES

- The CIRC screened sixty-three (63) reported incidents. Seventeen (17) of the reported incidents were determined to not meet the formal definition of a critical incident, so forty-six (46) were reviewed in committee
- The CIRC continues to further investigate incidents and the circumstances surrounding their occurrence to ensure compliance with policies and processes affecting the quality of consumer care, health and safety
- The CIRC highlights and pursues specific incidents that provide examples of region-wide need or challenges in consumer care that may be impacted by provider directed system changes or policy development
- The CIRC and critical incident review process continue to work in tandem and cooperation with other NSMHA quality assurance and improvement activities including denial review requests, utilization review, formal audits and selected projects aimed at improved consumer outcomes and decreased risk to consumers
- The CIRC continues to be active in spearheading new ways to utilize Critical Incident Data to best facilitate quality improvement activities for the benefit of consumers in the NSMHA region
- The CIRC continues to follow specific incidents of concern that affect consumers

Attachments:

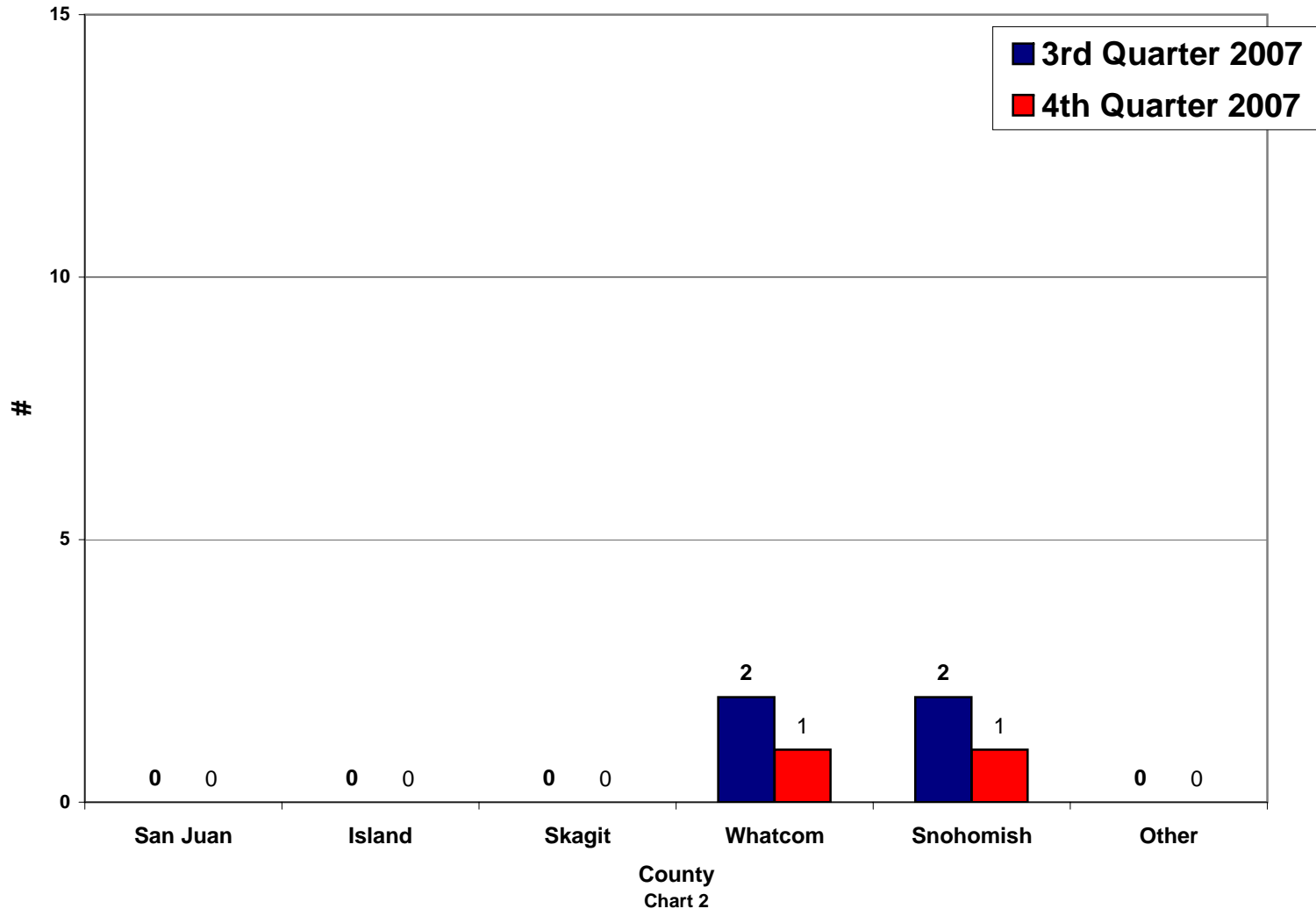
1. Bar Chart Showing the Total Number of Reported Critical Incidents
2. Bar Chart Showing the Number of Reported Deaths by Unusual Circumstances
3. Bar Chart Showing the Number of Reported Suicide Attempts
4. Bar Chart Showing the Number of Reported Incidents of Rape (Victim)

Bar Chart Showing the Total Number of Reported Critical Incidents in the North Sound Region
July - December 2007
By County

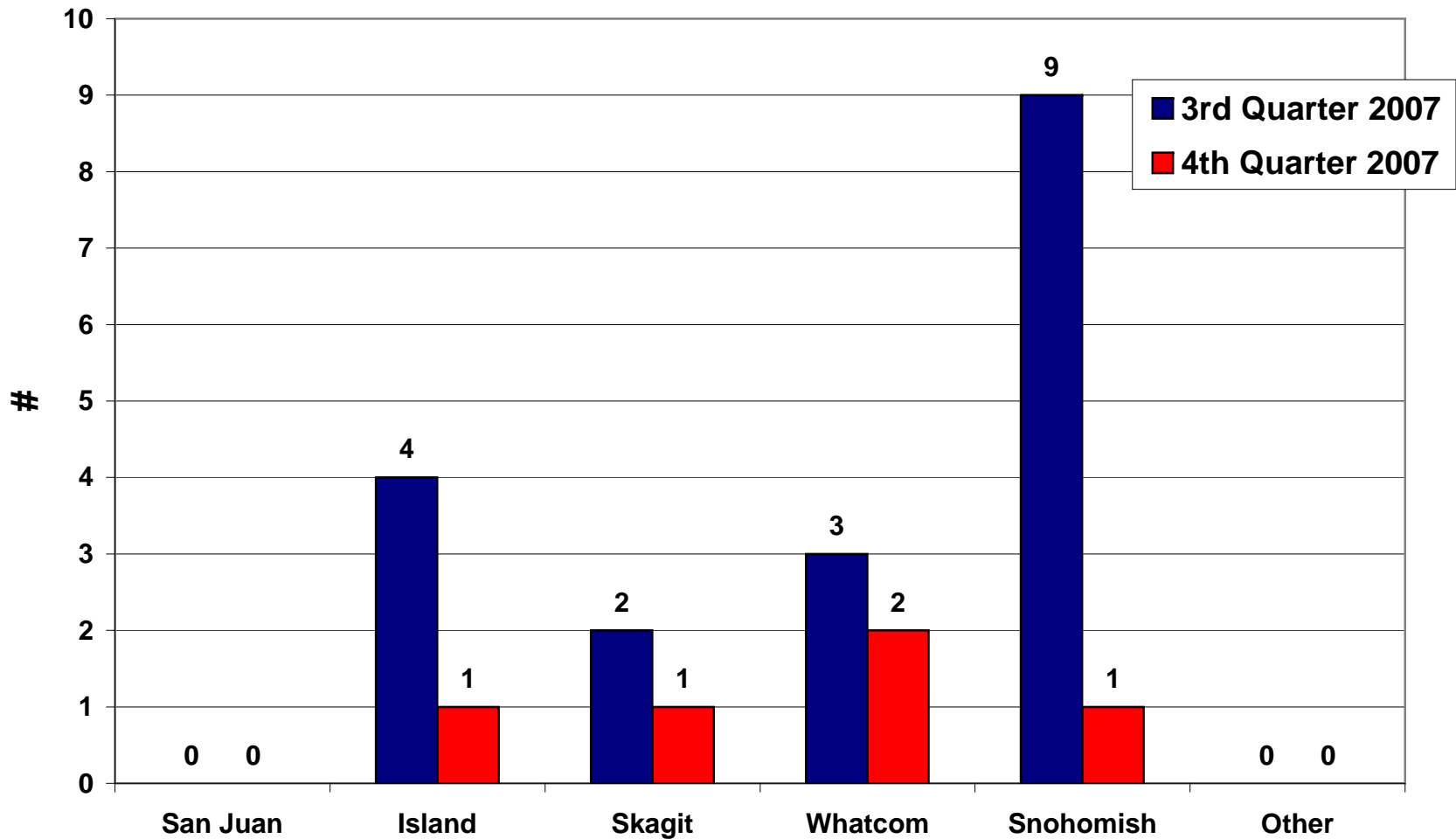


County
Chart 1

Bar Chart Showing the Number of Reported Deaths by Unusual Circumstances in the North Sound Region
July - December 2007
By County

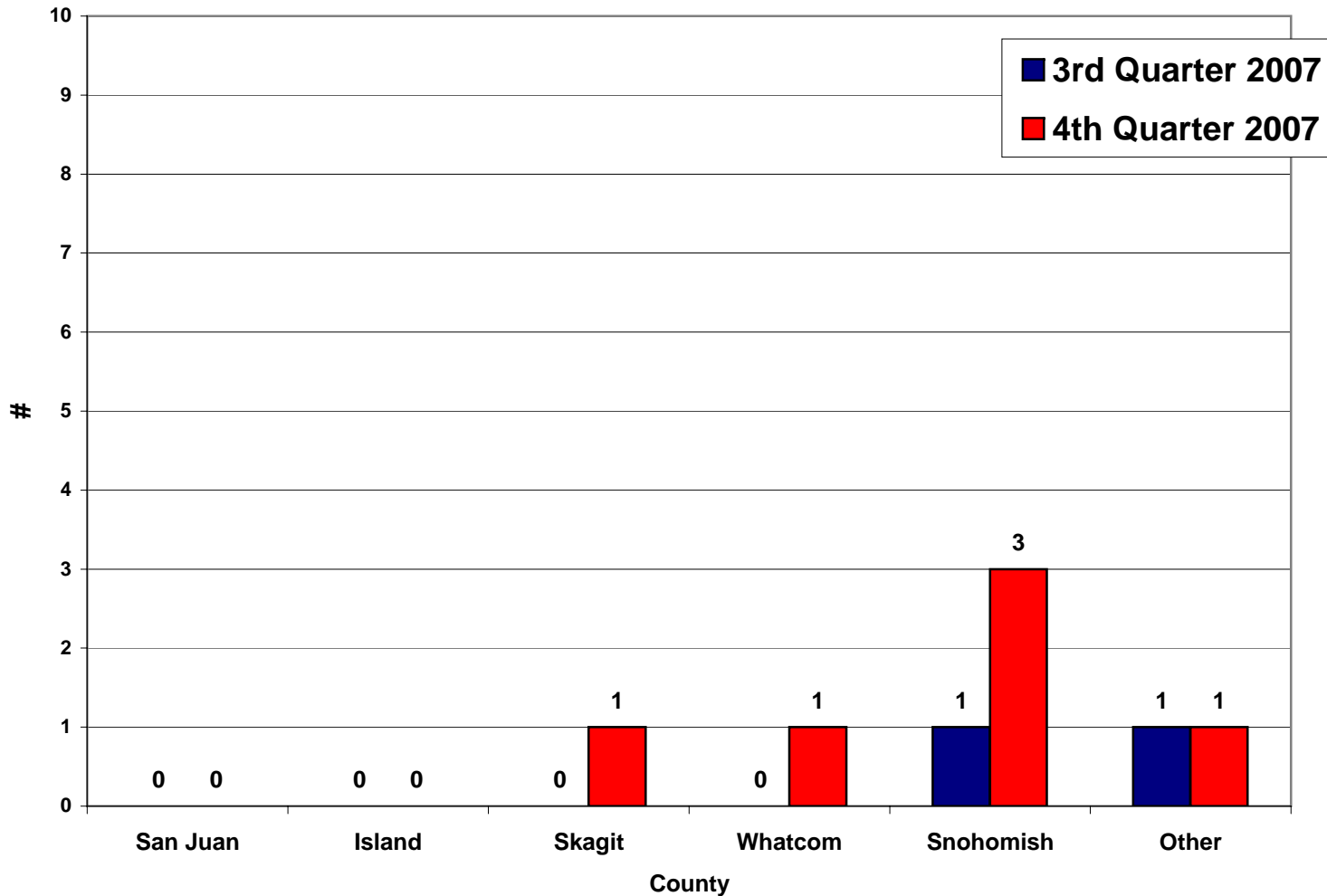


Bar Chart Showing the Number of Reported Suicide Attempts in the North Sound Region
July - December 2007
by County



County
Chart 3

Bar Chart Showing the Number of Reported Incidents of Alleged Rape (Victim) in the North Sound Region
July - December 2007
By County



County
Chart 4