

North Sound Mental Health Administration

Critical Incident Review Committee

Semi-Annual Report

First & Second Quarter 2008

NSMHA Semi-Annual Critical Incident Report

January – June 2008

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 second to reflect the revised CI categories required by MHD in the new contract language that went into effect July 1, 2007. As anticipated, the revision of CI categories/sub-categories has had 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 JANUARY THROUGH JUNE, 2008

- The total number of reported critical incidents dropped from 26 in the 1st quarter to 23 in the 2nd quarter, a 12% reduction (Chart 1)
- There was a reduction in total reported critical incidents in Snohomish (16 – 13) and Whatcom (6 – 2) Counties from the 1st quarter to the 2nd. San Juan County reported no incidents in either quarter. Skagit County showed an increase from 4 to 6; and Island from 0 to 2. (Chart 1)
- The number of deaths by unusual circumstances decreased from 5 in the 1st quarter to 2 in the 2nd; one incident each in Island and Snohomish Counties (Chart 2)
- The reported incidents of alleged rape where a NSMHA consumer was the alleged victim remained at 2 for both quarters in Snohomish County. Skagit County showed an increase from 0 to 2. The three remaining counties reported no such incidents (Chart 3)
- The reported incidents of sexual assault where a NSMHA consumer was the alleged perpetrator decreased from 3 in the 1st quarter to 2 in the 2nd quarters in Snohomish County. The four remaining counties reported no such incidents (Chart 4)

- The reported incidents of sexual assault where a NSMHA consumer was the alleged victim increased from 0 in the 1st quarter to 2 in the 2nd quarters in Snohomish County. The four remaining counties reported no such incidents (Chart 5)
- Aside from San Juan County which reported no (0) suicide attempts in either quarter, the remaining 4 counties reported reductions in suicide attempts from the 1st to the 2nd quarter. Reported suicide attempts in the North Sound Region dropped from 15 to 8, a 47% decrease (Chart 6)
- No more than one critical incident were reported by any of the 5 counties, in either quarter, in any of the following categories:
 - a. Homicide (perpetrator)
 - b. Alleged rape (perpetrator)
 - c. Non-fatal injury resulting in arrest (perpetrator)
 - d. E&T elopement
- There were no critical incidents reported in the following categories:
 - a. Homicide (victim)*
 - b. Attempted homicide (perpetrator)*
 - c. Attempted homicide (victim)*
 - d. Medicaid fraud*
 - e. Financial exploitation (client)*
 - f. Financial exploitation (provider)*
 - g. Assault of staff by client resulting in hospitalization*
 - h. Assault of client by staff
 - i. Non-fatal injury resulting in arrest (victim)
 - j. Arson*

CONCLUSIONS FROM ANALYSIS OF HISTORIC DATA

- No incidents have been reported in any of the categories designated above with * since the new MHD reportable categories were implemented on July 1, 2007.
- Gains have been held in the quality improvement efforts to prevent elopements from E&T's. Since the relatively large number of elopements in 2005 (8), and the subsequent quality improvement efforts, there have not been more than two elopements in any quarter. There were two in the 2nd quarter of 2007. Other than that quarter, there have been zero or one elopement per quarter. There were none in the 1st quarter of 2008, and only one in the 2nd quarter.

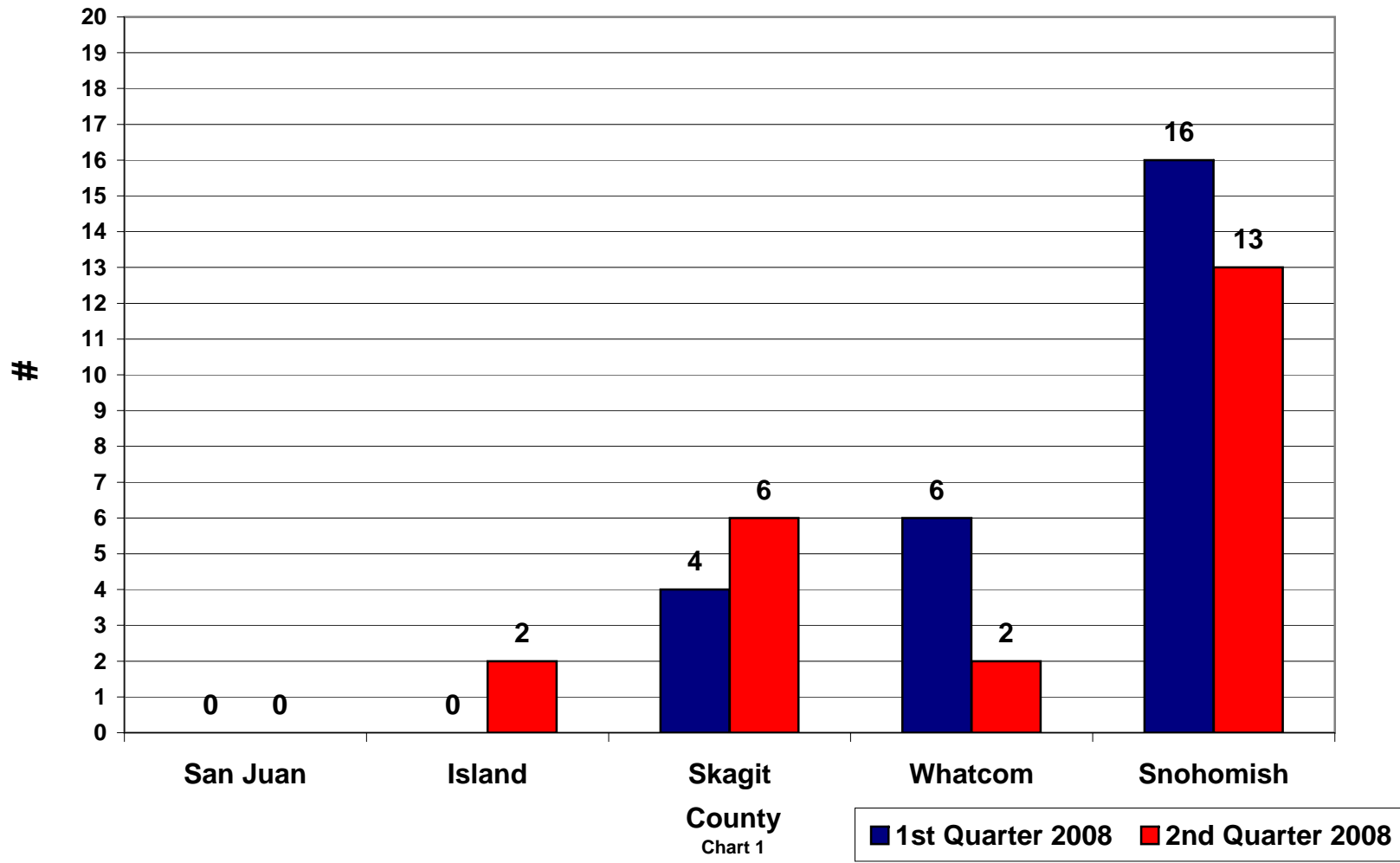
ONGOING CRITICAL INCIDENT QUALITY MANAGEMENT RECOMMENDATIONS AND REVIEW ACTIVITIES

- CIRC screened fifty-nine (59) reported incidents. Ten (10) of the reported incidents were determined to not meet the formal definition of a critical incident, so forty-nine (49) were reviewed in committee
- At the request of the Internal Quality Management Committee (IQMC) in 2007, CIRC began tracking those reported incidents that may or may not meet MHD and NSMHA criteria as “critical incidents” but are determined to be “system issues” that are forwarded by CIRC to other committees for intervention and disposition. One of these system issues was forwarded to other committees in each of the last two quarters
- 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
- 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
- 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
- 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
- CIRC continues to follow specific incidents of concern that affect consumers

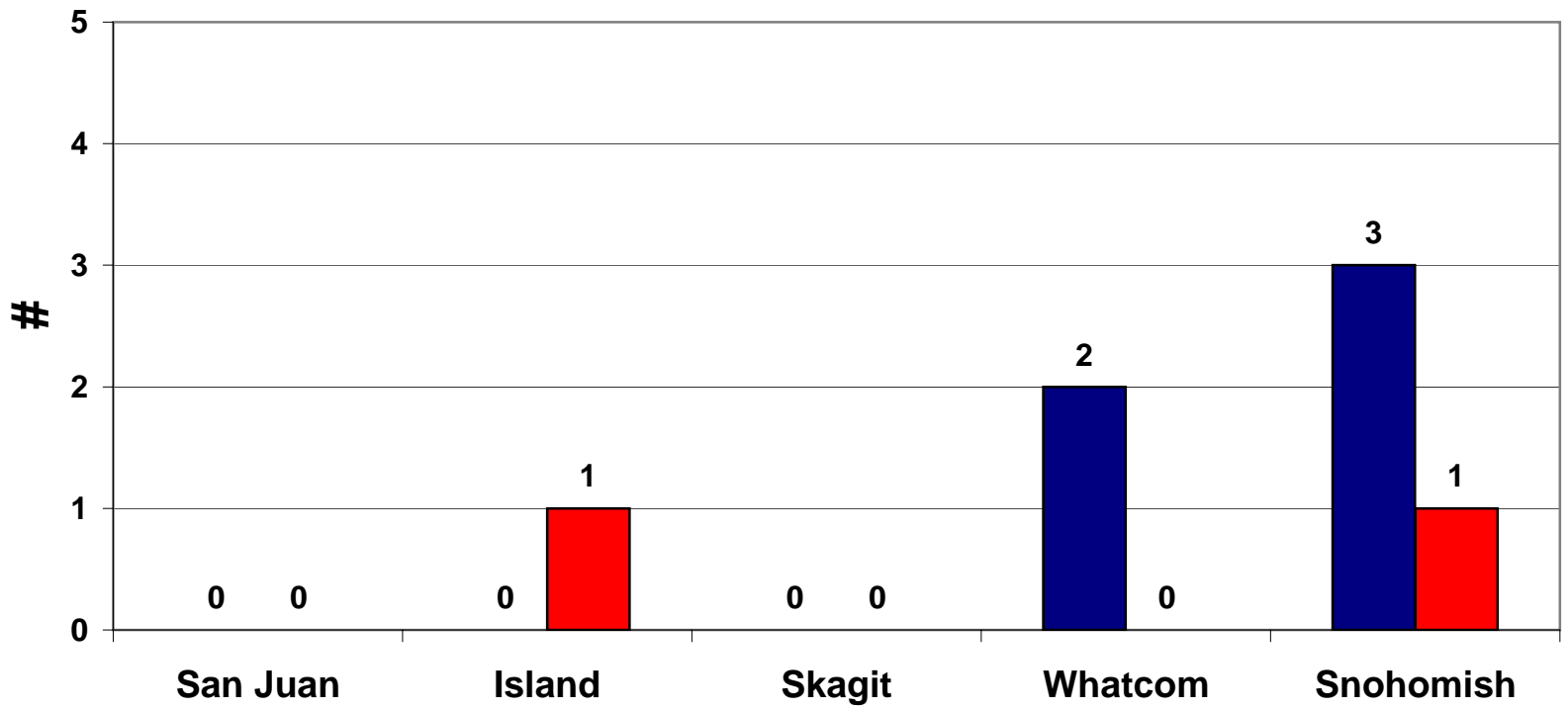
Attachments:

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 Incidents of Alleged Rape Where a NSMHA Consumer was the Alleged Victim
4. Bar Chart Showing the Number of Reported Incidents of Alleged Sexual Assault Where a NSMHA Consumer was the Alleged Perpetrator
5. Bar Chart Showing the Number of Reported Incidents of Alleged Sexual Assault Where a NSMHA Consumer was the Alleged Victim
6. Bar Chart Showing the Number of Reported Suicide Attempts

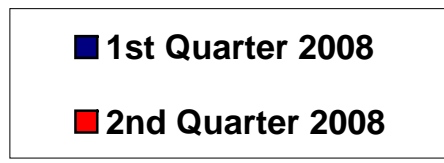
**Bar Chart Showing the Total Number of Reported Critical Incidents
North Sound Region
January - June 2008**



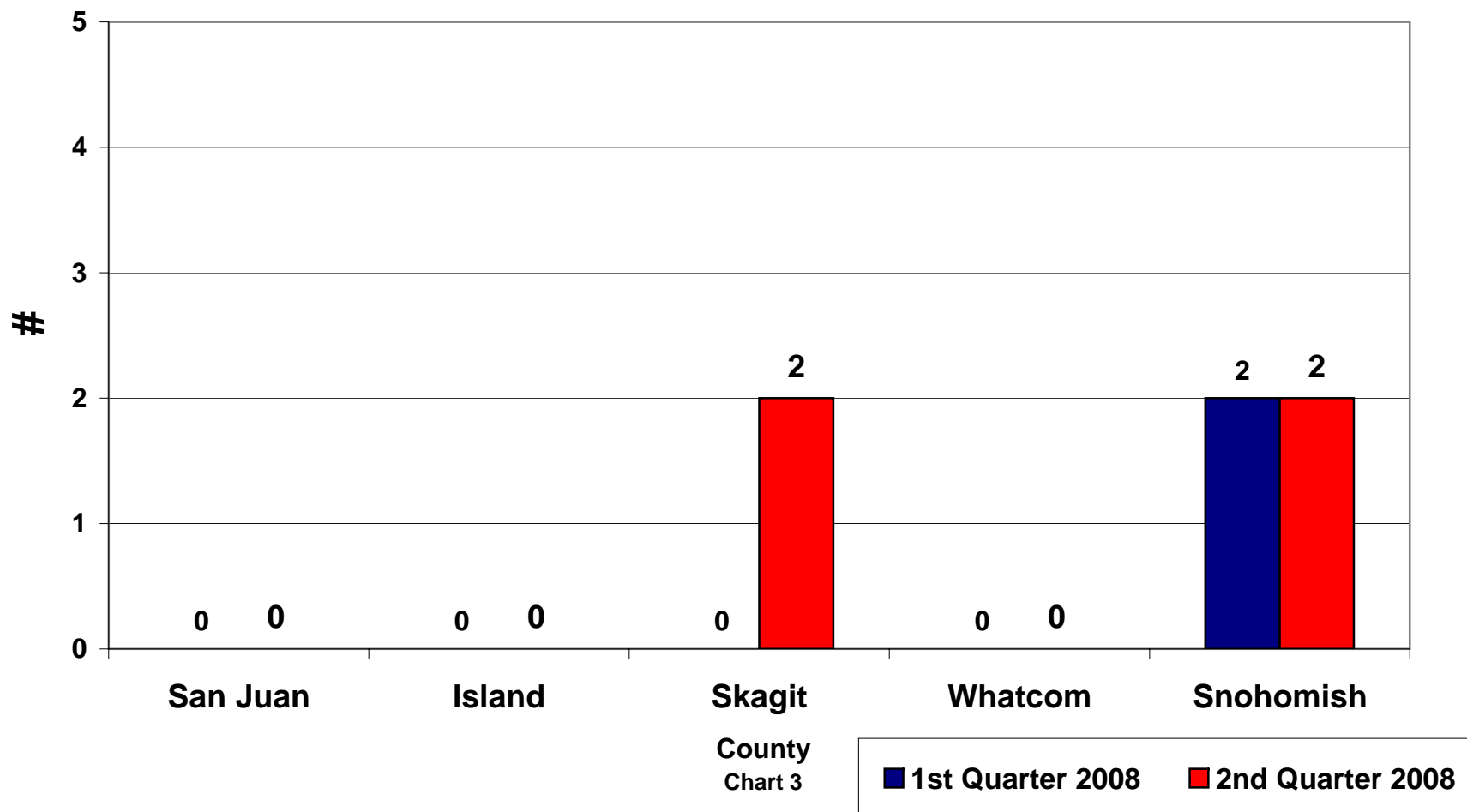
**Bar Chart Showing the Number of Reported Deaths by Unusual Circumstances
North Sound Region
January - June 2008**



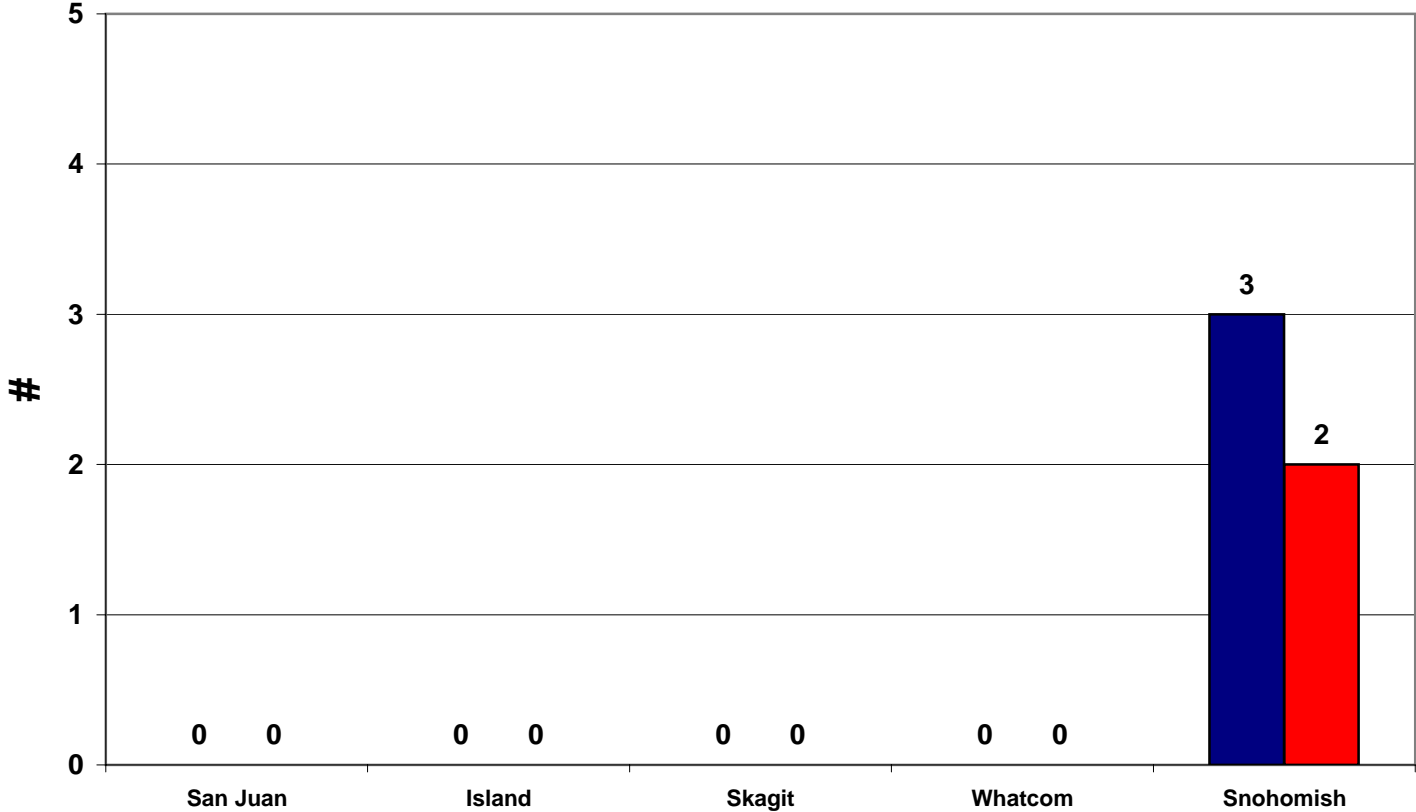
County
Chart 2



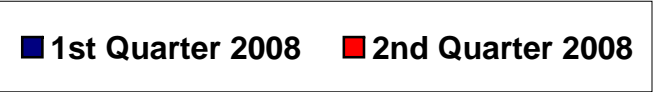
Bar Chart Showing the Number of Reported Incidents of Alleged Rape
Where a NSMHA Consumer was the Alleged Victim
North Sound Region
January - June 2008



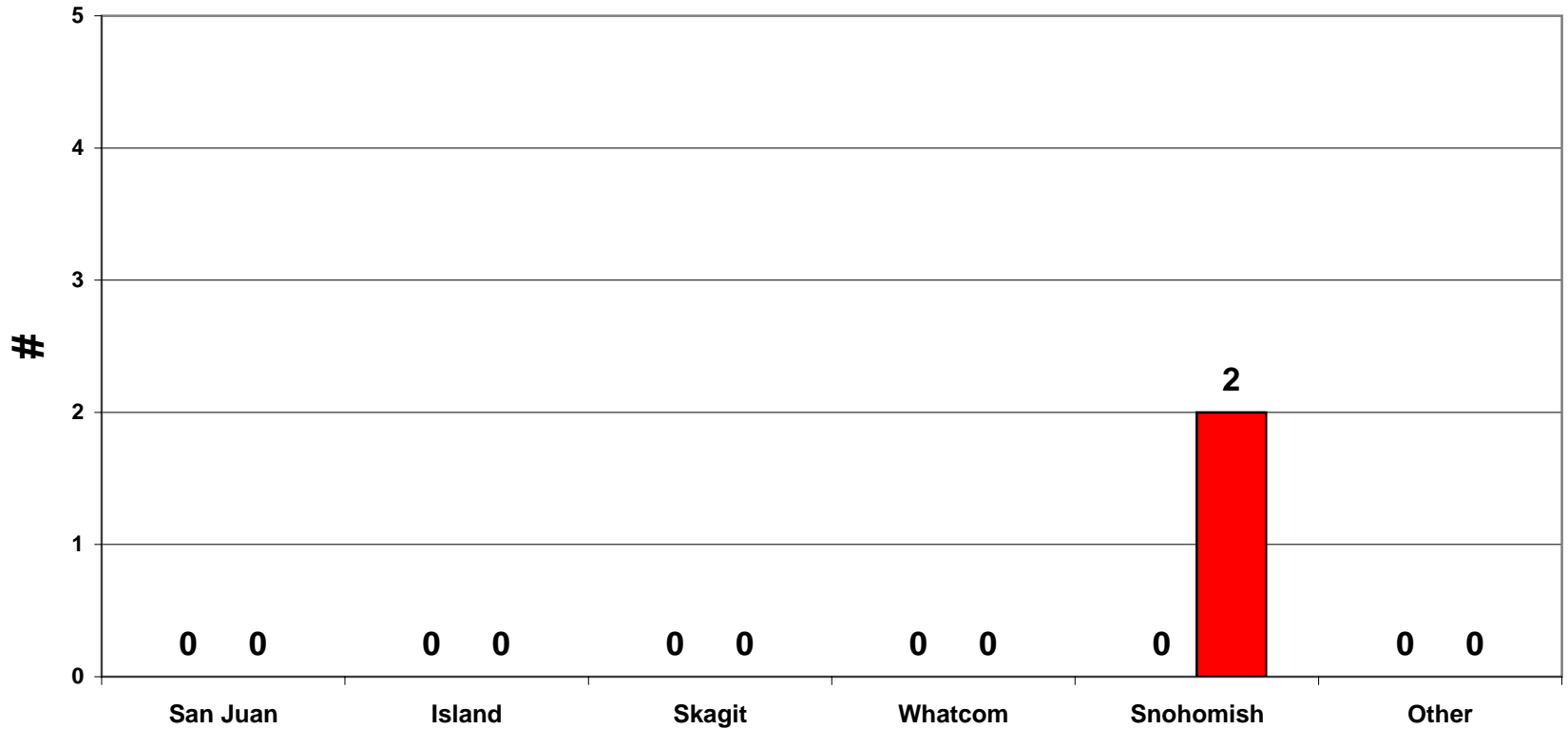
Bar Chart Showing the Number of Reported Incidents of Alleged Sexual Assault
Where a NSMHA Consumer was the Alleged Perpetrator
North Sound Region
January - June 2008



County
Chart 4



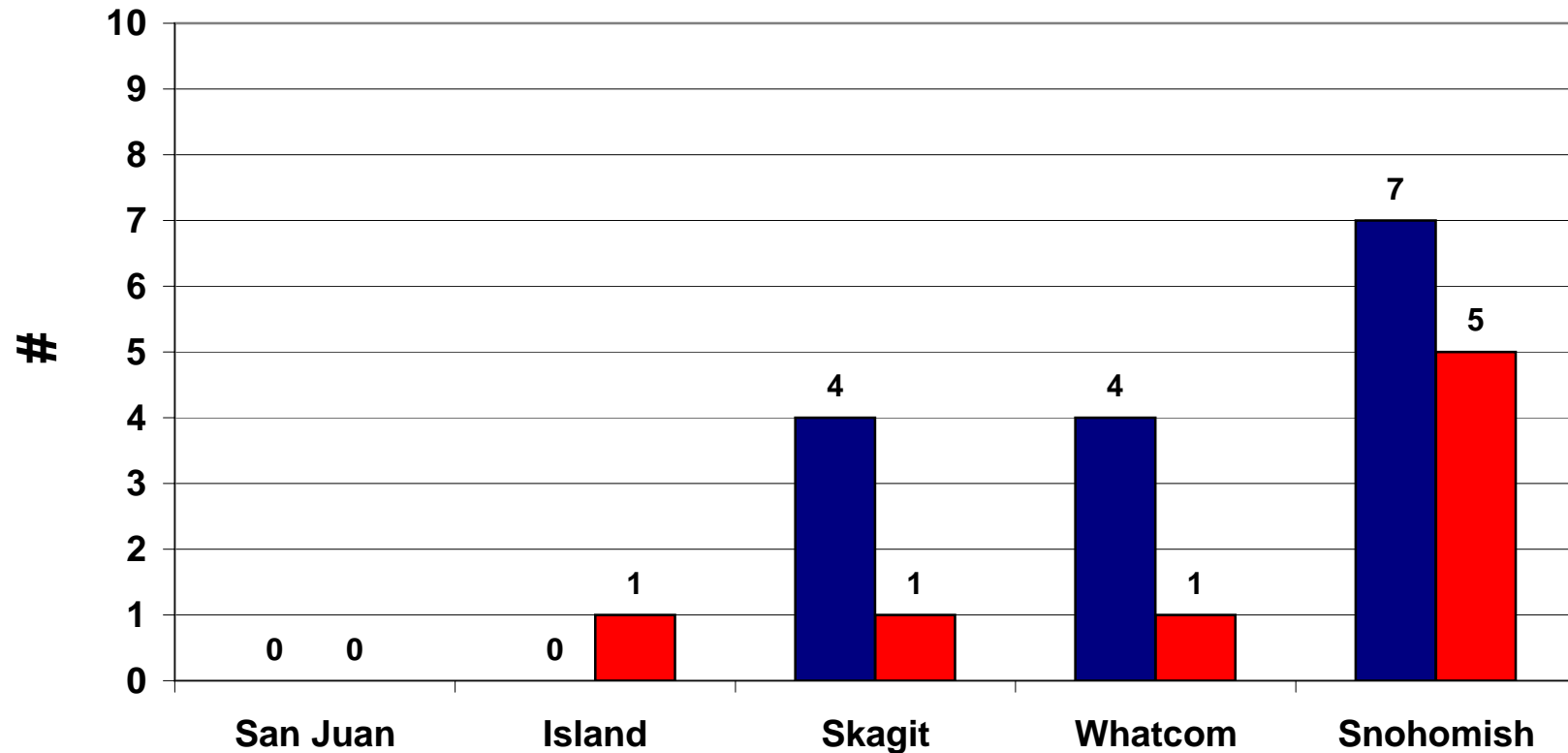
Bar Chart Showing the Number of Reported Incidents of Alleged Sexual Assault
Where a NSMHA Consumer was the Alleged Victim
North Sound Region
January - June 2008



County
Chart 5



**Bar Chart Showing the Number of Reported Suicide Attempts
North Sound Region
January - June 2008**



County

Chart 6

■ 1st Quarter 2008

■ 2nd Quarter 2008