North Sound Mental Health Administration

Critical Incident Review Committee

Semi-Annual Report

Third & Fourth Quarter 2008

NSMHA Semi-Annual Critical Incident Report

July – December 2008

PURPOSE: To inform NSMHA Executive Board and Executive Director, county coordinators, CIRC, 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 third 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 and is expected 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 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 an additional time period
- 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, 2008

- The total number of reported critical incidents dropped from 26 in the 1st[rd] quarter to 23 in the 2nd quarter, climbed to a high for the year of 28 in the 3rd quarter, then dropped back down to 23 in the 4[th] quarter. (Appendix II)
- The number of deaths by unusual circumstances increased from 7 in the 1st half of the year to 12 in the 2[nd]half, with 6 reported deaths in each of the last 2 quarters. (Appendix III)
- The reported incidents of alleged rape where a NSMHA consumer was the alleged victim decreased from 6 in the 1[st] half of the year to 4 in the 2[nd] half. Snohomish County decreased from 4 alleged victims to 0 during this time period. Skagit County and Whatcom counties reported 1 per quarter during the 2[nd] half of the year. The 2 remaining counties reported no such incidents. (Appendix IV)
- The reported incidents of sexual assault where a NSMHA consumer was the alleged perpetrator decreased from 5 in the 1[st] half of the year to only 1 in the 2[nd] half. The 1 allegation occurred in Snohomish County in the 4[th] quarter. The 4 remaining counties reported no such incidents. (Appendix I)
- The reported incidents of sexual assault where a NSMHA consumer was the alleged victim increased from 2 in the 1[st] half of the year to 3 in the 2[nd] half. All 5 allegations occurred in Snohomish County. The 4 remaining counties reported no such incidents. (Appendix I)
- Aside from Island and San Juan Counties which reported no (0) suicide attempts in the 3[rd] and 4[th] quarters of 2008, the remaining 4 counties collectively reported a small increase in suicide attempts from 23 in the 1[st] half of the year to 25 in the 2nd half. (Appendix I)
- No more than one critical incident was reported in any of the 5 counties, in any of the 4 quarters of 2008, 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
    e. Homicide (victim)
    f. Financial exploitation (client)
    g. Arson
- There were no critical incidents reported in the following categories:
    a. Attempted homicide (perpetrator)*
    b. Attempted homicide (victim)*
    c. Medicaid fraud*
    d. Financial exploitation (provider)*
    e. Assault of staff by client resulting in hospitalization*
    f. Assault of client by staff
    g. Non-fatal injury resulting in arrest (victim)

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&Ts. 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 has been zero or one elopement per quarter. There was only 1 reported in all of 2008, and none in the last 2 quarters.

ONGOING CRITICAL INCIDENT QUALITY MANAGEMENT RECOMMENDATIONS AND REVIEW ACTIVITIES

- The 4th quarter of 2008 saw the adoption of the first CIRC Charter which will continue to be developed and revisited through 2009
- CIRC screened one hundred thirteen (113) reported incidents in 2008. Fourteen (14) of the reported incidents were determined no to meet the formal definition of a critical incident, so ninety-nine (99) 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 1st two quarters of 2008. None were forwarded in the 3rd and 4th 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 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

FINDINGS FROM THE 2008 WASHINGTON STATE MENTAL HEALTH DIVISION AUDIT OF STATE-WIDE REGIONAL SUPPORT NETWORK CRITICAL INCIDENT REPORTING PROGRAMS

Dear Regional Support Network Administrator:

The Mental Health Division performed a quality assurance process that involved provider information. The Incident Manager selected two providers from each RSN and gathered all the incidents reported for January 2008 through June 2008. The Incident Manager examined the information to ensure that incidents are consistent and reported in a timely manner. An important aspect of this review is to identify any reporting barriers. The results are below.

NORTH SOUND REGIONAL SUPPORT NETWORK

Providers:
The two selected were Compass Mental Health and North Sound E&T

Incidents Reported:
Compass Mental Health reported 20 incidents and North Sound E&T reported 0. North Sound RSN reported all 20 incidents to the Mental Health Division.

Timely Reported:
All 20 incidents were reported within the required timeframes.

Overall Process:
North Sound incident reports are consistently well written. All incidents are followed up and resolved in a timely manner. The incident reports always contain the relevant information and always exceed MHD requirements. The North Sound RSN IR process is exemplary and is the model for RSN incident reporting.

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Attachments:
APPENDIX I: Table Showing # of Reported Critical Incidents by County, by Quarter July – December 2008
APPENDIX II: Bar Char Showing the Total Number of Reported Critical Incidents in the North sound Region 2008
APPENDIX III: Bar Char Showing the Total Number of Reported Deaths Under Unusual Circumstances, by County, by Quarter July – December 2008
APPENDIX IV: Bar Char Showing the Number of Reported Allegations of Rape Where North Sound Consumers Were the Alleged Victim, by County, by Quarter July – December 2008

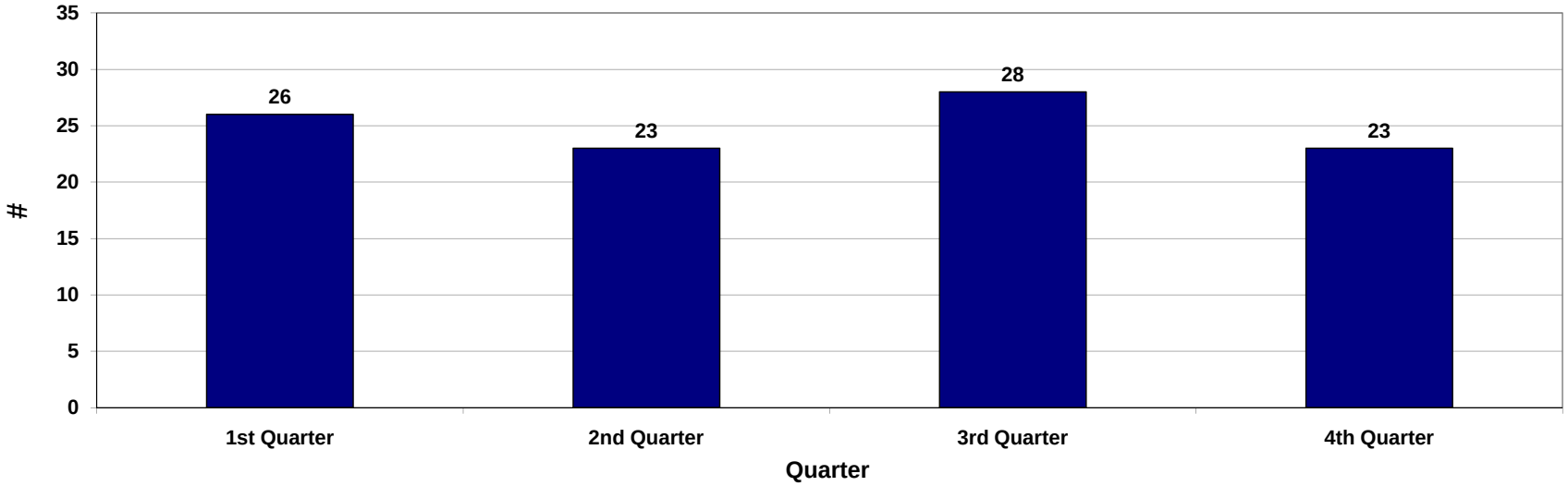
APPENDIX I

Table Showing # of Critical Incidents by County, by Quarter
July - December 2008

County of Incident	Alleged Rape (Perpetrator)	Alleged Rape (Victim)	Alleged Sexual Assault (Perpetrator)	Alleged Sexual Assault (Victim)	Arson Resulting in Arrest	Death Under Unusual Circumstances	Homicide (Victim)	Property Damage With Arrest	Suicide Attempt (With No Arrest)	Totals
San Juan 3rd Quarter	0	0	0	0	0	0	0	0	0	0
San Juan 4th Quarter	0	0	0	0	0	0	0	0	0	0
Island 3rd Quarter	0	0	0	0	0	0	0	0	0	0
Island 4th Quarter	0	0	0	0	0	0	0	0	0	0
Skagit 3rd Quarter	0	1	0	0	0	1	0	0	5	7
Skagit 4th Quarter	1	1	0	0	0	2	0	0	4	8
Whatcom 3rd Quarter	0	1	0	0	0	1	0	1	2	5
Whatcom 4th Quarter	0	1	0	0	0	2	1	0	0	4
Snohomish 3rd Quarter	0	0	0	3	0	3	1	0	8	15
Snohomish 4th Quarter	0	0	1	0	1	2	0	0	6	10
Other 3rd Quarter	0	0	0	0	0	1	0	0	0	1
Other 4th Quarter	0	0	0	0	0	0	0	0	0	0
Totals	1	4	1	3	1	12	2	1	25	50

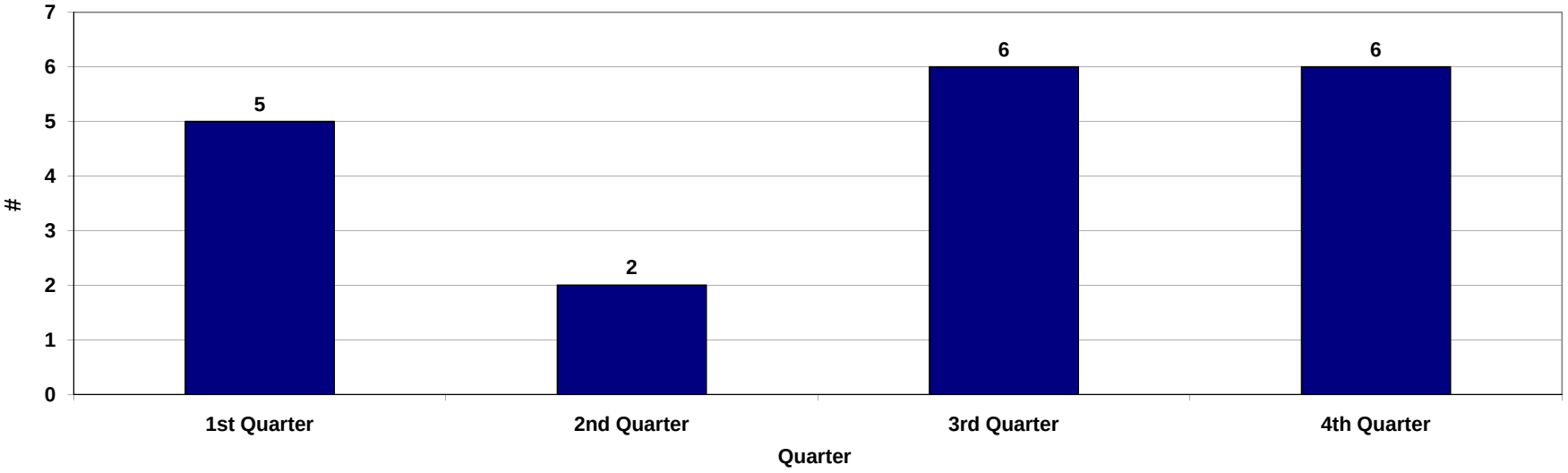
APPENDIX II

Bar Chart Showing the Total Number of Reported Critical Incidents
North Sound Region
2008



APPENDIX III

Bar Chart Showing the Total Number of Reported Deaths by Unusual Circumstances
North Sound Region
2008



APPENDIX IV
Bar Chart Showing the Number of Reported Allegations of Rape
Where North Sound Consumers Were the Alleged Victim
by County, by Quarter
2008