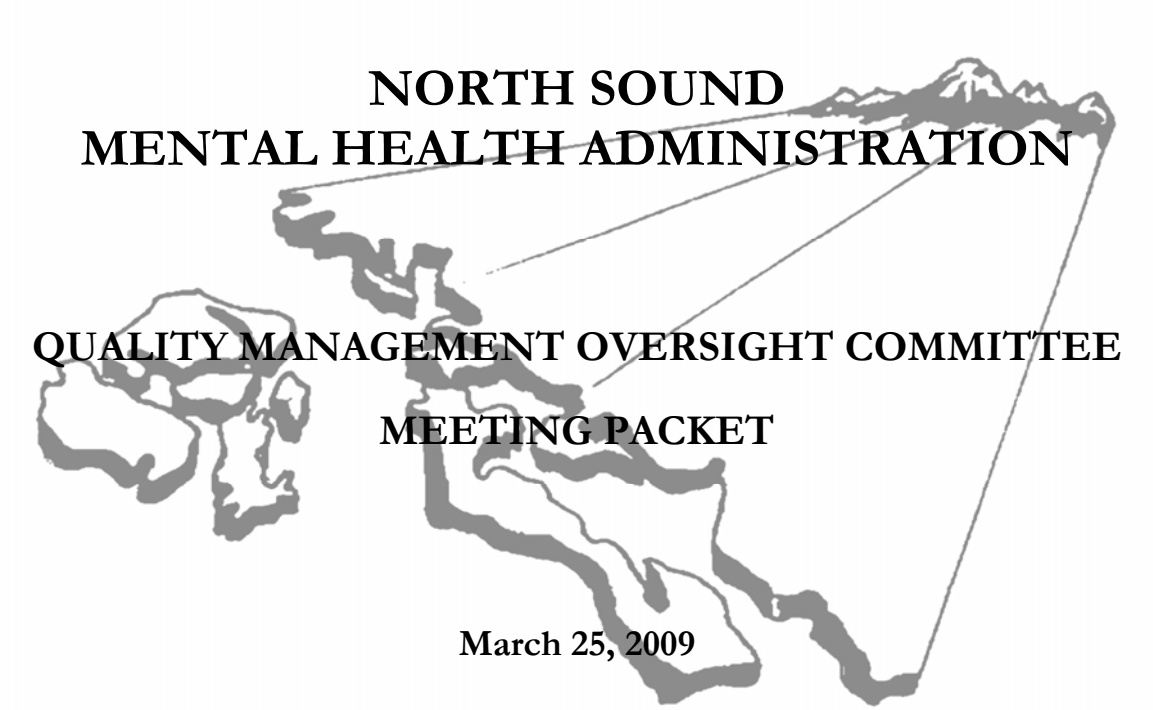
NORTH SOUND
MENTAL HEALTH ADMINISTRATION



QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

March 25, 2009

QMOC GUIDING PRINCIPLES

The QMOC charge is to guide the quality assurance and quality improvement activities of mental health services within the NSMHA region. In assessing the necessary data and making appropriate recommendations, the QMOC members agree to the following:

- **Help create an atmosphere that is SAFE.**
- **Maintain an atmosphere that is OPEN.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **Practice CANDOR and PATIENCE.**
- **Accept a minimum level of TRUST so we can build on that as we progress.**
- **Be SENSITIVE to each other's role and perspectives.**
- **Promote the TEAM approach toward quality assurance.**
- **Maintain an OPEN DECISION-MAKING PROCESS.**
- **Actively PARTICIPATE at meetings.**
- **Be ACCOUNTABLE for your words and actions.**
- **Keep all stakeholders INFORMED.**

Adopted: 10-27-99
Revised: 01-17-01

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: March 25, 2009 **Time: 12:30 – 2:30 PM**
Location: NSMHA Conference Room
For information Contact Meeting Facilitator: Cindy Ainsley or Greg Long, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introduction	Welcome guests; presenters and new members		Chair				5 min
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed.	Approve Agenda	Chair	Agenda		**1**	5 min
Review and Approval of Minutes of Previous Meeting	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Minutes	Chair	Minutes		**2**	5min
Announcements and Updates	Inform QMOC of news, events; Policy 1007 updates as FYI, Grievance Timelines Reminder; Correction to Core Elements study; Binder Updates, if any; other topics?	Inform/discuss	ALL	Policy 1007; Correction to Core Elements Study		**3**	10 min
Evaluation forms from last meeting, if any	Discuss feedback, if any		Chair/Cindy				10 min
Follow-up on old business, if any	Inform/discuss		Cindy/Greg				5min
Comments from the Chair			Chair/June				5 min
Discussion/ about Minutes including names of speaker	Inform/discuss	decision	Cindy				10 min
Policy Sub Committee Report	Inform/discuss			1541		**4**	10 min
ICRS Policy Committee Report	*Inform/discuss*			*None at this time*			
Critical Incidents: Changes and Training	Inform/discuss		Kurt			**5**	20 min
QMOC Charter Review	Discuss	Approve	Cindy/Greg			**6**	15 min
Open Forum			Chair				10 min

Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						5 min
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms						5 min

Next meeting: April 22, 2009

Potential Future Agenda Items:

UR Responses
EQRO 2008 report
CMHS issue revisit (7/09)
Dashboard discussion/review
Policy 1546 from PolSub
QM Plan Update
Expedited auths

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
February 25, 2009
12:30 – 2:30 pm
MINUTES

Present:	**Excused:**
June LaMarr, The Tulalip Tribes, Chair	Jackie Henderson, Island County Coordinator
Jonathan Vander Schuur, Sea Mar	Karen Kipling, VOA
Dan Bilson, NAMI Whatcom County	Mary Good, NSMHA Advisory Board
Sara Bender, *bridgeways*	
Kay Burbidge, Lake Whatcom Center	**Not Present:**
Susan Ramaglia, NAMI Skagit County	Edward Page, NAMI Skagit
Susan Schoeld, Snohomish County	Michele Hall, WCPC
Kathy McNaughton, Catholic Community Services	
Arthur Jackson, NSMHA Advisory Board	**Others Present:**
Cindy Paffumi, Interfaith	Rebecca Pate, NSMHA
Heather Fennell, Compass Health	Greg Long, NSMHA
Charles Albertson, NSMHA Advisory Board	Cindy Ainsley, NSMHA
Mike Manley, Sunrise Community Services	Barb McFadden, Compass Health
Susan Lange, Ombuds	
Rebecca Clark, Skagit County Coordinator	
Anne Deacon, Whatcom County Coordinator	
Joan Lubbe, NSMHA Advisory Board	

1. Introductions, Review of Agenda, Previous Meeting Minutes

June convened the meeting at 1:32 and introductions were made.

Cindy said the expedited auths discussion would be postponed to next month's meeting.

Dan suggested adding projected additions to the agenda. Dan asked about future trainings and Cindy said if training is coming up she does her best to announce them ahead of time. We will continue and try to be even more diligent about this.

Cindy said a QMOC orientation was held prior to the meeting. We will hold these routinely as interest/need is noted.

The committee reviewed the minutes. It was reminded that the review of the minutes was for approval of accuracy of information from last month.

Susan L. mentioned that Chuck wanted the following comments noted:

- He wanted to voice his concern regarding Child Mental Health Specialist assessments

It was noted the date is missing from the January QMOC minutes.

A motion was made to approve the minutes as amended, Arthur seconded and discussion followed. Dan expressed concern over the Child Mental Health Specialist issue of a lesser clinician conducting the assessment. Charles called for the question and motion carried.

Kathy asked to address the CMHS and clarify for Ombuds. Cindy said she could do this in the expedited auths slot as Open Forum, and noted that Open Forum was accidentally deleted from the agenda. It will be added back in..

2. Announcements and Updates

Mike announced the new Sunrise Offices in Everett are across from the Everett Community College. Mike said there are new phone numbers but if one dials the old numbers the call will be automatically transferred to the new numbers. A communiqué will be going out regarding the new address and phone numbers.

Greg announced that the RFP for FBG has gone out and to date there has not been a lot of interest shown. He said this is a pool of money received each year. Charles asked if Whatcom County/Rainbow Center/Harmony House have applied. Greg said he did not know who has expressed interest. The Letters of interest are due to NSMHA by Friday.

Greg said NSMHA would like to encourage clinical directors and personnel to get encrypted email so communication of PHI can be expeditious. He distributed information regarding it. Charles asked if the jail system/hospitals have this information. Susan R. said she is having trouble responding to encrypted emails. Greg asked everyone to check with Michael White of NSMHA staff regarding any problems occurring on their end so problems can be resolved. Cindy suggested having Michael come speak at a QMOC meeting regarding this issue. Discussion followed and members requested this.

Cindy announced MHD would be conducting an audit of NSMHA in April.

Binder updates were distributed.

Greg mentioned revisions to the MHD contract amendments were made to provider contracts and will be sent out this week. He said additional cuts are expected but no official word as to how much is available. He added that Flex Funds are still available and Secure Detox was extended until June 2009. Greg said word would be distributed when available regarding additional cuts. Greg added, at this point, cuts should not have any effect on client services. Discussion followed.

3. Evaluation Forms from Last Meeting – June/Cindy

Cindy reviewed the responses from January's meeting. Cindy encouraged all to fill out the evaluation forms in the back of their table binders.

A comment was made regarding serving of food and Cindy said NSMHA has opted to continue to serve food at meetings that included consumers/advocates/volunteers convening over the lunch period. Cindy said this group could either reduce the amount of food ordered (snacks only), change meeting time, or brown bag. Cindy said the costs run about $1,200 per year and June suggested providing feedback as to desires on the evaluation forms. Discussion followed. June suggested writing thoughts down on evaluation forms and a decision would be made from information collected.

4. Comments from the Chair – June LaMarr

June had no comments.

5. Policy Sub Committee Report – Cindy

Cindy said it was decided to eliminate this in-person committee and policies will now be distributed via email with a 30 day timeframe for response to the members of this committee. Input would be incorporated into policies and they would be brought before QMOC for approval. Discussion followed.

Policy 1511.00 – Choice or Changes of Mental Health Care Provider (MHCP)

Cindy reviewed the policy with the committee. Susan L. said Chuck wanted the third paragraph down to include Ombuds. Charles made a motion to approve the policy with modification, Susan R. seconded and discussion followed. Cindy acknowledged changes and Charles amended his original motion to include changes, Susan R. seconded and motion carried.

Policy 1545.00 – Voluntary Hospital Certification – Tribal Community Members

Cindy reviewed the policy. Susan made a motion to approve, Joan seconded and discussion followed. June called for the question and motion carried.

Policy 1563.00 – Program of Assertive Community Treatment (PACT)

Cindy acknowledged the changes. Joan made a motion to approve, seconded and discussion followed. June called the question and motion carried.

6. ICRS Policy Sub Committee Report – Greg

There are no policies at this time.

7. WSH Discharge Practices Changing – Greg

Greg announced NSMHA is now screening all referrals for WSH wait list and as of May 1 another floor will be closed.

Greg added calls will begin to occur now where WSH liaisons may call providers requesting recommendations regarding discharge at the time of admission. This call would be to identify treatment planning and support available at time of discharge. Greg stated providers are not required to keep client cases open once transferred to WSH but the liaisons may call for additional information because the last provider would know the client better than NSMHA. Discussion followed.

8. Practice Guideline Workgroup Recommendation – Cindy/workgroup

Cindy reviewed the recommendations from the workgroup. She said at last month's meeting she believed her write up was not clear and she re-worked it for better clarity. Discussion followed. She summarized the workgroup wanted to have links to the APA and AACAP with perhaps a TOC with specific information. Susan R. said a link to the Executive Summary would be more beneficial in regards to training. Further discussion followed. Sara said she would like the workgroup to re-convene and decide exactly what they want to approve and table this issue for now. Barb suggested having the Executive Summary mentioned as a good starting point and continues from there. Susan S. accepted the amendment, seconded and motion carried.

9. Beta Testing Results for Clinical Guidelines/Core Elements – Kurt

Kurt said when URs are conducted they try to see if the clinician is utilizing the guidelines as a resource for documentation. Kurt said NSMHA went to Dr. Brown and requested he identify two or three core elements that could be utilized during URs. Kurt reviewed the checklist used by reviewers and chart regarding information collected during the reviews. Discussion followed. Kurt said the reason for conducting the test was to identify whether these core elements would provide necessary information. Cindy said this is a report out to QMOC that additional guidelines are not needed and the UR staff will continue to use these core elements to conduct and score their reviews. No action is required of QMOC.

10. Critical Incident Changes and Training – Kurt

Deferred due to time constraints.

11. Clarification of CMHS – Kathy

Kathy wanted to assure Susan L. and Chuck that an assessment is being done by qualified staff and perhaps the CMHS status is lacking perhaps because documentation (i.e., hours of service) could not be verified from another state. Supervisors are CMHS staff and assessments are reviewed and signed off by supervisors.

12. QMOC Charter Review – Cindy/Greg

Deferred due to time constraints.

13. Date and Agenda for Next Meeting/Review of Meeting

The meeting was adjourned at 2:30. The next meeting will be March 25th in the NSMHA Conference Room.

14. Review of Meeting

Cindy said Critical Incident Changes and Training will be postponed to next month. Expedited auths will be next month. QMOC Charter will be next month.

Effective Date: 6/24/2004
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 1000 – Administrative: Primary Source Verification Credentialing, Re-Credentialing, Appointment and Privileging of Contracted or Employed Staff

Authorizing Source: 42 CFR 438-214; WAC 388-865-284;0405
Cancels:
See Also:
Providers are required to have a policy "consistent with" this policy
Responsible Staff: Contracts Coordinator

Approved by: Executive Director
Signature:

Date:

Deleted: Quality Manager

POLICY #1007.00

SUBJECT: PRIMARY SOURCE VERIFICATION CREDENTIALING, RE-CREDENTIALING, APPOINTMENT AND PRIVILEGING OF CONTRACTED OR EMPLOYED STAFF

PURPOSE

To provide guidelines and instructions for the process of credentialing/ re-credentialing, appointment and privileging, through such activities as verifying current registration, licensure, relevant education, training, experience and competence to meet position qualifications for North Sound Mental Health Administration (NSMHA) contracted or employed staff providing direct care services to and/or clinical oversight of NSMHA enrollees. This policy also establishes the standards for NSMHA Contractor's credentialing/re-credentialing, appointment and privileging programs.

POLICY

To ensure that all NSMHA contracted or employed staff who provide direct care to and/or clinical oversight of NSMHA enrollees meet the standards for the relevant job functions and to ensure that their credentials are confirmed through primary source verification.

To provide for appointment and privileging of NSMHA contracted or employed staff who provide direct care to and/or clinical oversight of NSMHA enrollees and whose job function requires them to exercise significant independent judgment and clinical responsibility. The appointment process will require additional credentialing/re-credentialing steps and privileging.

To ensure that NSMHA-Contractors comply with NSMHA policy and procedure governing credentialing, re-credentialing, appointment and privileging, which substantially comply with the procedures set forth in this policy.

To establish a process for monitoring of the credentialing, re-credentialing, appointment and privileging activities of NSMHA -Contractors. .

DEFINITIONS

Credentials
Documented evidence of registration, licensure, education, training, experience or other qualifications.

Credentialing
The process of assessing and validating the qualifications of a registered and/or licensed individual.

Criteria
Expected levels of achievement or specification against which performance can be assessed.

Current Competence
Verification of abilities and experience, in writing, by individuals personally acquainted with the person's professional and clinical performance.

Privileging
A process whereby an individual is formally granted permission to perform specific duties and job functions as defined in clinical privileges or job descriptions based on the individual's qualifications, experience, education, training and credentials.

Primary Source Verification
The process of validating stated credentials from their original source.

Re-credentialing
The process whereby the credentialing information is updated.

PROCEDURE

A. NSMHA ensures criteria is validated in the following manner for all contracted or employed staff who provide direct care to and/or clinical oversight of NSMHA enrollees:

1. Applicants sign a statement attesting to the accuracy and completeness of all information and consenting to inspection of records and documents pertinent to the application.
2. All applications are screened to confirm that the minimum requirements for the job functions are met prior to hire.
3. Information submitted on applications that is essential to the functions of the job (i.e., licensure, training and experience) is confirmed through primary source verification. Additional data is requested where relevant to the functions of the job to be performed (i.e., DEA certificate for jobs requiring prescriptive authority) and is confirmed through primary source verification.
4. The applicant will be responsible for requesting certified copies of academic credentials and certificates of insurance when required.
5. Re-credentialing activities are performed, at a minimum, every two (2) years. Steps to be taken shall include primary source verification of information submitted on initial application, which is subject to change (i.e., expiration of a required license).
6. The competence of all contracted and employed staff who provide direct care to and/or clinical oversight of NSMHA enrollees is assessed, maintained and improved on an ongoing basis through the development and implementation of a training plan that is pertinent to each position.

B. Appointment and Privileging Process:
NSMHA shall provide for the appointment and privileging of contracted or employed staff who provide direct care to and/or clinical oversight of NSMHA enrollees and whose job function requires them to exercise significant independent judgment and clinical responsibility. All steps taken in the appointment process will be in addition to the steps required above.

1. Prior to appointment:

a. Applicant's current registration, licensure, and/or certification are verified from the primary source where claimed and relevant to the functions of the job to be performed.

b. Successful completion of a course of study is verified from the primary source, where claimed and relevant to the functions of the job to be performed.
c. Experience is verified from the primary source, where claimed and relevant to the functions of the job to be performed.
d. Information about involvement in professional liability actions is verified and good standing is confirmed where relevant to the functions of the job to be performed.
e. When information from a primary source is not available, a reliable secondary source is used. The attempt to contact the primary source is documented.

2. Provisional Appointment:

a. When information is available but not yet received from the primary source the applicant may be appointed for a provisional period.
b. During this provisional period, the applicant will complete an orientation designed to promote safe and effective performance of their job responsibilities by their supervisor.

3. Primary Source Verification Received:

a. Primary Source Verification of criteria is provided to the appropriate NSMHA staff and then placed in the contracted or employed staff's credential file. Any discrepancies may be grounds for termination.
b. Once appointment and privileging have occurred in accordance with subsection B, a provisional period is changed to a probationary period. The provisional period and probationary period will equal a minimum of three (3) months from the date of appointment/hire. At the end of the period a performance appraisal will be conducted.

4. Appointment/privileging activities are performed, at a minimum, every two (2) years.

C. NSMHA
1. NSMHA shall:

a. Review credentialing/re-credentialing files;
b. Assess the individual's ability to meet performance expectations as defined in clinical privileges or job descriptions;
c. Document competency assessment activities;
d. Recommend whether or not appointment should be made and the specific privileges that may be granted to an individual under consideration for initial or renewed employment or contract; and
e. Convene a Peer Review Committee, if necessary.

2. NSMHA will retain and have access to the credentialing, appointment and privileging files of NSMHA-contracted or employed staff in accordance with state and federal laws governing access to credentialing/ re-credentialing files and laws regarding quality management and peer review confidentiality and privileging guidelines and requirements.

D. Responsibilities of the NSMHA Contractors:

Contractors have and enforce their own policies and procedures governing credentialing/re-credentialing, appointment and privileging which substantially comply with the procedures set forth in this policy.

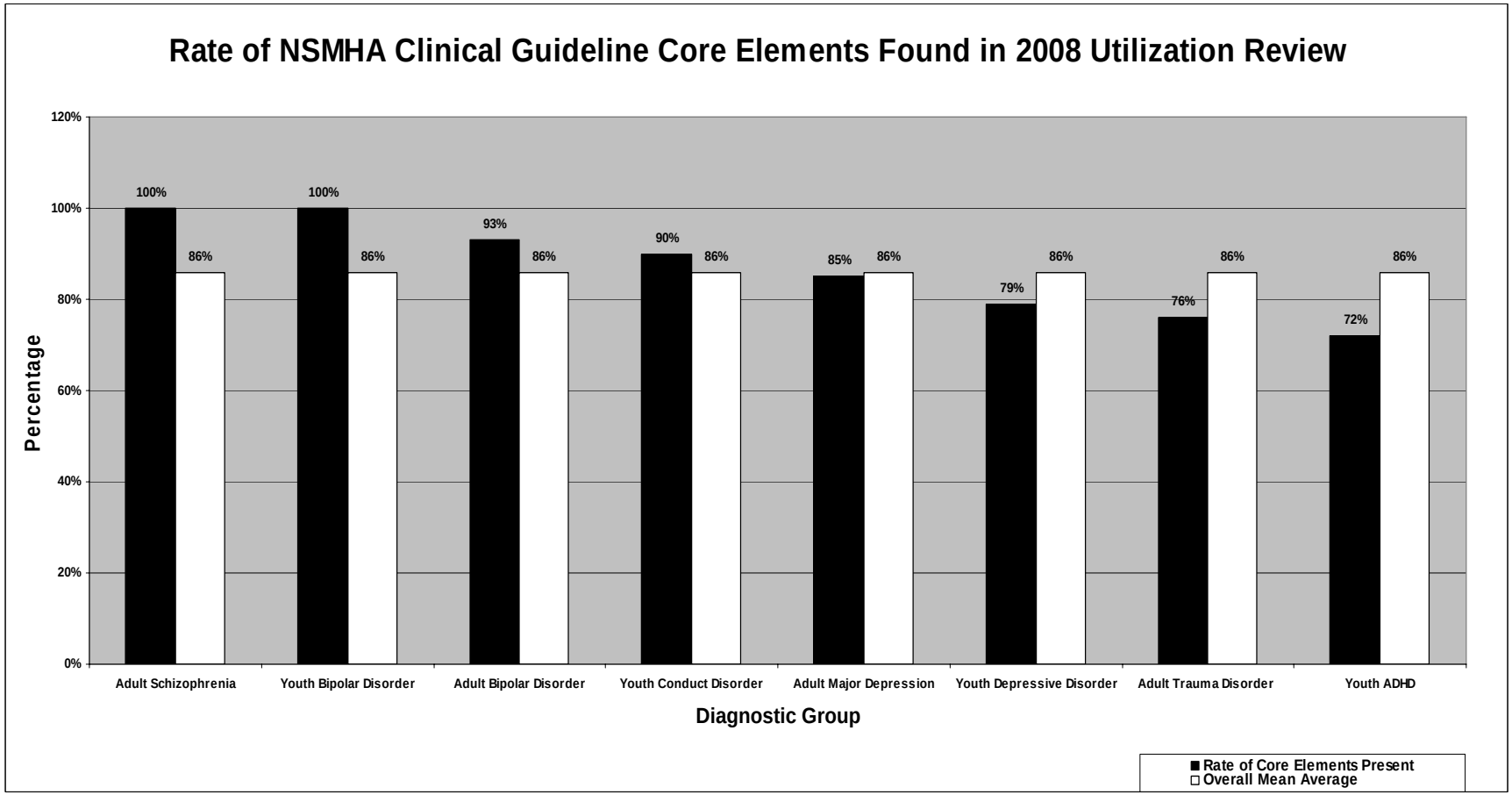
1. Contractors retain and have access to the credentialing files of the contracted or employed staff in accordance with state and federal laws governing access to credentialing/re-credentialing files and laws regarding quality management and peer review confidentiality and privileging guidelines and requirements.
2. Contractors perform credentialing/re-credentialing, appointment and privileging activities in accordance with their policies and procedures that substantially comply with the procedures set forth in this policy.
3. Contractors will report to the NSMHA Quality Manager or designee any individual reports of change in licensure or certification status, and/or any adverse actions.
4. Exceptions will be granted to the requirement of substantial compliance upon a showing that the Contractor's program meets generally accepted industry standards.

E. NSMHA Monitoring Responsibilities

1. NSMHA retains responsibility for oversight and monitoring of the credentialing/re-credentialing, appointment and privileging processes and associated activities performed by Contractor. .
2. NSMHA shall review Contractors' existing and/or new policies and procedures related to credentialing/re-credentialing, appointment and privileging during its administrative review.
3. NSMHA retains the ability to, at any time, review credentialing/re-credentialing files for purposes of quality management oversight. At a minimum, NSMHA will periodically conduct a review of Contractors' credentialing/re-credentialing processes and files.

ATTACHMENTS

None



Method:

- During 2008 Utilization Review in the North Sound Region, 179 cases were randomly selected for analysis of CMHA provider compliance in meeting clinical guidelines, as indicated by the presence of the 1 to 3 indentified clinical guideline core elements in the outpatient records reviewed.
- Aggregate review reflects varying numbers of cases from each of the North Sound CMHA providers.
- Of the 179 cases with 283 possible elements, diagnosis data was not gathered in 6, and elements were not scored in 2. Core elements have not yet been established for the 5 Adult Anxiety cases, 18 Youth Anxiety cases, 1 Adult Dementia case, or 1 Mood Disorder case. Therefore, the N (denominator) used in determining the aggregate rate was 243, and the total number of test cases appropriate for analysis was 146.

Findings:

- In four (4) diagnostic groups, Adult Schizophrenias, Youth Bipolar Disorders, Adult Bipolar Disorders, and Youth Conduct Disorders, the CMHA provider outpatient charts reflected the presence of core treatment elements at a rate of at least 90%.
- In four (4) diagnostic groups, Adult Major Depressive Disorders, Youth Depressive Disorders, Adult Trauma Disorders, and Youth ADHD, the CMHA provider outpatient charts reflected the presence of core treatment elements at a rate of less than 90%.
- Overall, the appropriate core elements met across all diagnostic groups and all CMHA providers was 86%.
- Unanticipated positive result from the study, identified by the reviewers in collecting the data: The establishment of clinical guideline core elements increases objectivity inter-rater reliability in scoring the clinical guideline question in routine utilization reviews
- Drilldown of diagnostic groups that did not meet the 90% compliance rate
    - Youth ADHD scored 72%. The "parent management" and "school based accommodations" elements both scored 67%, and the documentation of consideration of "psycho-stimulants" element scored 83%
    - Adult Trauma Disorder scored 76% on the single element, "focus on resolving trauma, through CBT"
    - Youth Depressive Disorder scored 79%, negatively skewed by scoring only 65% on the "documentation of consideration of anti-depressants" element
    - Adult Major Depression scored 85%, negatively skewed by scoring only 81% "documentation of consideration of psychotherapy" element

Effective Date: 11/21/2005
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Rationale and Use of Seclusion and Restraint at Evaluation and Treatment Facilities

Authorizing Source: WAC 246-337-110; WAC 388-865-0545; 42CFR438.100; 42CFR483; 42CFR482
Cancels:
See Also: Approved by: Executive Director Date:
E&T Facilities must have a "policy consistent with" this policy
Responsible Staff: Quality Manager Signature:

POLICY #1541.00

SUBJECT: RATIONALE AND USE OF SECLUSION AND RESTRAINT AT EVALUATION AND TREATMENT FACILITIES (E&Ts)

PURPOSE

To describe the rationale, conditions and parameters in the use of seclusion and restraint for the purpose of maintaining health and safety for individuals 18 and older who are in danger of harming themselves or others and utilizing these measures as a last resort. *This document is not meant to describe seclusion and restraint policy and procedure for individuals under the age of 18 as North Sound Mental Health Administration (NSMHA) does not oversee any facilities permitted to utilize seclusion or restraint for individuals in that age group.*

DEFINITIONS

Seclusion: The involuntary confinement of a person in a room or an area where the person is physically prevented from leaving.

Restraint: Includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove and which restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to manage an individual's behavior in a way that reduces the safety risk to the individual and/or others, has the temporary effect of restricting the person's freedom of movement and is not a standard treatment for the person's medical or psychiatric condition.

POLICY

1) Individuals have the right to be free of seclusion and restraint, including chemical restraint.
2) Individuals have the right to be free from any form of seclusion and restraint used as a means of coercion, discipline, convenience or retaliation.
3) The use of seclusion or restraint must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the individual and/or others from harm.
4) Should these less restrictive measures not ensure safety, persons dangerous to themselves or others who may require the use of seclusion and restraint have a right to the least restrictive use of seclusion and restraint in the safest fashion for the least amount of time.
5) The reasons for the determination to use seclusion or restraint must be clearly documented.

Individuals admitted to an E&T or the legal guardian(s), shall be provided with a copy and be informed of the facility's policy regarding the use of seclusion and restraint. The policy must provide contact information, including the phone number and mailing address, for the regional Ombuds and Department

of Health Complaint Investigations (1-800-633-6828 or P.O. Box 47857, Olympia, WA 98504). Written acknowledgement by the individual or legal guardian that he/she has been informed of the facility's policy on the use of seclusion and restraint shall be filed in the individual's chart.

PROCEDURE

Interventions Utilized Prior to Seclusion and/or Restraint

Less restrictive measures are interventions that can effectively keep the individual or others safe without requiring seclusion or restraint. All less restrictive measures to be utilized shall be part of the individual's treatment plan. If the individual has an Advance Directive, refer to that document for notation of preferred less restrictive measures. If those measures identified on the treatment plan are utilized but ineffective, consideration shall be given to other less restrictive measures prior to use of seclusion or restraint. Measures utilized but not previously on the treatment plan shall be added. Seclusion and/or restraint will be utilized only after other less restrictive measures have been attempted as appropriate and are determined to be ineffective.

1) Examples of less restrictive measures include but are not limited to:

    a) Verbal re-direction/reassurance
    b) Removal of source of stimuli (e.g., music, TV, another individual)
    c) Environmental change
    d) Limit setting
    e) Diversionary activities
    f) Encouragement for individual to express concerns
    g) Alternative/choice
    h) Comfort
    i) 1:1 staff interaction
    j) Voluntary time-out
        i. Time out may take place away from the area of activity or from other individuals, such as in the individual's room (exclusionary), or in the area of activity or other residents (inclusionary)
        ii. Individual in time out must never be physically prevented from leaving the time out area
        iii. Staff must monitor the individual while in time out
    k) Medication
    l) Increased staff presence

Use of Seclusion and Restraint

Seclusion or restraint can only be used in emergency situations if needed to ensure the individual's and/or others' physical safety and less restrictive interventions have been determined to be ineffective. When utilizing seclusion and/or restraint for the safety of the individual or others, the individual must be informed of the reasons for the use of seclusion or restraint and the specific behaviors which must be exhibited in order to gain release from these procedures.

The use of seclusion and/or restraint must be:

1) In accordance with the order of a licensed physician or other licensed practitioner permitted by the State and facility to order seclusion and/or restraint. The following requirements will be superceded by existing State laws if they are more restrictive:

    a) Orders for the use of seclusion or restraint must never be written as a standing order or on an as needed basis (that is, PRN).
    b) Staff must notify, and receive authorization by, a licensed physician or other authorized licensed practitioner within one hour of initiating individual seclusion or restraint.
    c) Within one hour of initiation of restraint or seclusion, a physician or other authorized licensed practitioner must conduct a face-to-face assessment of the physical and psychological well-being of the individual.
    d) Each written order for a physical restraint or seclusion is limited to 4 hours for adults. The original order may only be renewed in accordance with these limits for up to a total of 24 hours.
    e) If the use of restraint or seclusion exceeds 24 hours, a licensed physician or other authorized licensed practitioner must examine the individual and write a new order if the intervention will be continued. This procedure is repeated again for each 24 hour period that restraint and seclusion is used.
    f) The clinical record must contain documentation of staff observation of the individual at least every fifteen minutes.
    g) The individual's clinical record must document all assessments and justification for the use of seclusion or restraint in addition to the following documentation should seclusion or restraint be used:

        i) Order authorizing the restraint or seclusion including the name of the licensed physician, or other licensed practitioner permitted by the State and facility to order seclusion and/or restraint;
        ii) Date/time order obtained;
        iii) Individual behavior prior to initiation of restraint or seclusion;
        iv) The specific intervention ordered, including length of time and behavior that would determine the intervention be discontinued;
        v) Time restraint or seclusion began and ended;
        vi) Time and results of one hour assessment; and
        vii) Any injuries sustained during the restraint or seclusion.

2) In accordance with a written modification to the individual's plan of care;
3) Implemented in the least restrictive manner possible;
4) In accordance with safe appropriate restraining techniques;
5) Ended at the earliest possible time;
6) Seclusion may not be used unless the individual is continually monitored 1:1 by staff either face-to-face or using both video and audio equipment. The video and audio monitoring must be done in close proximity to the individual.
7) Restraint may not be used unless the individual is observed under the following conditions:

    a) Wrist-to-waist restraint in the milieu is continuously monitored by assigned staff member(s).

b) Wrist-to-waist restraint plus seclusion requires continuous monitoring by assigned staff member(s) using video and audio equipment.
c) Gurney five-point restraint must be continually monitored, face-to-face by assigned staff member(s).

8) The facility/licensee must ensure that seclusion and restraint is carried out in a safe environment:

a) Restraint equipment must be clean and in good repair.
b) Equipment used for restraint shall meet current best-practice safety standards and meet infection control standards.
c) The seclusion room must:

i) Be designed to minimize potential for stimulation, escape, hiding, injury or death;
ii) Have a maximum capacity of one individual;
iii) Have a door that opens outward;
iv) Have a staff-controlled, lockable, adjoining toilet room;
v) Have a minimum of three feet of clear space on three sides of the bed; and
vi) Have a negative pressure with an independent exhaust system with the exhaust fan at the discharge end of the system.

9) In most cases, the facility staff restrains in the supine (back) position; however, each situation is evaluated with the ultimate goal of providing maximum safety and comfort for the individual.

10) The condition of the individual who is in a restraint or in seclusion must continually be assessed, monitored, and reevaluated to include:

a) Safety checks to be conducted and documented every:

i) Fifteen (15) minutes: assess and document individual's activity, behavior, food and fluids offered, toileting if needed, interventions used and individual's response and physical condition
ii) 1 Hour: Open door/view individual (if in seclusion)
iii) 2 Hours: Exercise, range of motion out of restraint
iv) 4 Hours: Vital signs (unless otherwise indicated)
v) 12 Hours: Bathing and oral care

b) At the change of shift, the supervisors/charge nurses of both shifts (those leaving duty and those beginning their duty) will enter the seclusion room, evaluate the individual's mental and physical status and assess the need for continuation of restraint.
c) When the individual is removed from seclusion or restraint, a licensed physician or other authorized licensed practitioner must evaluate the individual's well-being immediately and must document the individual's status in the chart.

Conditions for the Discontinuation of Use of Seclusion & Restraint

When utilizing seclusion and/or restraint for the safety of the individual or others, staff must communicate to the individual and document what necessary actions/behaviors are required for release at 60-minute intervals while individual is awake.

Reporting of Injury or Death

The E&T must report any death or injury, per NSMHA's Critical Incident Reporting Policy, that occurs while an individual is restrained or in seclusion, or where it is reasonable to assume that an individual's death/injury is a result of restraint or seclusion.

Education and Training

1) All staff that have direct individual contact must have ongoing education and training and demonstrated knowledge, on a semiannual basis, of:

    a) Techniques to identify staff and resident behaviors, events, and environmental factors that trigger emergency safety situations;
    b) The use of nonphysical interventions skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations;
    c) The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

2) Certification in the use of cardiopulmonary resuscitation (CPR), including periodic recertification, is required. Staff must demonstrate their competencies in this area on an annual basis.

3) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency and safety situations.

4) Training identified in 1 and 2 of this section must be provided by individuals who are qualified by education, training and experience.

5) The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.

6) All training programs and materials used by the facility must be available for review by NSMHA, Centers for Medicare and Medicaid Services and relevant state agencies.

Conditions for Debriefing/Quality Improvement Activities

1) Staff must conduct and document a post-intervention debriefing with individual to discuss precipitating factors leading to the need for intervention.
2) Staff involved in the restraint or seclusion will debrief and address effectiveness and safety issues to include the following questions. The results of these questions will be documented and monitored with quality improvement activities initiated as warranted:

    a) Has a treatment environment been created where conflict is minimized?

b) Could the trigger for conflict (disease, control, environmental, medication, etc) have been avoided?
c) Did staff notice and respond to events in a timely way?
d) Did staff choose an effective intervention?
e) If the intervention was unsuccessful, was another chosen?
f) Did staff order seclusion and/or restraint only in response to imminent danger?
g) Was seclusion and/or restraint applied safely?
h) Was the individual monitored safely?
i) Was the individual released as soon as possible?
j) Did post-event activities/debriefing occur?
k) Did learning occur and was it integrated into the treatment plan and practice?

3) E&Ts must provide a quality management plan for the timely and efficient collection of data for the purpose of continuous quality improvement activities.

ATTACHMENTS

None

Effective Date: 4/28/2008; 6/25/2007; 11/10/2005; 10/9/2003, Motion #03-054
Revised Date: 6/27/2008
Review Date: 7/7/2008

North Sound Mental Health Administration

Section 1000 – Administrative: Critical Incident Reporting and Review Requirements
CIRC Quality Assurance and Improvement Process

Authorizing Source: MHD PIHP Contract; 42 CFR482 & 42CFR483
Cancels:
See Also: Approved by: Executive Director Date:
Providers must have a "policy consistent with" this policy
Responsible Staff: Quality Manager Signature:

POLICY #1009.00

SUBJECT: CRITICAL INCIDENT REPORTING AND REVIEW REQUIREMENTS CIRC QUALITY ASSURANCE AND IMPROVEMENT PROCESS

PURPOSE

The purpose of the Critical Incident Reporting and Review Requirements and the North Sound Mental Health Administration (NSMHA) Critical Incident Review Committee (CIRC) quality improvement and assurance process is to:

A. Ensure that, in its ongoing commitment to quality assurance and improvement initiatives, NSMHA promotes consumer safety and risk reduction by requiring the recognition and reporting of extraordinary occurrences. Specifically, the purpose of this policy is to ensure that:

   1. Care and services delivered meet the requirements of the Mental Health Division (MHD)/NSMHA and NSMHA/provider contracts, including NSMHA Clinical Eligibility and Care Standards, relevant WACs, RCWs and the Federal Waiver.
   2. There is a timely and systematic reporting mechanism that promotes appropriate responses to critical incidents/extraordinary occurrences.

B. Provide a framework, structure and set of guidelines for the timely reporting of critical incidents, as defined by the Washington State MHD.
C. Support and protect the reporting and documentation of critical incidents under NSMHA's Coordinated Quality Improvement Program (CQIP). NSMHA maintains CQIP status through the Washington State Department of Health for the purpose of improvement of the quality of health care services rendered to consumers and the identification and prevention of medical malpractice as set forth in RCW 43.70.510. NSMHA encourages the development of a system-wide culture, which minimizes individual blame or retribution for involvement in critical incidents and emphasizes accountability, trust, system improvement and continuous learning.

   To provide quality assurance all documents related to critical incident reporting will contain the following language:

COORDINATED QUALITY IMPROVEMENT DOCUMENT

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POLICY
This policy describes the processes, circumstances, methods and timelines by which providers must provide information to NSMHA; the processes, circumstances, methods and timelines by which NSMHA must provide information to MHD; and, the quality assurance and improvement activities involved regarding reporting and responding to critical incidents (extraordinary occurrences) affecting mental health consumers of NSMHA services and NSMHA providers.

PROCEDURE

CATEGORIES OF CRITICAL INCIDENTS

1. **Allegation of rape (perpetrator)**
2. **Allegation of rape (victim)**
3. **Allegation of sexual assault (perpetrator)**
4. **Allegation of sexual assault (victim)**
5. **Nonfatal injury resulting in arrest (perpetrator)**
6. **Nonfatal injury resulting in arrest, including suicide attempt (victim)**
7. **Arson resulting in arrest**
8. **Substantial property damage resulting in arrest**
9. **Assault of an RSN or subcontracted staff by consumer resulting in hospitalization**
10. **Assault of consumer by an RSN or subcontracted staff**
11. **Attempted homicide (perpetrator) resulting in arrest**
12. **Attempted homicide (victim) resulting in arrest**
13. **Homicide (perpetrator) resulting in arrest**
14. **Homicide (victim) resulting in arrest**
15. **Completed suicide or death under unusual circumstances**
16. **Incident referred to Medicaid Fraud Control Unit**
17. **Allegation of financial exploitation involving consumer**
18. **Allegation of financial exploitation involving provider**
19. **Attempted Suicide not resulting in charges or pending charges**
20. **Elopement from a provider involuntary treatment program**
21. **Injury &/or death while in restraint &/or seclusion while an inpatient at a provider involuntary treatment program**

NSMHA and its providers are required to report on incidents involving persons with mental illnesses and having an open case with NSMHA. An open case is defined as an individual that is currently receiving crisis services or outpatient mental health services from a NSMHA provider.

1. Outpatient consumers are those who have received an intake assessment and meet eligibility criteria for outpatient services. These individuals are considered outpatient consumers until their case has been officially closed.
2. Crisis Services consumers are currently being served by Crisis Services personnel, and remain so until their case has been closed and/or they have begun receiving outpatient services.
3. Jail Mental Health Services consumers are those who have received an initial assessment and meet eligibility criteria for Jail Mental Health Services, and remain so up to 90 days post-release, and/or they have begun outpatient services as described above.

Note: By definition, a precipitating event that causes an individual to seek any of the above services should not be considered a reportable critical incident as it occurred prior to that individual having an open case with any of the above services.

NON-MHD REPORTABLE CRITICAL INCIDENT REPORTING AND REVIEW REQUIREMENTS

The Non-MHD reportable incidents include:

1. **Attempted Suicide not resulting in charges or pending charges**
2. **Elopement from a provider involuntary treatment program**
3. **Injury &/or death while in restraint &/or seclusion while an inpatient at a provider involuntary treatment program. NOTE: Injuries are counted as Non-MHD Reportable critical incidents. Deaths are reported to MHD under the category of "Completed suicide or death under unusual circumstances"**

When any critical incident occurs, it is the responsibility of the service provider to notify NSMHA:

- Via fax on the appropriate NSMHA provider-specific critical incident form; providers shall use the NSMHA Critical Incident Form available online at http://www.nsmha.org/forms/index.asp.
- The report form shall be faxed to NSMHA within 24 hours of the determination that the event meets the definition of a critical incident. When faxed, the form must include a cover sheet with a confidentiality disclaimer.
- In cases where essential additional information that is necessary to understanding the incident is obtained by the provider, it shall be submitted to NSMHA within 5 business days.

When a provider initiates and conducts a formal incident review as requested by CIRC or NSMHA, the provider shall submit the written report of the review findings to NSMHA dated within 5 business days of the review.

Critical incidents listed below shall require a formal review by the provider Quality Committee unless waived by CIRC, and findings shall be submitted to CIRC within 5 business days of the review:

- **Completed suicide or death under unusual circumstances**
- **Homicide (perpetrator) resulting in arrest**
- **Homicide (victim) resulting in arrest**
- **Attempted homicide (perpetrator) resulting in arrest**
- **Attempted homicide (victim) resulting in arrest**
- **Incident referred to Medicaid Fraud Control Unit**
- **Allegation of financial exploitation involving consumer**
- **Allegation of financial exploitation involving provider**
- **Assault of consumer by an RSN or subcontracted staff**

Critical incidents listed below may require a formal review by the provider, at the discretion of the provider Quality Committee or CIRC, and findings shall be submitted to CIRC within 5 business days of the review:

- **Allegation of rape (perpetrator)**
- **Allegation of rape (victim)**
- **Allegation of sexual assault (perpetrator)**
- **Allegation of sexual assault (victim)**
- **Nonfatal injury resulting in arrest (perpetrator)**
- **Nonfatal injury resulting in arrest, including suicide attempt (victim)**
- **Arson resulting in arrest**
- **Substantial property damage resulting in arrest**
- **Assault of an RSN or subcontracted staff by consumer resulting in hospitalization**

MHD REPORTABLE CRITICAL INCIDENT REPORTING AND REVIEW REQUIREMENTS

1. **Allegation of rape (perpetrator)**
2. **Allegation of rape (victim)**
3. **Allegation of sexual assault (perpetrator)**
4. **Allegation of sexual assault (victim)**
5. **Nonfatal injury resulting in arrest (perpetrator)**
6. **Nonfatal injury resulting in arrest, including suicide attempt (victim)**
7. **Arson resulting in arrest**
8. **Substantial property damage resulting in arrest**
9. **Assault of an RSN or subcontracted staff by consumer resulting in hospitalization**
10. **Assault of consumer by an RSN or subcontracted staff**
11. **Attempted homicide (perpetrator) resulting in arrest**
12. **Attempted homicide (victim) resulting in arrest**
13. **Homicide (perpetrator) resulting in arrest**
14. **Homicide (victim) resulting in arrest**
15. **Completed suicide or death under unusual circumstances**
16. **Incident referred to Medicaid Fraud Control Unit**
17. **Allegation of financial exploitation involving consumer**
18. **Allegation of financial exploitation involving provider**

Initial notification and any follow-up shall be provided to MHD by NSMHA using the MHD electronic incident reporting system. If the electronic reporting system is unavailable, MHD will provide a standardized form with instructions on how to submit.

NSMHA shall notify the MHD Incident Manager within one working day of becoming aware of a critical incident involving a person who has an open case and is the alleged victim or perpetrator of any of the aforementioned MHD reportable incident types.

ACTIONS TAKEN AFTER A MHD REPORTABLE CRITICAL INCIDENT

Provider:

1. Responds within the requested timeframes (24-hour faxed incident report) and cooperates in other requests for documentation as requested by NSMHA.
2. Conducts a formal internal critical incident review (as required above), following prescribed NSMHA format review template and submits findings within 5 business of review to NSMHA.
3. Ensures that all plans for corrective action following a review or investigation are implemented for quality assurance and improvement and incorporated into all administrative areas as necessary for quality assurance and improvement.

NSMHA Staff Designee:

1. Notifies County Coordinators, NSMHA Board Chair, and NSMHA Executive Director via a blinded copy of the MHD critical incident report. Notification shall occur within 24 hours of NSMHA reception of the provider critical incident report.
2. Notifies MHD via the electronic incident reporting system, or the standardized form if indicated, within 24 hours of NSMHA reception of the provider critical incident report.
3. Tracks critical incidents reported to MHD, maintains log, database and timeline and writes any follow-up reports required. In some instances, initiates region-wide quality improvement activities related to an incident or group of incidents.

CIRC QUALITY IMPROVEMENT PROCESS

1. NSMHA will maintain a Critical Incident Review Committee (CIRC) whose purpose is to review all critical incidents submitted. The NSMHA CIRC membership will include Executive Director/staff designee, Quality Manager, Risk Management Quality Specialist, Adult Care Coordinator Quality Specialist, Child Care Coordinator Quality Specialist and a designated administrative support staff. The CIRC will meet regularly to review all critical incident reports, request written follow-up reports from providers, investigate critical incidents utilizing internal selective reviews and make quality improvement recommendations related to critical incidents to the Quality Manager and department for further appropriate action.
2. During the regularly scheduled CIRC meeting, the Risk Management Quality Specialist will facilitate review and discussion of each new critical incident and critical incidents from previous months on which the committee determined further review was required before proper disposition of the case could be determined
3. During a CIRC review, the committee members shall address each incident in the following context:

    - Does the description of the critical incident and/or subsequent, supplemental information warrant concern about quality or appropriateness of care delivered by the provider?
    - Does the incident report indicate that appropriate action was taken immediately after the incident to lessen or prevent consumer loss or harm?
    - Does the incident report indicate that an appropriate plan for future action has been made to decrease the likelihood of this type of incident occurring again?
    - Can/should any further action be pursued by NSMHA or the provider?

4. When the CIRC members reach a consensus that the critical incident report and any follow-up documentation/information answer the preceding questions satisfactorily, the incident is considered "closed."
5. NSMHA may deem further action is warranted in the case of a particular critical incident or group of incidents. Actions may include but are not limited to:

    a. NSMHA selective review.
    b. Request for provider internal case review.
    c. Request for parts of or complete medical records.
    d. Requests for special meetings or quality initiatives (e.g., Root Cause Analysis) regarding quality concerns involved.
    e. Requests for provider initiated quality assurance and improvement activities based on incidents or groups or types of incidents.
    f. Other requests as deemed necessary.

    Actions taken as a result of the occurrence, results of said actions, additional actions that are planned in the future and efforts that have been undertaken designed to lessen the potential for recurrence shall be reported to CIRC within 21 days of becoming available. A copy of the written report should be sent to the provider Quality Manager.

6. CIRC will develop a summary report and data analysis each biennial quarter. Reports of these quality improvement activities will be distributed to NSMHA Board of Directors, NSMHA Advisory Board, NSMHA Quality Management Oversight Committee (QMOC) and County Coordinators.

ATTACHMENTS

None

North Sound Mental Health Administration	TSK 101-E

CRITICAL INCIDENT REPORT (Extraordinary Occurrences)

To:	Fax Number	FYI – Telephone Numbers
NSMHA	360-428-1068	800-684-3555 or 360-416-7013

Note: Faxed reports must include cover sheet with confidentiality disclosure.

From: (Print name & credentials of staff completing form) _____

Signature of staff completing form: _____

Telephone: _____ **E-mail if Applicable:** _____

Agency: ☐ Compass Health Sno Co. ☐ Compass Health Skagit Co. ☐ Compass Health San Juan Co. ☐ Compass Health Island Co.
☐ North Sound E&T ☐ Snohomish Co. E&T ☐ LWC, clinic ☐ LWC, residential ☐ *bridgeways* ☐ SEA MAR Sno Co.
☐ SEA MAR Whatcom Co. ☐ SEA MAR Skagit Co. ☐ Snohomish Co ITA ☐ VOA ☐ WCPC ☐ CCS Sno Co. ☐ CCS Skagit Co.
☐ CCS Whatcom Co. ☐ Interfaith ☐ Sunrise Sno Co. ☐ Sunrise Skagit Co. ☐ LKI

Location of Incident: _____ County of Incident: _____

Consumer Name: _____ DOB: _____ Age: _____ Consumer ID: _____

Date & Time of Incident: _____ Date & Time Incident Known: _____

Date & Time of Report: _____

CHECK ONE TYPE OF INCIDENT IN TYPE I (non-MHD) <u>OR</u> TYPE II (MHD-REPORTABLE), <u>NOT BOTH</u>:

I. Non-MHD Reportable Critical Incident

Incident Type	
☐ Suicide Attempt (not resulting in charges or pending charges)	☐ Elopement from provider involuntary treatment program
☐ Injury &/or death while in restraint &/or seclusion while an inpatient at a provider involuntary treatment program	NOTE: Injuries are counted as Non-MHD Reportable critical incidents. Deaths are reported to MHD under the category of "Completed suicide or death under unusual circumstances"

Others notified (check all that apply) ☐ DCR ☐ Emergency Medical Services ☐ CPS/APS ☐ Volunteers of America
☐ Provider Executive Director ☐ Provider Clinical Director ☐ Primary Clinician ☐ Provider Quality Manager ☐ Provider Prescriber
☐ Local Law Enforcement ☐ Washington State Patrol

II. MHD Reportable Critical Incident

Incident Type: (Requires formal review by provider unless waived by CIRC. Forward findings to NSMHA)	(Need for formal internal review is determined by provider or CIRC. Forward findings to NSMHA)
☐ Completed suicide, or death under unusual circumstances	☐ Allegation of rape (perpetrator)
☐ Homicide (perpetrator) resulting in arrest	☐ Allegation of rape (victim)
☐ Homicide (victim) resulting in arrest	☐ Allegation of sexual assault (perpetrator)
☐ Attempted homicide (perpetrator) resulting in arrest	☐ Allegation of sexual assault (victim)
☐ Attempted homicide (victim) resulting in arrest	☐ Nonfatal injury resulting in arrest (perpetrator)
☐ Incident referred to Medicaid Fraud Control Unit	☐ Nonfatal injury (including suicide attempt) resulting in arrest (victim)
☐ Allegation of financial exploitation involving consumer	☐ Arson resulting in arrest
☐ Allegation of financial exploitation involving provider	☐ Substantial property damage resulting in arrest
☐ Assault of consumer by staff	☐ Assault of staff by consumer resulting in hospitalization

Others notified (check all that apply) ☐ DCR ☐ Emergency Medical Services ☐ CPS/APS ☐ Volunteers of America
☐ Provider Executive Director ☐ Provider Clinical Director ☐ Primary Clinician ☐ Provider Quality Manager ☐ Provider Prescriber
☐ Local Law Enforcement ☐ Medicaid Fraud Control ☐ Washington State Patrol

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III. Describe the incident: (*Be specific about what happened, to whom, when and where. Include current diagnosis and treatment services. Include relevant witnesses or additional staff/consumers involved, and any attachments as appropriate.*) DO NOT IDENTIFY NAMES OF PEOPLE INVOLVED OTHER THAN THE CONSUMER ON THIS FORM. WHEN IDENTIFYING INVOLVED INDIVIDUALS, USE TITLES OR RELATIONSHIP TO CONSUMER AND AVOID USING NAMES IF POSSIBLE.

IV. Is there essential information you are gathering that is necessary to understanding the critical incident?

☐ **YES** ☐ **NO** - *If yes, please send addendum information to your Quality Manager within 5 business days.*

V. Immediate Action Taken: *(What was done immediately to lessen or prevent consumer loss or harm?)*

VI. **Future Action:** *(What will be done to decrease the likelihood of this type of incident occurring for this &/or other individuals occurring in the future?)*

Management Reviewer (Signature): _____

Title: _____ Date: _____

Quality Manager (Signature): _____ Date: _____

Internal Review: Are there plans for a formal internal review of this incident? ☐ YES ☐ NO
(If YES, submit written findings to NSMHA within 5 business days of the review.)

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CMHA FORMAL INTERNAL REVIEW SUMMARY

Client Name:	**Type(s) of Review:**
Client ID Number:	□ **Clinical Record**
Incident Type:	□ **Death Certificate &/or Toxicity Screen**
Incident Date:	□ **Interview(s) with CMHA Staff**
Reason for Review:	□ **Interview(s) with other agency Staff**
Date of Review:	**Date summary findings sent to NSMHA:**
Diagnosis:	**Types of Services Received:**
	□ Outpatient
	□ Crisis
	□ E &T
	□ Residential
	□ Housing
	□ Psychiatric
	□ Other

DESCRIPTION OF INCIDENT:

CLINICAL DOCUMENTATION: Did documentation in the consumer record meet standards?
□ Yes □ No

SUMMARY OF SERVICES (*leading up to & including the incident*):

SYSTEMS INVOLVED IN INCIDENT:

□ **Hospital**	□ **Criminal Justice**	□ **DSHS**	□ **Family**
□ **DMHP/DCR**	□ **Medical Examiner/Coroner**	□ **CPS/APS**	□ **Other**
□ **Local Law Enforcement**	□ **Paramedic**	□ **DDD**	

CLINICAL CONCLUSIONS:

ACTIONS RESULTING FROM REVIEW:
□ Quality Improvement activity not indicated
□ Quality Improvement activity to be implemented (see plan below)

AREAS FOR QUALITY IMPROVEMENT:
□ Individual Staff
□ Agency-wide

ACTION PLAN FOR IMPROVEMENRT:
Additional data/information needed: □ Yes □No
Describe need:

Who needs to be involved?

System challenges to pursuing these quality improvements:

Signatures:

Date

Print Name & Title:

Date

Print Name & Title:

Date

Print Name & Title:

Date

Print Name & Title:

Quality Management Oversight Committee
Charter *Revision*
Proposed 4/23/08 to begin July 2008, to be reviewed after 6 months in effect

The Quality Management Oversight Committee (QMOC) is a standing committee of the North Sound Mental Health Administration (NSMHA) Board of Directors. It is responsible for the oversight of quality management systems of the entire NSMHA, and for reviewing all quality management activities and making recommendations for quality improvement to the Board. QMOC ensures the gathering and analysis of data and reports to recognize the need for improvement or change (as outlined in the Quality Management Work Plan).

The Quality Management Oversight Committee (QMOC) is chaired by a Member of the Board of Directors (or designated alternate). Two Members of the Board of Directors (or designated alternates) are voting members of QMOC.

Other voting members are:

- Eleven members nominated by the NSMHA Advisory Board, at least three of whom shall be current Advisory Board members, and of the eleven, membership must include a minimum of four current consumers. Facilitation and support will be provided to assist consumers to participate if needed.
- One Ombuds representative
- Three County Coordinators who report QMOC activities to colleague county coordinators who then report to their Advisory Boards
- One representative from each contracted provider who deliver services in each of the five counties.
- In addition, NSMHA would ask our Tribal Committee to appoint a representative to QMOC

Nonvoting member:

- NSMHA's Quality Manager (staff to the committee)

Because of the important role of this Board committee in the oversight of NSMHA's Quality Management program, members of the committee are expected to participate in an orientation session upon joining the committee, attend a majority of meetings unless excused by the Chair, and review all meeting materials. If a QMOC Committee member cannot attend, the designated alternate listed on the Membership list can attend in their place.

At any given meeting where actions are required, a Quorum must be present to vote, with a simple majority of those present being non-provider participants (consumer/advocate/family, Ombuds and County Coordinators). This is both for Coordinated Quality Improvement Program (CQIP) status and to ensure balance.

Members of the Quality Management Oversight Committee are approved annually by the Board of Directors. The Committee meets at least quarterly. Subcommittees of QMOC will meet as often as needed to accomplish their tasks in a timely manner.

The Quality Management Oversight Committee is accountable for:

- Overseeing the development, approval, and evaluation of the biennial NSMHA Quality Management Plan, including its submission to the Board of Directors for adoption, as well as any needed revisions
- Reviewing and recommending action on reports from NSMHA and contracted service providers
- Reviewing data from providers and from NSMHA's measurement tools

- Making recommendations to all providers on actions to be taken for continuous quality improvement
- Reviewing the NSMHA quarterly and biennial quarter (every 6 months) reports related to concurrent/retrospective reviews, consumer and advocate reports and reports on performance indicators; makes recommendations for future service needs
- Establishing ad hoc committees to review issues/concerns that need more time to fully assess and make recommendations
    - All ad hoc committees will include consumer/advocate/family member participation as well as provider participation
- Keeping attendance and minutes of all QMOC and subcommittee meetings

Request: list of Membership from Providers as well as a Designated Alternate