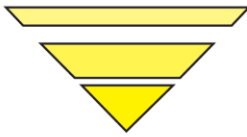


DIVISION OF
**DEVELOPMENTAL
DISABILITIES**



Division Directive Number
3.070
Effective Date: Oct 01, 2008

Bernard Simons

Bernard Simons, Director

Title: Division of DD Consumer Death Notification & Mortality Review Process

Applications: Applies to Department of Mental Health (DMH), Division of Developmental Disabilities Regional Offices & Habilitation Centers.

Purpose: To prescribe procedures for the standardized evaluation of circumstances surrounding the death of a consumer. The purpose of the mortality review is to ascertain whether all necessary and reasonable measures were taken to provide for the health, safety, and welfare of the individual under the responsibility of a DMH provider, and to identify and mitigate any preventable findings that could affect the health, safety, and welfare of other consumers receiving supports and services from DMH.

Policy: This directive establishes a mortality review system that includes an initial and a comprehensive level of review and analysis of the death of individuals receiving supports and services from DMH. This Mortality Review process will provide a clinical and interdisciplinary review that identifies areas where improvement is needed within the service delivery system of the Department of Mental Health. This systematic review will identify measures to be taken to improve supports and services.

Definitions:

Community Event Report Form (CERF) & DMH Facility Event Report Forms: A Department of Mental Health form identifying reportable events and the timelines for reporting such events into the Event Management Tracking (EMT) system by contracted providers and Habilitation Centers to the Department as required by 9 CSR 10-5.206 & DOR 2.220.

Expected Death: Death was anticipated, considered likely or probable given the diagnosis and/or prognosis. Examples may include such circumstances as a consumer receiving hospice services who dies from the terminal condition; multiple and complex chronic medical condition(s) where death may not be imminent but life expectancy was limited and death was foreseen; subsequent to hospitalization due to an existing / known life threatening medical/physical condition.

Mental Health Fatality Review Panel (MHFRP): In accordance with regulation, a Panel of professionals including Mental Health Medical Director or Associate Medical Director, whose function will be to validate appropriate action has been implemented and identify any Department implications to be addressed.

Regional Mortality Review Committee: A panel of professionals at each Regional Office and Habilitation Center that meet to review and complete the Mortality Review document, evaluating all death events of persons enrolled in community placement, residing in state facilities, or who die during receipt of a DMH paid service. They will evaluate to determine if anything unusual or unexpected in manner, timing, or in circumstances occurred; to assure the event was addressed per Department policy and that appropriate preventative action was planned. The Committee may provide recommendations to Administration based on each review.

Root Cause Analysis: A standardized tool and process designed specifically to identify any root or contributing cause/factors in an adverse or sentinel event and to identify opportunities to correct and/or improve our service delivery to achieve better outcomes.

Sentinel Event: A sentinel event is an unexpected occurrence involving death or the risk that reoccurrence of the event would carry a significant chance of an adverse outcome.

Suspicious Death: A death that occurs under questionable circumstances or a death that is related to or is result of an allegation of abuse, neglect, exploitation, or mistreatment.

Unexpected Death: Deaths that occur without warning or are unanticipated. Examples may include such circumstances as sudden cardiac arrest; choking; death of a consumer who otherwise appeared healthy; death as a result of an accident; suicide or homicide; a death which was otherwise unforeseen.

Overview of Process

- Deaths of all Division of DD consumers, regardless of service type, must be reported to the head of the facility or designee immediately when notification is received and entered into the Event Management Tracking (EMT) system within 24 hours or by the end of the next working day.
- A death that occurs under questionable circumstances or as a result of an allegation of abuse, neglect, exploitation, or mistreatment additionally requires an investigation in accordance with Department Operating Regulation 2.210 <http://www.dmh.mo.gov/diroffice/gencounsel/regs/dors/ch2/DOR2.210final8-28-07.pdf> Deaths meeting established criteria will be referred for a Root Cause Analysis and be reviewed by the Division's Central Mortality Review Panel (described above). The head of the facility or designee must immediately notify the District Administrator of all suspicious, unexpected, or high profile deaths, including such deaths referred to another authority for follow-up. The District Administrator or designee shall notify the Division Director of these deaths.
- All deaths of Division of DD consumers who are recipients of state or contracted residential services as well as consumers who die during receipt of a DMH paid service (state or contracted), require a Mortality Review comprised of the Provider's Section, Regional Mortality Review Committee Section, and Executive Review Section by the Division of DD. Such deaths may be referred to, or selected for review by the Mental Health Mortality Review Panel.
- When requested by the Regional Director, Superintendent, or designee, a Mortality Review may be completed for consumers whose death occurred under the supervision of a DMH licensed, certified, or contracted provider, even though the Department of Mental Health was not funding the provider for that consumer's service.
- DD Regional Offices will be the lead facility in performing Mortality Reviews for consumers discharged into community placement from state habilitation centers. However, when a consumer death occurs within 30 days of discharge from a state Habilitation Center to community placement, the Regional Office Mortality Review Committee will include personnel from the discharging Habilitation Center to better review any causal or proximal factors and/or related events and actions involving Habilitation Center performance.
- The **Mortality Review** will include but not be limited to the collection and combination of the following documents for each death event:
 - Event Report of Death
 - Electronic Consumer Death Notification
 - Mortality Review Provider Section & supporting documentation
 - Regional Mortality Review Committee Section & supporting documentation
 - Administrative Action Section
 - DD Executive Level Review Section
 - Death Certificate
 - If applicable, autopsy report (if or when available)
 - If applicable, Root Cause Analysis Report
 - If applicable, Medical and Law Enforcement Documents.

- A **Regional Mortality Review Committee** will function at both the Regional Office and Habilitation Centers for review and analysis of all qualifying deaths in their region. The participants will be designated by the Regional Director or Habilitation Center Superintendent, and will include but not be limited to:
 - Quality Assurance RN or Habilitation Center RN as indicated.
 - Assistant Director of Habilitation (Consumer Relations Lead) or Assistant Superintendent as indicated.
 - Regional Quality Assurance Lead for RO & HC Quality Director or designee for Habilitation Centers.
 - Provider Relations Lead from Regional Offices.
 - For Habilitation Centers, UPS or Habilitation Specialist not associated with the consumer, their residence, unit, or program.
 - Physician or Nurse Practitioner, Senior RN if available within the structure of the organization.

PROCEDURES

The Mortality Review document shall be electronic with each section of the Mortality Review completed by the designated party of Provider, Regional Office or Habilitation Center Administration, and Executive Team within the designated timelines. The following actions are to occur subsequent to a consumer death and are categorized by the responsible party.

State and Contracted Provider Notification & Mortality Review Procedures

Precautionary Action:

- **Immediately**, Providers will ensure necessary and reasonable precautions are taken to secure the safety of others with the identification of conditions or practices requiring immediate intervention in order to protect other individuals from problematic events. Actions taken will be documented on the Event Report and/or within the Provider section of the Mortality Report as appropriate.

Notifications:

- **Immediately** report death of **all** DMH consumers (state facility, natural home and community placement status) to:
 - Guardian/ appropriate family
 - Regional Director / Habilitation Center Superintendent or designee
 - Medical Examiner / Coroner (Required for state Habilitation Centers)
 - Law Enforcement as indicated (Required for state Habilitation Centers)
- **Immediately** complete and submit the “**Community Event Report Form - DMH 9719B**” or “**Habilitation Center Event Form-**” as required for reporting **all** consumer deaths. Designated provider staff will ensure the report is completed in accordance with Department Operating Regulation 4.270 and CSR 10-5.206.

Mortality Review Process, Required Documents, & Instruction for Completion:

- **Within 5 business days**, the provider agency (contract provider and habilitation centers) will complete the Mortality Review section I. entitled “Provider Mortality Review” for all deaths of consumers receiving state or contracted residential services or who die during receipt of any DMH paid service. The provider’s Mortality Review section will be completed by designated **professional level staff** and submitted to the Regional Office or Habilitation Center Superintendent within **5 business days** from date of death unless a documented extension is granted by the Regional Director or HC Superintendent. Extensions should be documented within the Mortality Report.
- **Within the same 5 business days** unless an extension is granted and documented, the Provider agency (contracted and habilitation center) should submit with Section I “Provider Mortality Review”, the following documentation:

- 1) Physician Orders and Medication Administration Records from residential setting at time of death or transfer to hospital or other care facility for the current month and 3 previous months.
- 2) All staff documentation & progress notes (Nurses, Physicians, direct care and/or staffing /observation/ communication notes or logs etc.) for at least 3 days prior to the date of death or transfer to hospital or other care facility.
- 3) Most recently completed Community RN Monthly Summary, including at least three (3) Community RN Monthly Summaries, prior to the death event or transfer.
- 4) All health monitoring records being completed by your organization for this individual such as vital signs, weights, blood pressure, blood sugar, bowel or urine records, Intake/Output etc. for the current month and 3 previous months prior to death event or transfer to hospital or other care facility.
- 5) All medical and behavioral consultation records for 6 months prior to death or transfer of care.
- 6) Documentation of all nursing delegation for this individual performed within a month prior to death event or transfer to hospital or other care facility.
- 7) If ordered, a copy of DMH Non-Hospitalization DNR documentation or Alternative to CPR document.
- 8) Hospital, Emergency Room, and/or Emergency Response reports (Paramedic/EMT/Ambulance/ First Responder etc) occurring within 12 months prior to death event or transfer of care.
- 9) All documents specifically requested by Division of DD.

Regional Office & Habilitation Center **Notification & Mortality Review Procedures**

Precautionary Action:

- **Immediately**, Regional Office and Habilitation Center Administration will assure necessary and reasonable precautions were taken by the provider to secure the safety of others with the identification of conditions or practices requiring immediate intervention to protect other individuals from problematic events. Any additional actions taken by the Regional Office or Habilitation Center Administration will be documented on the Event Report or within the Regional Office/Habilitation center section of the Mortality Report as appropriate.

Notifications:

- **Immediately** upon notification, the Regional Director/Hab Center Superintendent will be notified of **all** consumer deaths.
- **Immediately**, the Regional Director / Habilitation Center Superintendent or designee will determine:
 - If an autopsy is recommended or required and will arrange family/guardian contact to recommend autopsy if applicable. (*see Autopsy Section)
 - If additional information is needed.
 - If the case is to be referred to abuse/neglect investigations unit in accordance with Department operating Regulation 2.205, <http://www.dmh.mo.gov/diroffice/gencounsel/regs/dors/ch2/Dor2.205final8-28-07.pdf> “Abuse and Neglect Definitions, Investigation Procedures and Penalties, State Operated Facilities” or Department Operating Regulation 2.210, <http://dmh.mo.gov/diroffice/gencounsel/regs/dors/ch2/DOR2.210final8-28-07.pdf> “Abuse and Neglect Definitions and Procedures; Community Provider Facilities”.
- **Within one (1) business day**, Regional Director/ Habilitation Center Superintendent will ensure all necessary authorities were notified; documenting contacts and dates in CIMOR-EMT:
 - DMH Director, Division DD Director, and District Administrator are to be notified of all deaths.
 - Appropriate Regional Office and Habilitation Center staff are notified (Quality Assurance, Business Admin, Clinical, Provider and Consumer Relations).
 - Deaths that occur in community ICF/MRs need to be flagged in CIMOR-EMT as such for follow-up by the Investigations Unit.

- Electronic DMH Consumer Death Notification form must be completed and submitted to Central Office Division Director's office.
- Local law enforcement must be notified. The Community Event Report Form should be faxed to the Missouri State Highway Patrol Troop serving that area in which the consumer death occurred, refer to the executive order http://governor.mo.gov/eo/2006/eo06_049.htm; refer to the following web site for troop areas and contact information: <http://www.msdp.dps.missouri.gov/MSHPWeb/Root/index.html>
- Deaths of consumers under the age of 18 must be reported to Department of Social Services' Child Abuse Hotline at 1-800-392-3738.
- Community Event Report Form must be faxed to the Medical Examiner/Coroner for the area in which the consumer death occurred. <http://www.fidnet.com/~ewilson/roster.htm>
- Assure state or contracted provider notified Family/Guardian.

Mortality Review Process, Required Documents, & Instruction for Completion:

- **Within 1 business day from receipt of the EMT**, the Community Event Report Form (DMH 9719B) or Habilitation Center Facility Event Form shall be entered into the CIMOR-EMT database for **all** deaths (1 business day is measured from the date the Regional Office or Habilitation Center administration is notified of the death). A copy of the EMT will be provided to designated QA staff for inclusion in the Division of DD Mortality Review.
- **Upon receipt of the EMT**, the designated Regional Office or Habilitation Center lead Quality Assurance staff will determine need for a Mortality Review in accordance with this Directive. The lead QA staff will coordinate and track the collection of necessary documentation from the provider as well as the overall timelines for the Mortality Review process.
- **Upon receipt of the Provider's Mortality Review Section and required documents**, the **Designated Quality Assurance RN** will prepare the Mortality Review for presentation to the Regional Mortality Review Committee as scheduled. The Mortality Review Committee will complete the identified sections of the report for each individual Mortality Review and submit to Regional Director or HC Superintendent.
- **Upon receipt of the Mortality Review**, the Regional Director/Superintendent will complete the Administrative Review, validating action steps / prevention strategies to be taken, ensuring documented communication with provider, assuring necessary action steps are completed; and assuring the action planned and completion of action are entered into EMT system.
- **Following Administrative Review**, the Regional Office and Habilitation Center shall forward a copy of the completed electronic Mortality Review to the Division of DD Administrator for QA (or designee) for Regional Office cases and the Administrator for Habilitation Center Operations (or designee) for Hab Center cases, for completion of the Executive Level Review. Supporting documentation will be requested when needed.

Regional Mortality Review Committee:

- The Regional Office / Habilitation Center Mortality Review Committee will meet in person **monthly** to review and complete the designated Committee Section on pending Mortality Reviews for their Region or Habilitation Center as applicable.
- The Mortality Review Committee will complete their section of the Mortality Report determining if:
 - there is anything unusual or unexpected in manner, timing, or in circumstances surrounding the death,
 - the death event was handled per Department policy and procedure,
 - the necessary notifications were carried out appropriately and timely,

- the case was appropriately referred to the Abuse & Neglect Investigations Unit or other investigative authorities, as applicable,
 - the case meets criteria to complete a Root Cause Analysis, and
 - appropriate preventative action was planned and executed.
- The completed Mortality Review from Provider and Regional Office or Habilitation Center (includes section I & II) shall be submitted to Central Office Division of DD (Administrator of QA or designee for Regional Office cases and to the Administrator for Habilitation Center Operations or designee for Habilitation Center cases) within **45 business days from the date of the death event** unless an extension is granted by the designated Division Quality Assurance Unit Administrator. All approved extensions should be documented.

Division of DD (Central Office) Procedures

Notifications:

- Within **one business day** from receipt of the Electronic Death Notification, the Division Director's Administrative Assistant or designee will review and distribute the Notification to Division of DD Administrative staff and forward the Electronic Death Notification to Office of General Council (OGC) in accordance with policy. (OGC will notify Missouri Protection & Advocacy and/or State Technical Assistance Team [STAT] for a child fatality review.)

DD Executive Level Review:

- **Executive Mortality Reviews** will be conducted **monthly** and cases will be reviewed at the next available meeting following the referral.
- The Division Director of QA for Regional Offices and Deputy Director of Habilitation Center Operations for Habilitation Centers or their designees will conduct Executive Level Reviews for all Division of DD Mortality Reviews.
- The Executive Review will validate that appropriate action has been implemented and will identify any Department or Division implications to be addressed. The purpose of this review is to ensure that required reviews have occurred; that appropriate rigor and "due diligence" has been brought to bear in the previous review activity; and that appropriate action has been taken. The reviewing Division Administrators may return the case for additional information, close the case, determine a need for a Root Cause Analysis and/or refer the case to the **Mental Health Fatality Review Panel (MHFRP)** as indicated by Department regulation/policy.
- Consultation with the Department's Medical Director or Associate Medical Director should be sought as necessary.
- The Executive Reviewers will refer all Mortality Reviews meeting the following criteria to the Mental Health Fatality Review Panel:
 - At the request of the Division Administrator, Division Director or Department Director, and
 - All Deaths in the following categories
 - Deaths investigated for physical abuse, sexual abuse or maltreatment; and all investigated suspicion of Neglect including but not limited to inadequate supervision, inadequate care, possible malnutrition or dehydration, poisoning, chemical or drug ingestion, and medication error.
 - Suspicious/Criminal activity;
 - Possible suicide;
 - Sudden, suspicious unexplained death; including but not limited to death by:
 - Choking

- Scalding/Burn
- Ingestion of inedible item
- Confinement/Restraint
- Fire
- Drowning
- Firearm

Division Quality Assurance

The Mortality Review shall be maintained as a secured electronic record. Supporting documentation shall be maintained in a secured Division file, separate from the consumer's record.

- **Annually**, Missouri Division data on consumer deaths will be summarized, identifying statewide trends and recommendations. This annual report will be shared with the Division of DD Management Team and incorporated into the Statewide Quality Management Plan as indicated.
- **Quarterly**, Regional QA and Habilitation QA will conduct data Integrity Reviews of CIMOR EMT and applicable databases for Mortality Review information and shall be shared with regions for necessary action.
- **Every 6 months** State QA will review the Mortality Review tracking system and communicate deficiencies with responsible sites. State QA will review 10% or 2 cases, whichever is more, of the Mortality Reviews conducted during the previous 6 months that did not meet the level of referral to the MHFRP, to determine consistency in reviewer reliability and in actions taken.

Autopsies

Autopsy requests can be coordinated with the local Medical Examiner/Coroner's office; or by request of family/ guardian.

- **Habilitation Centers:**
ALL Habilitation Center Deaths will receive an autopsy except expected deaths of individuals with previously identified terminal illness and for which there are not unusual or suspicious circumstances; or as jointly determined by the Superintendent, Administrator of Habilitation Center Operations and DMH Medical Director that an autopsy is not warranted.
- **Community Placement:**
 An autopsy will be requested and paid for by the Department for the deaths of individuals enrolled in DD Community Placement Services and who die during receipt of a DMH state funded service for the following conditions or suspected conditions and/or as requested by Division of DD Administration:
 - Deaths investigated for physical abuse, sexual abuse or maltreatment; and all investigated suspicion of Neglect including but not limited to inadequate supervision, inadequate care, possible malnutrition or dehydration, poisoning, chemical or drug ingestion, and medication error.
 - Suspicious/Criminal activity;
 - Possible suicide;
 - Sudden, suspicious unexplained death; including but not limited to death by
 - Choking
 - Scalding/Burn
 - Ingestion of inedible item

- Confinement/Restraint
 - Fire
 - Drowning
 - Firearm
- The Regional Director, Superintendent, or designee will be responsible to contact the family or guardian when an autopsy is required or recommended. The state will fund requested or required autopsies if applicable.
 - Pending autopsy results should not alter the established timelines. The pending nature of the autopsy may be referenced in the Mortality Review along with any outstanding questions that might be answered by the autopsy report. The report may be amended upon receipt of the final autopsy results if needed.

Root Cause Analysis (RCA)

All state and community provider consumer deaths and surrounding events **may** be subject to a Root Cause Analysis (RCA). The RCA process is designed specifically to identify any root or contributing cause/factors in an adverse event and to identify opportunities to correct and/or improve our service delivery to achieve better outcomes.

Root Cause Analysis is not conducted on every incident of system failure or when the reason is obvious however it may be requested when there are repeated failures that are attributed to human error or when a sentinel event results in death. A sentinel event is an unexpected occurrence involving death or the risk that reoccurrence of the event would carry a significant chance of an adverse outcome.

- RCA's will be completed at the request of Division Administration. RCA's will be completed by designated and trained Division of DD Regional Office and Habilitation Center staff. RCA's are recommended when deaths occur in the following categories or patterns:
 - Deaths investigated for physical abuse, sexual abuse or maltreatment; and all investigated suspicion of Neglect including but not limited to inadequate supervision, inadequate care, possible malnutrition or dehydration, poisoning, chemical or drug ingestion, and medication error.
 - Suspicious/Criminal activity;
 - Possible suicide;
 - Sudden, suspicious unexplained death; including but not limited to death by
 - Choking
 - Scalding/Burn
 - Ingestion of inedible item
 - Confinement/Restraint
 - Fire
 - Drowning
 - Firearm
- The RCA report must be generated and submitted to the Director or Superintendent in accordance with the Division's training curriculum and timelines for Root Cause Analysis. (see separate Division Directive).