

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: MORTALITY REVIEWS POLICY 7.05

Authority: [Chapter 71A RCW](#) *Developmental Disabilities*
[Chapter 388-825 WAC](#) *Developmental Disabilities Services*

Reference: DSHS Administrative Policy 9.01 *Incident Reporting*
DSHS Administrative Policy 9.03 *Administrative Review - Death of a Residential Client*
DDA Policy 9.10 *Client Autopsy*
DDA Policy 12.01 *Incident Reporting and Management for DDA Employees*
DDA Policy 12.02 *RHC Incident Investigations*

PURPOSE

To establish guidelines for mortality reviews following the death of clients of the Developmental Disabilities Administration (DDA). These reviews monitor support systems and program operations to verify if reasonable medical, educational, or psychological interventions were provided to the deceased client. A reasonable intervention is one that would have been possible given known circumstances and available resources. The mortality review described in this policy does not replace procedures conducted by investigative agencies.

SCOPE

This policy applies to all DDA staff and service providers.

DEFINITIONS

Anticipated death means a client died after a new medical condition (such as acute cerebrovascular accident, myocardial infarction, or sepsis) was found and the client's care became palliative. The client may have been transferred to another care setting such as a skilled nursing facility.

Business day means Monday through Friday and excludes Saturday, Sunday, and state and federal holidays.

CRM means the DDA Case Resource Manager.

Expected death means the client died of a chronic condition (such as a chronic heart disease, cancer, dementia, or reoccurring aspiration pneumonia) and their decline in health was addressed. The client may have had a physician's order for life sustaining treatment (POLST) before their final decline and death. This includes a client returning home with a new POLST and palliative care plan.

Initial review means the comprehensive five-day incident report investigation on form [DSHS 16-202](#), conducted by a residential habilitation center (RHC) to determine cause of death, contributing factors, and any concerns that require an independent investigation, such as a State Investigations Unit (SIU) assisted investigation.

Mortality Review Log means a list of client deaths and related details. The Mortality Review Log is stored on a DDA SharePoint site.

Palliative care plan means “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.” See 42 CFR §418.3.

Residential habilitation center (RHC) means a residential facility for individuals with intellectual disabilities or other condition similar to intellectual disability operated by the DDA. RHCs may meet the requirements to be certified as an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or a nursing facility, or both. When an RHC meets the requirements for both, the ICF/IID and nursing facility are separate facilities and have different requirements.

Statewide RHC mortality review means the secondary review of the initial investigation to resolve findings, concerns, or plans of correction. Reviews involve all RHCs, and include peer reviews with nursing, pharmacy, and medical providers. Review findings go to the statewide Mortality Review Team (MRT).

Unexpected death means a death not resulting from a previously diagnosed terminal illness or other debilitating or deteriorating illness or condition where death is anticipated. Examples of an unexpected death may include an accidental death or the client is found deceased, and the cause is determined later by autopsy or medical staff.

Suspicious means there is reasonable cause to believe that either criminal activity or inferior, negligent, or abusive treatment was a factor in the death and the case is under investigation.

POLICY

- A. DDA has established a consistent process for review of all deaths of clients supported by the Administration, as defined in this policy and Attachment A, in an effort to:
 1. Identify factors that may have contributed to the deaths; and

2. Recommend measures to improve supports and services for persons served by DDA.
- B. The DDA Assistant Secretary or designee shall establish and appoint members to the Central Office Mortality Review Team. The Central Office Mortality Review Team must review the information entered in the electronic DDA Mortality Review Log. The Central Office Mortality Review Team includes:
1. Chief, Office of Quality Assurance and Communication;
 2. Chief, Office of Compliance, Monitoring, and Training;
 3. Community Residential Services Unit Representative;
 4. Incident Management Program Manager;
 5. Registered Nurse or Physician;
 6. Statewide Investigations Unit Manager, and
 7. Other program managers or staff, when applicable.

PROCEDURES

- A. Deaths of an individual who resides in a Residential Habilitation Center (RHC)
1. An RHC must follow the procedures and requirements of [DSHS Administrative Policy 9.03](#), *Administrative Review – Death of a Residential Client*.
 2. No more than **seven calendar days** after completion of the RHC five-day incident report investigation, the designated RHC staff reviews the findings and confirms any Plan of Correction or if additional investigations are necessary. The designated RHC staff reviews the report, scans and enters the information into the Mortality Review Log. The RHC must include incident report investigations, plans of correction, and evidence the plans of correction have been implemented.
 3. No more than **14 calendar days** after the information being entered into the Mortality Review Log, the Superintendent or designee must approve the report or request additional information and follow-up. If additional information is requested, the Mortality Review Team chair at Central Office must be notified of the delay.
 4. No more than six weeks after the five-day incident report investigation is completed, the Statewide RHC Mortality Review will be completed.

5. RHC staff must comply with recommendations or findings from the Statewide Mortality Review Team.

B. Type of mortality review required for a client not in an RHC

To determine the type of mortality review required for a client not in an RHC, see Attachment A or the sections below.

1. DDA must conduct a mortality review for a client who received the following services and died while in those services or within **30 days** of transfer or admittance to a long-term care or medical facility from those services:
 - a. Adult family home services;
 - b. Children's intensive in-home behavior services;
 - c. Community ICF/IID services;
 - d. Companion home services;
 - e. Group home services;
 - f. Group training home services;
 - g. Medically intensive children's program services;
 - h. Private duty nursing services;
 - i. Supported living services, including state-operated living alternative (SOLA) services; or
 - j. Voluntary placement services.
2. DDA must conduct a mortality review if a client dies while receiving:
 - a. Children's dedicated respite services
 - b. Community crisis stabilization services;
 - c. County services funded by DDA;
 - d. Diversion bed program services;
 - e. Enhanced respite services;
 - f. Overnight planned respite services; or
 - g. PASRR specialized services in community nursing facilities.
3. The case resource manager (CRM) must consult their regional administrator, or the regional administrator's designee, and the quality assurance manager (QAM) to determine if a mortality review is required when a client dies while:

- a. Receiving alternative living services;
- b. Receiving personal care services in a child foster home; or
- c. In the care of an Individual or Agency provider, such as a personal care or respite care provider.

C. Mortality Reviews

1. The CRM must complete an incident report in accordance with DDA Policy 12.01, *Incident Reporting and Management for DDA Employees*. The CRM must include the nursing care consultant (NCC) and QAM staff on the notification of the incident during the distribution process.
2. The regional QAM will determine if the death meets criteria for review within this policy. The regional QAM will notify the CRM that a mortality review is required, and request they initiate the process. The QAM will enter the initial information into the Mortality Review Log no more than **five business days** after receipt of the death incident report.
3. The CRM will remind the provider that a DDA Mortality Review Provider Report is required, or complete one, as described below.
4. If the client was supported in a residential setting, the client's residential provider must complete [DSHS 10-331](#), *DDA Mortality Review Provider Report*. For children:
 - a. The CRM must complete the *DDA Mortality Review Provider Report* if the child was a Children's Intensive In-Home Behavioral Supports client; or
 - b. The nursing agency must complete the *DDA Mortality Review Provider Report* if the client:
 - 1) Received private-duty nursing; or
 - 2) Was a Medically Intensive Children's Program client.
5. If a client dies while receiving services from a county-contracted service provider, the provider must complete the *DDA Mortality Review Provider Report*.
6. The provider or nursing agency must return the *DDA Mortality Review Provider Report* to the CRM no more than **seven calendar days** after the client's death.
7. No more than **five business days** after the CRM receives the *DDA Mortality Review Provider Report*, the CRM must:

- a. Complete the CRM section at the end of the report;
 - b. Confirm all attachments were provided;
 - c. Request any missing attachments from the provider; and
 - d. Submit the following documents to the regional NCC and copy the QAM and CRM Supervisor:
 - i) [DSHS 10-331](#), *DDA Mortality Review Provider Report*;
 - ii) The incident report submitted by the provider if it contains additional details beyond the CRM incident report; and
 - iii) All documents listed in the *DDA Mortality Review Provider Report*.
8. No more than **14 calendar days** after the NCC receives the report, the NCC must:
- a. Review the report and all attachments;
 - b. Request additional documents from the CRM, if needed;
 - c. Upload the report and all attachments onto the Mortality Review Log;
 - d. Complete the initial mortality review by:
 - i) Requesting the cause of death from the coroner or primary care physician if the cause is unknown;
 - ii) Determining if a plan of correction is needed, and indicating if there are any questions or concerns;
 - iii) Documenting their review in the Mortality Review Log;
 - iv) Notifying the regional QAM that the NCC review is complete; and
 - v) Advising the QAM on whether a regional staffing is needed.
9. No more than **14 calendar days** after the QAM receives notification from the NCC, the QAM must review the Mortality Review Log. The QAM will confirm all necessary attachments were uploaded into the Mortality Review Log.
- a. If there are no recommendations for plans of correction and the NCC has no concerns, the QAM will complete the regional section of the Mortality Review Log and send to the regional administration for review.

- b. If there are recommendations for plans of correction or if the NCC has questions or concerns, the QAM must schedule a regional staffing with the NCC, CRM, and CRM supervisor if appropriate.
 - i) The regional staffing must occur no more than **30 calendar days** after the QAM receives notification from the NCC.
 - ii) The QAM must document findings and recommendations from the regional staffing in the Mortality Review Log and notify the Regional Administrator that the case is ready for review.
- 10. No more than **14 calendar days** after notification from the QAM that the regional staffing is complete, the regional administrator must:
 - a. Review and approve the report in the Mortality Review Log; or
 - b. Request additional information or follow-up from the QAM, and notify the Central Office Mortality Review Team chair of the delay.

F. DDA Central Office Mortality Review Team

- 1. The Central Office Mortality Review Team must schedule a review no more than **30 calendar days** after a client's mortality review was approved in the Mortality Review Log by the RA, Superintendent, or designee.
- 2. The Central Office Mortality Review Team reviews client deaths entered into the statewide Mortality Review Log that:
 - a. Were unexpected;
 - b. Occurred under suspicious circumstances;
 - c. May have involved provider misconduct, abuse, or neglect; or
 - d. Resulted in findings during the regional staffing.
- 3. In conducting its review, the Central Office Mortality Review Team may:
 - a. Review each client's information in the Mortality Review Log;
 - b. Review information in the CARE System, the Incident Reporting System, the client's Individual Instruction and Support Plan (IISP), and other relevant care plans; and
 - c. Identify trends or patterns in order to recommend necessary system changes, policy changes, and training.

4. The Central Office Mortality Review Team may request follow-up from the QAM or RHC. The QAM or RHC must complete the follow-up no more than **30 calendar days** after receiving the request from Central Office. In some circumstances, follow up may be completed by Central Office. Follow-up information will be entered in the Mortality Review Log.
5. If asked to do so, the QAM or RHC must report the results of the mortality review to the client's service providers and case resource manager.
6. The Central Office Mortality Review Team submits an annual report to DDA executive management.
7. For cases not requiring a full Central Office Mortality Review, one of the Central Office Mortality Review Team members will conduct a Quality Assurance review and enter the information in the Mortality Review Log for data collection purposes.

EXCEPTIONS

Any exception to this policy must have the prior written approval of the Deputy Assistant Secretary.

SUPERSESSSION

DDA Policy 7.05

Issued February 15, 2018

Approved: /s/ Deborah Roberts
Deputy Assistant Secretary
Developmental Disabilities Administration

Date: January 1, 2019

Attachment A: *Type of Mortality Review Required*

Attachment B: *Cause of Death Flow Chart*

Attachment C: *Mortality Review Process Flow Chart for Field Staff*

ATTACHMENT A

Type of Mortality Review Required

Program or service	A mortality review is required if the client dies		Type of mortality review required	
	While receiving the service	OR Within 30 days of transfer to a medical or LTC facility from the service	mortality review	Consultation with RA or designee and QAM
Adult Family Homes	X	X	X	
Alternative Living	X			X
Children's Dedicated Respite Services	X			
Children's Intensive In-Home Behavior Services	X	X	X	
Community Crisis Stabilization Services	X		X	
Community ICF/IID	X	X	X	
Companion Homes	X	X	X	
County services funded by DDA (including employment and day program services)	X		X	
Diversion Bed Program Services	X		X	
Enhanced Respite Services	X		X	
Group Homes	X	X	X	
Group Training Homes	X	X	X	
Individual Provider or Agency Provider	X			X
Medically Intensive	X	X	X	

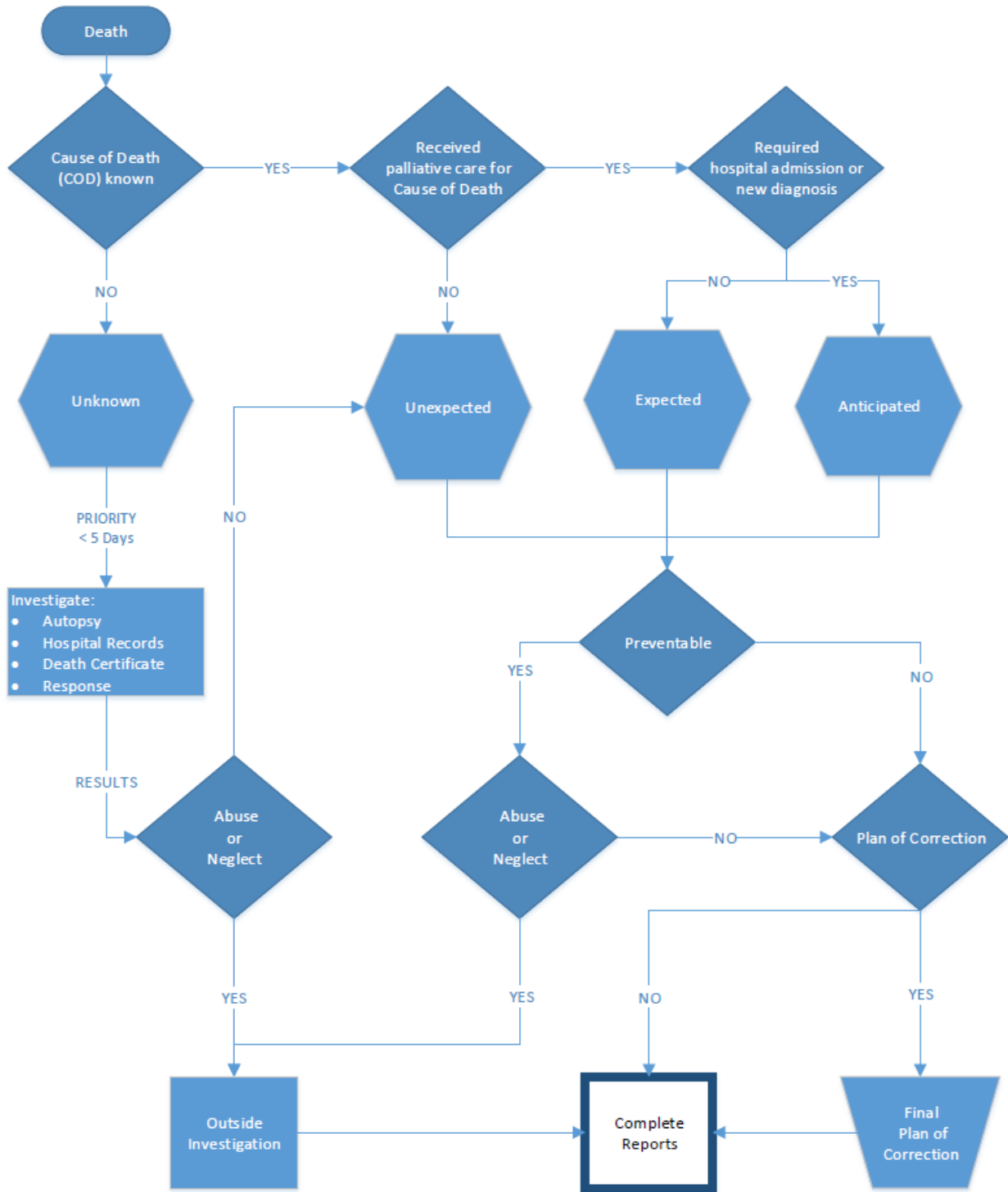
ATTACHMENT A

Type of Mortality Review Required

Children's Program Services			
Overnight Planned Respite Services	X		X
PASRR Specialized Services in community Nursing Facilities	X		X
Private Duty Nursing	X	X	X
Specialized Children's Caseload (reside in foster home and receive personal care)	X		X
Supported Living (including SOLA)	X	X	X
Voluntary Placement Services	X	X	X

ATTACHMENT B

Cause of Death Flow Chart



ATTACHMENT C

Mortality Review Process Flow Chart for Field Staff

