

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 appropriate 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

Administration means the Department of Social and Health Services (DSHS) Developmental Disabilities Administration (DDA).

CRM or SSS means the DDA Case Resource Manager or the Social Service Specialist.

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.

Statewide RHC mortality review means the secondary review of the initial investigation to resolve findings, concerns, or plans of correction. To ensure objectivity, this involves all RHCs, and findings go to the statewide Mortality Review Team (MRT).

Anticipated death is when the acute medical condition deteriorates and the care becomes palliative. This includes hospital care and referrals to hospice care. For RHCs, this is a Category II incident.

Expected death means the client has a Physician's Order for Life Sustaining Treatment (POLST) before the hospitalization or acute illness and decline in health has been addressed. This includes a client returning home with a new POLST and palliative care plan in place. For RHCs, this is a Category II incident.

Unexpected death means a death not resulting from a diagnosed terminal illness or other debilitating or deteriorating illness or condition where death is anticipated. For RHCs, this is a Category I Incident.

Unexpected deaths requiring independent investigation means there is reasonable cause to believe that either criminal activity or inferior, negligent, or abusive treatment was a factor in the death. For RHCs, this would be discovered during review of the care before the hospitalization or findings during the initial Category I or II investigation.

POLICY

- A. DDA has established a consistent process for review of all deaths of clients supported by the Administration, as defined in the Procedures section of 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 (MRT). The MRT must review the information entered in the electronic DDA Mortality Review Log. See Procedures Section E for more information. The MRT includes:
1. Chief, Office of Quality Assurance and Communication;
 2. Chief, Office of Compliance, Monitoring, and Training;
 3. Community Residential Services Program Manager;
 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. Within seven calendar days of the RHC five-day Incident Report Investigation, the designated RHC Administrative staff reviews the findings and confirms any Plan of Correction or if additional investigations are necessary. The designated RHC Administrative staff reviews the report, scans and enters the information into the Mortality Review Log, and includes any Plans of Correction or other documents if there are findings.
3. Within 14 calendar days of the information being entered into the Mortality Review Log, the Superintendent or designee must review and either approve the report or request further information or follow-up. If further information is requested, the Mortality Review Team chair at Central Office must be notified of the delay.
4. The Statewide RHC Mortality Review will review the findings from the five-day Incident Report investigation within six weeks and report to the MRT any additional findings. This includes peer review with nursing, pharmacy, and medical providers - preferably anyone not involved directly in the care.

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 formal mortality review for a client who received the following services and died while in those services, or died within 30 days of transfer or admittance to a long-term care or medical facility:
 - 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 formal mortality review if a client dies while receiving:
- a. Community crisis stabilization services;
 - b. County services funded by DDA;
 - c. Diversion bed program services;
 - d. Enhanced respite services;
 - e. Overnight planned respite services; or
 - f. PASRR specialized services.
3. The case resource manager (CRM) or social service specialist (SSS) must consult their regional administrator (RA) or the RA's designee, and the quality assurance manager (QAM) to determine the type of mortality review 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. Formal Mortality Reviews

- 1. The CRM or SSS must complete an incident report in accordance with DDA Policy 12.01, *Incident Reporting and Management for DDA Employees*.
- 2. If the client was an adult or a child in a residential setting, the client's provider must complete [DSHS 10-331](#), *DDA Mortality Review Provider Report*. For children:

- a. The CRM or SSS must complete the *DDA Mortality Review Provider Report* if the child was a CIIBS client; or
 - b. The nursing agency must complete the *DDA Mortality Review Provider Report* if the client:
 - i. Was a Medically Intensive Children’s Program (MICP) client; or
 - ii. Received private-duty nursing.
 3. The provider or nursing agency must return the *DDA Mortality Review Provider Report* to the CRM or SSS no more than **14 days** after the client’s death.
 4. No more than **seven days** after the CRM or SSS receives the *DDA Mortality Review Provider Report*, the CRM or SSS must complete the section at the end of the report and submit the report to the QAM.
 5. No more than **21 days** after the QAM receives the report, the QAM must:
 - a. Review, scan, and enter the report into the Mortality Review Log;
 - b. Request additional information, if needed; and
 - c. Initiate a regional fact finding review if the client’s death was unexpected.
 6. The *DDA Mortality Review Provider Report* must include:
 - a. Any incident reports from the previous 12 months that include the client;
 - b. Any relevant information in the client’s latest Individual Instruction and Support Plan (IISP) or equivalent; and
 - c. Any other relevant documents or service plans, such as a CIIBS Child and Family Team Care Plan.
 7. No more than 14 days after the QAM enters the report into the Mortality Review Log, the regional administrator must:
 - a. Review and approve the report; or
 - b. Request additional information or follow-up, and notify the Mortality Review Team at central office of the delay.
- D. Consultation with regional administrator and QAM
1. If consultation with the RA or RA’s designee and QAM is required, the consultation must state if:

- a. Follow-up is necessary; and
 - b. A formal mortality review is necessary.
2. The CRM or SSS must document outcomes and justifications from the consultation in the Service Episode Record.

E. Regional Fact Finding Review

In cases where the circumstances of the death were unexpected, and there is reasonable cause to believe that either criminal activity or inferior, negligent, or abusive treatment caused or was a factor in the death, the Region may assemble a “mortality review team” to conduct an additional internal fact finding review and make recommendations for follow up action, as appropriate.

See also [DSHS Administrative Policy 9.03, Administrative Review - Death of a Residential Client.](#)

1. The fact finding review may identify issues in three areas:
 - a. Policy and procedures;
 - b. Clinical support practices; and
 - c. Medical practice.

Note: Specific personnel issues must be addressed separately.
2. The regional mortality review team must review its preliminary fact finding report with an Assistant Attorney General.
3. Upon completion, the regional mortality review team scans and uploads its fact finding report and recommendations to the Mortality Review Log.
4. Additionally, if the RA or designee develops an action plan, a copy of this plan must be scanned and uploaded to the Mortality Review Log within ten working days of completion of the plan.

F. DDA Central Office Mortality Review Team

1. The Central Office Mortality Review Team will review all client deaths entered into the statewide Mortality Review Log.
2. In conducting its review, the MRT will:
 - a. Review each individual’s mortality review information in the Mortality Review Log;

- b. Review data from the CARE System, Individual Instruction and Support Plan (IISP) as applicable, and the Incident Reporting System;
- c. Identify any trends or patterns;
- d. Make recommendations concerning needed training, policy changes, and other related issues;
- e. Submit an annual report to DDA executive management;
- f. Schedule its review within 30 calendar days of the individual's mortality review being approved by the RA, Superintendent or designee, in the Mortality Review Log. The QAM will be notified of any needed follow up via email from the Chief, Office of Quality Assurance and Communication, or designee. Follow-up by the QAM or RHC must be completed and communicated within 30 days of the request. In some circumstances, follow up may be completed by Central Office staff. The results will be entered in the Mortality Review Log; and
- g. The Regional QAM or RHC will provide any necessary follow up information and the results of the mortality review with the CRM or SSS and the service provider.

EXCEPTIONS

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

SUPERSESSION

DDA Policy 7.05
Issued October 15, 2017

Approved: /s/Donald Clintsman
Deputy Assistant Secretary
Developmental Disabilities Administration

Date: February 15, 2018

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	Formal mortality review	Consultation with RA or designee and QAM
Adult Family Homes	X	X	X	
Alternative Living	X			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 Children's Program Services	X	X	X	

ATTACHMENT A

Type of Mortality Review Required

Overnight Planned Respite Services	X		X	
PASRR Specialized Services	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	