

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

This policy establishes guidelines for the review of clients of the Developmental Disabilities Administration (DDA) who were receiving certain paid services within 60 days of their death or transfer to a medical or long-term care facility. 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 applicable service providers. This policy applies to clients who received services in the following programs or settings within 60 days of their death or transfer to a medical or long-term care facility:

- Adult Family Homes (AFH);
- Children’s Intensive In-home Behavioral Support (CIIBS) services;
- Community Crisis Stabilization Services (CCSS);
- Community Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID);
- Companion Homes (CH);

- County Programs funded by DDA, including employment and day program services, when the death occurs during employment or day program services;
- Certified Residential Services, which includes Supported Living (SL) and State-Operated Living Alternatives (SOLA) programs, Group Homes (GH), Group Training Homes (GTH);
- Diversion Bed Programs;
- Children’s Licensed Staffed Residential Homes;
- Licensed Child Foster Homes;
- Licensed Children’s Group Care Facilities;
- Medically Intensive Children’s Program (MICP) nursing agencies;
- Overnight Planned Respite Services for Adults;
- Preadmission Screening Resident Review (PASRR), when the death occurs during participation in a PASRR Specialized Service;
- Private-Duty Nursing (PDN); and
- Residential Habilitation Centers (RHCs).

DEFINITIONS

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

CRM/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, 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 (MRL), and includes any Plans of Correction or other documents if there are findings.

4. 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.
5. 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. Death within 60 days of transfer to a facility or receipt of a paid service

1. The CRM/SSS must follow procedures under Section C if an adult client dies within 60 days of transfer to a medical or long-term care facility or receipt of any of the following services:
 - a. Supported Living Services (including State-Operated Living Alternatives), Adult Family Homes, Companion Homes, Group Homes, or Group Training Homes;
 - b. Services in a Community ICF/IID; or
 - c. Private-Duty Nursing.
2. The CRM/SSS must follow procedures under Section C if a client age 21 or younger dies within 60 days of transfer to a medical or long-term care facility or receipt of any of the following paid services:
 - a. Residential services in a Children's Licensed Staffed Residential Home, Licensed Child Foster Home, or Licensed Children's Group Care Facility;
 - b. Medically Intensive Children's Program Services; or
 - c. Children's Intensive In-Home Behavior Services.
3. The CRM/SSS must follow procedures under Section C if a client dies while receiving:
 - a. County services funded by DDA, including employment and day program services;

- b. Community Crisis Stabilization Services;
 - c. Diversion Bed Program Services;
 - d. Overnight Planned Respite Services; or
 - e. PASSRR Specialized Services.
- C. Process for death within 60 days of transfer to a facility or receipt of a specific service
- 1. The CRM/SSS must complete an incident report according to [DDA Policy 12.01](#), *Incident Reporting and Management for DDA Employees*.
 - 2. The CRM/SSS will notify the provider regarding the provider's responsibility to complete [DSHS 10-331](#), *DDA Mortality Review Provider Report*.
 - 3. The provider must send the mortality report to the CRM/SSS within 14 calendar days of the client's death. The following exceptions apply:
 - a. If the death occurs while a child is being served under the CIIBS waiver, the CRM/SSS completes the report; and
 - b. If the death occurs while a child is being served in the Medically Intensive Children's Program (MICP), the nursing agency completes the report.
 - 4. Within seven calendar days of receipt of the provider's report, the CRM /SSS reviews the report, completes the CRM section at the end of the report, and sends it to the regional Quality Assurance Manager (QAM) or designee.
 - 5. Within 21 calendar days of receipt of the report, the QAM reviews the report, and scans and enters the information into the Mortality Review Log. If additional information is needed, the QAM requests it. If the death was unexpected, refer to Section E of this policy. The QAM will notify the Regional Administrator when it is ready for review and approval.
 - 6. The report must include copies of incident reports from the previous 12 months, other relevant documents, and pertinent information contained in the latest Individual Instruction and Support Plan (IISP) or other pertinent service plans (e.g., CIIBS Child and Family Team Care Plan).
 - 7. Within 14 calendar days of the information being entered into the Mortality Review Log, the Regional Administrator will 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 should be notified of the delay.

D. Death of a client who lives in a setting other than those described in Sections A and B above

1. The CRM/SSS will file an incident report according to [DDA Policy 12.01, Incident Reporting and Management for DDA Employees](#).
2. If the death occurred when the client was in the care of an Individual or Agency Provider (e.g., Personal Care or respite care provider) or Alternative Living program, the CRM/SSS must consult with the RA or designee and the QAM to determine whether additional follow up is warranted. This also includes children on the specialized caseload who reside in a child foster home setting and receive personal care services. The outcome of this consultation and the justification for the decision on whether or not to request a mortality review must be documented in the DDA incident report.
3. If the death was unexpected, refer to Section E of this policy.

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 60 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/SSS and the service provider.

EXCEPTIONS

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

SUPERSESION

DDA Policy 7.05
Issued March 1, 2016

Approved: /s/ Donald Clintsman Date: October 15, 2017
Deputy Assistant Secretary
Developmental Disabilities Administration