Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: MORTALITY REVIEWS POLICY 7.05

Authority:	Title 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 5.13	*Protection from Abuse: Mandatory Reporting*
	DDA Policy 9.10	*Client Autopsy*
	DDA Policy 12.01	*Incident Reporting and Management for DDA Employees*
	DDA Policy 12.02	*RHC Incident Investigations*
	DDA Policy 12.04	*Youth Transitional Care Facility Incident Investigations*

PURPOSE

To establish mortality review procedures following the death of a client.

The mortality review described in this policy does not replace procedures conducted by investigative agencies.

SCOPE

This policy applies to all DDA staff.

DEFINITIONS

Client means a person who has a developmental disability as defined in RCW 71A.10.020 and has been determined DDA-eligible under Chapter 388-823 WAC. For the purposes of this policy, "client" includes a youth, regardless of DDA eligibility, who is receiving specialized services at a Youth Transitional Care Facility.

Corrective action plan refers to actions that must be taken after an RHC or Youth Transitional Care Facility incident investigation reveals a potential threat to clients at the facility whether or not actual abuse, neglect, or mistreatment is confirmed.

CRM means the DDA case resource manager.

Death

- **Expected death** means a death resulting from a diagnosed terminal illness or other debilitating or deteriorating illness or condition where death is anticipated.

- **Suspicious** means there is no medically reasonable explanation for the cause of death, or it is possible that criminal activity, substandard care, negligence, or abusive treatment may have caused or was a factor in the death.

- **Unexpected death** means a death not resulting from a diagnosed terminal illness or other debilitating or deteriorating illness or condition where death is anticipated.

Investigation means the comprehensive five-day incident report investigation conducted in a RHC or ten-day incident report investigation conducted by the Youth Transitional Care Facility. This investigation is conducted by the Statewide Investigation Unit or internally by the RHC or Youth Transitional Care Facility according to Policies 12.02 and 12.04.

Mortality review log means a list of client deaths and related details. The Mortality Review Log is stored on a DDA SharePoint site and is only available to select staff.

Peer review means the review of a client death by a healthcare professional who is not the primary care professional who served the client.

Reasonable intervention means an action that would have been possible given known circumstances and available resources.

Regional follow-up plan means a document that lists one or more actions the region identifies as an opportunity for improvement. A follow-up plan is focused on internal DDA functions, such as assigning tasks to CRMs, regional QA staff, and others. A plan may also include internal DDA functions to support service providers and clients by providing information or recommending other available resources and services that may be available.

Residential habilitation center or **RHC** means a state-operated facility under RCW 71A.20.020, which may be certified as a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Working day means Mondays through Fridays, excluding state and federal holidays.

Youth Transitional Care Facility means the staff-secure and voluntary facility offering specialized treatment for suitable youth.

POLICY

A. The mortality review process is intended to:

1. Ensure timely reporting of all client deaths.

2. Evaluate whether clients received the care and services they required for their identified needs in accordance with applicable rules and DDA policies.

3. Develop, implement, and monitor corrective actions or regional follow-up tasks to address identified issues that may immediately impact the quality of life and services for DDA clients.

4. Analyze data for trends and patterns that may identify areas of potential system improvement.

5. Recommend measures to improve supports and services for clients.

B. Central Office Mortality Review Team

1. The Central Office Mortality Review Team must;

a. Review deaths to identify trends or patterns;

b. Ensure all corrective actions or regional follow-up tasks are completed;

c. Make recommendations for continued review, if necessary; and

d. Recommend systemic changes, which may include policy changes or training.

2. The Central Office Mortality Review Team includes:

a. Health Services Director (Physician);
b. Mortality Review Coordinator;
c. Quality Assurance Representative;
d. Incident Management Program Manager;

e. Registered Nurse;
f. Statewide Investigations Unit Representative; and
g. Other program managers or staff, when applicable.

C. Clinical Mortality Committee

1. The Clinical Mortality Committee must:

a. Review each completed Mortality Review;

b. Analyze the clinical information available; and

c. Make recommendations to the Clinical Mortality Committee for DDA systemic interventions, trainings, or tracking that might increase the quality of care or reduce negative outcomes for DDA clients.

2. The Clinical Mortality Committee is facilitated by the Mortality Review Coordinator and includes:

a. Health Services Director;

b. Nursing Services Unit Manager; and

c. Other clinicians or healthcare professionals as deemed appropriate by the Health Services Director.

PROCEDURES

A. Mortality Reviews: Residential Habilitation Centers

1. The RHC must conduct a mortality review for clients who died:

a. While admitted to the RHC; or

b. Within 30 days of discharge, transfer, or admittance to a long-term care or medical facility.

2. In addition to following requirements in this policy, Residential Habilitation Centers must follow the procedures and requirements under DSHS Administrative Policy 9.03*, Administrative Review – Death of a Residential Client*, and DDA Policy 9.10*, Client Autopsy.*

3. No more than **5 working days** after the client's death, the RHC must complete an internal investigation according to DDA Policy 12.02, *RHC Incident Investigations*. The investigation report must be reviewed by an RHC employee who was not involved in the client's care. This review must be documented and attached to DSHS 16-202, *5-Day Investigation Report.*

4. No more than **14 calendar days** after the completion of the 5-day investigation, the RHC must convene a team to:

   a. Review findings from the investigation;
   b. Determine a follow-up plan for each identified finding; and
   c. Determine if additional investigations are necessary.

5. Reviews typically involve the RHC Quality Assurance Director, Area Director, Medical Director, Director of Nursing, Pharmacy Director, and Superintendent or designee.

6. No more than **7 calendar days** after the RHC team review, a designated RHC employee must enter the information, findings, and recommendations into the Mortality Review Log. The RHC must upload the following documents into the Mortality Review Log related to the client's death:

   a. Incident report;

   b. Internal investigation report, including;

      i. Supporting documents; and
      ii. Corrective Action Plan (if needed);

   c. Medical, nursing, and pharmacy staff findings (if applicable);

   d. Any other pertinent information; and

   e. Evidence the corrective action plan has been implemented or at least initiated.

   Note: Documents should be saved with file names that are easily identifiable by the reader (e.g., "Internal Investigation (Client Name)").

7. No more than **14 calendar days** after the information is entered into the Mortality Review Log, the RHC Superintendent or designee must review and approve the report in the Mortality Review Log 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.

B. Mortality Reviews: Youth Transitional Care Facilities

1. Youth Transitional Care Facilities must conduct a mortality review for a youth who died:

   a. While admitted; or

   b. Within 30 days of discharge, transfer, or admittance to a long-term care or medical facility.

2. Youth Transitional Care Facility staff must follow the requirements under DSHS Administrative Policy 9.03, *Administrative Review – Death of a Residential Client*, and DDA Policy 9.10, *Client Autopsy*.

3. No more than **10 working days** after the client's death, Youth Transitional Care Facilities must complete an internal investigation according to DDA Policy 12.04, *Youth Transitional Care Facility Incident Investigations*. The investigation report must be reviewed by a Youth Transitional Care Facility employee who was not involved in the client's care. This review must be documented and attached to DSHS 16-202B, *10-Day Investigation Report*.

4. No more than **14 calendar days** after the completion of the 10-day investigation, the Youth Transitional Care Facility Executive Officer or designee must convene a team to complete an internal Mortality Review, including:

   a. Review findings from the investigation;
   b. Determine a follow-up plan for each identified finding; and
   c. Determine if additional investigations are necessary.

5. No more than **7 calendar days** after completing the internal Mortality Review, the Youth Transitional Care Facility Executive Officer or designee must enter the information, findings, and recommendations into the DDA Mortality Review Log. The Youth Transitional Care Facility must upload the following documents into the Mortality Review Log related to the youth's death:

   a. Incident report;

   b. Internal investigation report, including:

i. Supporting documents; and
ii. Corrective Action Plan (if needed);

c. Medical, nursing, and pharmacy staff findings (if applicable);

d. Any other pertinent information; and

e. Evidence the corrective action plan has been implemented or initiated.

6. No more than **14 calendar days** after the information is entered into the Mortality Review Log, the Executive Officer or designee must review and approve the report in the Mortality Review Log 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.

C. Mortality Reviews: Field Services Scope

1. Field services must review client deaths as outlined below. RHC and Youth Transitional Care Facility clients do not require a separate review by field services.

2. To determine the type of mortality review required for a client not in an RHC or Youth Transitional Care Facility, see Attachment C or the sections below.

3. DDA must conduct a mortality review for a client who received the following services at time of death, or within **30 calendar days** of transfer or admittance to a long-term care or medical facility following receipt of these services:

a. Adult family home;
b. Assisted living facility;
c. Children's intensive in-home behavior support;
d. Intensive habilitation services for children;
e. Medically intensive children's program;
f. Private duty nursing;
g. Stabilization, Assessment, and Intervention Facility;
h. Residential habilitation services from one of the following providers:

i. Companion home;
ii. Group home;
iii. Group training home;
iv. Out-of-home services provider;
v. Supported living;
vi. State-operated living alternatives for adults and children.

4. DDA must conduct a mortality review if a client dies while a provider is delivering:

   a. Children's dedicated respite services;
   b. County services funded by DDA;
   c. Diversion bed program services;
   d. Enhanced respite services; or
   e. Overnight planned respite services.

5. The case resource manager (CRM) must consult with their regional quality assurance manager (QAM), who must consult with a regional administrator or designee, to determine if a mortality review is required when a client dies:

   a. While receiving:

      i. Services from an alternative living provider;

      ii. Care in an assisted living facility (including adult residential care (ARC) facilities and enhanced adult residential care facilities (EARC));

      iii. Personal care services in a child foster home;

      iv. PASRR specialized services in community nursing facilities;

   b. In the care of an individual or agency provider, such as a personal care or respite care provider;

   c. While enrolled in the Enhanced Case Management Program; or

   d. The death is suspicious or unusual.

D. Mortality Reviews: Field Services Process

1. The CRM must:

   a. Complete an incident report in accordance with DDA Policy 12.01, *Incident Reporting and Management for DDA Employees;* and

   b. Include the regional nursing care consultant (NCC) and QAM staff on the notification of the incident during the distribution process.

2. The regional QAM must:

   a. Determine if the death meets criteria for a mortality review;

   b. Notify the CRM or regional performance and quality improvement specialist (PQIS) if a mortality review is required, and request that they initiate the mortality review process; and

   c. Enter the initial information into the Mortality Review Log no more than **7 calendar days** after receipt of the death incident report.

3. No more than **7 calendar days** after the client's death, the provider or designee identified in Attachment C, *Type of Mortality Review Required*, must submit to the CRM a completed DSHS 10-331, *DDA Mortality Review Provider Report*.

   Note: For adult family homes or assisted living facilities, the PQIS or CRM may request information from the provider to complete the review. The provider is not required to participate.

   Note: For employment and day programs, this is required only if the client dies while **actively participating** in Supported Employment or Community Inclusion services.

4. No more than **7 calendar days** after the CRM receives DSHS 10-331, the CRM must:

   a. Review DSHS 10-331;

   b. Confirm all attachments listed in the DSHS 10-331 were provided and review each;

   c. Request any missing documents from the provider, unless the provider is an Adult Family Home or Assisted Living Facility; and

   Note: DSHS 10-331 completed by PQIS or CRM for clients in Adult Family Homes or Assisted Living Facilities is considered complete when received from PQIS or CRM.

   d. Complete and sign the CRM section at the end of the report;

e. Submit the following documents to the regional NCC and copy the QAM and CRM Supervisor:

i. DSHS 10-331;

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 attachments section of the DSHS 10-331.

f. If the NCC has questions or needs additional documents for their review, the NCC will request assistance from the CRM. The CRM must follow-up with the provider and respond to the NCC, within **7 calendar days**.

5. No more than **14 calendar days** after the regional NCC receives the completed report and requested attachments, the NCC must:

a. Initiate the DDA provider mortality review in SharePoint. The review should include a review of all available information from DSHS 10-331, the DDA Incident Report database, the DDA CARE tool, and any supporting information collected during the review.

b. Request additional documents from the CRM, if needed to complete the Mortality Review

c. Request the cause of death from the coroner or medical examiner if an autopsy was performed or if they completed the death certificate;

d. Upload the attachments and complete the entry into the Mortality Review Log;

e. Notify APS, CPS, or CRU according to DDA Policy 5.13, *Protection from Abuse: Mandatory Reporting*, when there are suspicions of abuse or neglect.

f. Notify the regional QAM via email whenever there is an update to the NCC review or when the review is complete. This email must indicate if the draft or completed version includes quality improvement opportunities, a potential for abuse or neglect, or if the NCC has concerns related to the cause of death;

g. The NCC must alert the QAM if there is a delay during the process and the review will not be submitted on time.

6. No more than 14 calendar days after the QAM receives notification from the NCC, the QAM must:

a. Review the Mortality Review Log and confirm:

i. The review was completed in its entirety; and
ii. All necessary documents were uploaded.

b. Facilitate the development of a regional follow-up plan for any opportunities for quality improvement with the NCC, the CRM, the CRM Supervisor, and any other staff or providers at the discretion of the QAM.

c. Complete the regional section of the Mortality Review Log.

d. The QAM will notify the regional administrator that the case is ready for review and approval.

e. If additional recommendations occur prior to the completion of the review due to previously unknown information, the QAM will review the new information.

7. No more than 14 calendar days after notification from the QAM that a regional follow-up action plan is complete and available for review, the regional administrator must:

a. Review and approve the recommended regional follow-up 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.

E. The Clinical Mortality Committee

1. The Clinical Mortality Committee must schedule a routine meeting at least every 30 calendar days to review cases when:

a. A Field Service client's mortality review was finalized by the NCC and approved in the Mortality Review Log by the RA, Administrator, or designee;

b. An RHC client's mortality review was approved by the Superintendent or designee; or

c. A Youth Transitional Care Facility client's mortality review was approved by the Executive Officer or designee.

2. The Clinical Mortality Committee meetings will consist of:

a. A clinical review of each completed Mortality Review.

i. For cases where no recommendations were made during the initial regional, RHC, or Youth Transitional Care Facility review, a quality assurance review with at least one licensed physician will occur to categorize the cause of death. This review may not require a full review by the clinical team.

ii. For all other cases:

A) Determine whether or not to approve the final review. If not, the team will determine the conditions that should be met to approve the review.

B) Determine any recommendations for DDA interventions, trainings, or quality assurance activities that might increase the quality of care or reduce the negative outcomes for DDA clients related to the case.

C) Categorize the cause of death from the information available.

b. A review of mortality review data and trends. The team may make additional general recommendations for DDA interventions, trainings, or quality assurance activities due to any trend analysis completed by the team.

F. DDA Central Office Mortality Review Team

1. The Central Office Mortality Review Team will meet monthly to review the overall Mortality Review process at all levels.

2. The Central Office Mortality Review Team will have three primary purposes:

a. A review of the Mortality Review Log for procedural compliance, including:

   i. Checking for timely completion of each stage of the review process.

   ii. Ensuring that the Mortality Review Log is complete as required for each stage of the review process.

   iii. Requesting action or follow-up from the regions, Youth Transitional Care Facility, or RHCs about any identified concerns or questions.

b. A comprehensive final review of all Mortality Reviews that have been approved for completion by the Clinical Mortality Committee as well as all regional follow-up reports that are marked as complete.

   i. This will include a review of the timeliness of the Mortality Review process and an overview of the identified opportunities for improvement, findings from investigations, and regional follow-ups.

   ii. The team will also review the recommendations from the Clinical Mortality Committee and document a response.

   iii. The team will consider any additional follow-up or recommendations that are necessary. If no further action is determined necessary, the Mortality Review will be closed.

c. Trend analysis of deaths and regional follow-up. This trend analysis will focus on:

   i. Processes: Review of common inconsistencies or problems with adherence to the requirements of any portion of this policy or any associated policy. This may result in necessary system changes, policy changes, and training.

   ii. Outcomes: Review of common causes or contributing factors of death. This may result in identifying opportunities for system interventions to prevent or reduce deaths of DDA clients through system changes, policy changes, client and provider education, and training.

3. If asked to do so, the regional QAM or facility must report the results of the mortality review to the client's service providers and case resource manager.

4. The Central Office Mortality Review Team submits an annual report to DDA executive management and makes an annual report available to the public.

EXCEPTIONS

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

SUPERSESSION

DDA Policy 7.05
Issued August 15, 2023

Approved: _____ Date: July 1, 2024
Deputy Assistant Secretary
Developmental Disabilities Administration

Attachment A: *Type of Mortality Review Required*
Attachment B: *Mortality Review Process for Field Staff*
Attachment C: *Mortality Review Process for RHCs*
Attachment D: *Mortality Review Process for Youth Transitional Care Facility*

	A mortality review is required if the client dies		Type of mortality review required		
Program or service	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	DSHS 10-331 completed by
Adult Family Homes	X	X	X		PQIS or CRM
Alternative Living	X			X	Provider or CRM
Assisted Living Facilities				X	PQIS or CRM
Children's Intensive In-Home Behavior Services	X	X	X		CRM
Companion Homes	X	X	X		Provider
County services funded by DDA (including employment and day program services)	X		X		County-contracted provider
Diversion Bed Program Services	X		X		Provider
Enhanced Respite Services	X		X		Provider
Group Homes	X	X	X		Provider

	A mortality review is required if the client dies			Type of mortality review required		
Program or service	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	DSHS 10-331 completed by
Group Training Homes	X		X	X		Provider
Individual Provider or Agency Provider	X				X	Provider
Intensive Habilitation Services	X			X		Provider
Out-of-Home Services	X		X	X		Provider
PASRR Specialized Services in Community Nursing Facilities	X			X		CRM
Private Duty Nursing	X		X	X		Nursing agency
Residential Habilitation Center	X		X	X		RHC
Specialized Children's Caseload (reside in foster home and receive personal care)	X				X	CRM

	A mortality review is required if the client dies			Type of mortality review required		
Program or service	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	DSHS 10-331 completed by
State-Operated Community Residential Services	X		X	X		Provider
Supported Living	X		X	X		Provider